



**Community BlueSM PPO
Benefits-at-a-Glance for
46629/200/201/202/203/204/205**

HOPE COLLEGE – Plan Orange

This is intended as an easy-to-read summary. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

In-network

Out-of-network

Deductible, copays and dollar maximums

Note: Services from a provider for which there is no PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Deductible	\$250 for one member, \$500 for the family each benefit year Note: Deductible waived if service is performed in a PPO physician's office.	\$500 for one member, \$1,000 for the family each benefit year Note: Out-of-network deductible amounts also apply toward the in-network deductible.
Copays • Fixed dollar copays	\$20 for office visits and \$75 for emergency room visits and \$50 for ambulance services	\$75 for emergency room visits and \$50 for ambulance services
Copay dollar maximums • Fixed dollar copays • Percent copays – excludes mental health care, substance abuse treatment and private duty nursing copays	None \$1,500 for one member, \$3,000 for two or more members each benefit year	None \$2,500 for one member, \$5,000 for two or more members each benefit year Note: Out-of-network copays also apply toward the in-network maximum.
Dollar maximums	\$1 million lifetime per covered specified human organ transplant type and a separate \$5 million lifetime per member for all other covered services and as noted for individual services	

Preventive care services

Health maintenance exam – includes chest x-ray, EKG and select lab procedures	Covered – 100%, one per calendar year	Not covered
Gynecological exam	Covered – 100%, one per calendar year	Not covered
Pap smear screening – laboratory and pathology services	Covered – 100%, one per calendar year	Not covered
Well-baby and child care	Covered – 100% • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics	Covered – 100%	Not covered
Adult immunizations	Covered – 100%	Not covered
Fecal occult blood screening	Covered – 100%, one per calendar year	Not covered
Flexible sigmoidoscopy exam	Covered – 100%, one per calendar year	Not covered
Routine colonoscopy	Covered – 100%	Not covered
Prostate specific antigen (PSA) screening	Covered – 100%, one per calendar year	Not covered

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

bcbsm.com



In-network

Out-of-network

Mammography

Mammography screening	Covered – 100%	Covered – 70% after deductible
	One per calendar year, no age restrictions	

Physician office services

Office visits	Covered – \$20 copay	Covered – 70% after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 90% after deductible	Covered – 70% after deductible, must be medically necessary
Office consultations	Covered – \$20 copay	Covered – 70% after deductible, must be medically necessary
Urgent care visits	Covered – \$20 copay	Covered – 70% after deductible, must be medically necessary

Emergency medical care

Hospital emergency room	Covered – \$75 copay, waived if admitted	Covered – \$75 copay, waived if admitted
Ambulance services – must be medically necessary	Covered – \$50 copay	Covered – \$50 copay

Diagnostic services

Laboratory and pathology services	Covered – 90% after deductible	Covered – 70% after deductible
Diagnostic tests and x-rays	Covered – 90% after deductible	Covered – 70% after deductible
Therapeutic radiology	Covered – 90% after deductible	Covered – 70% after deductible

Maternity services provided by a physician

Prenatal and postnatal care	Covered – 100%	Covered – 70% after deductible
	Includes care provided by a certified nurse midwife	
Delivery and nursery care	Covered – 90% after deductible	Covered – 70% after deductible
	Includes delivery provided by a certified nurse midwife	

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	Covered – 90% after deductible	Covered – 70% after deductible
	Unlimited days	
Inpatient consultations	Covered – 90% after deductible	Covered – 70% after deductible
Chemotherapy	Covered – 90% after deductible	Covered – 70% after deductible

Alternatives to hospital care

Skilled nursing care	Covered – 90% after deductible	Covered – 90% after deductible
	Up to 120 days per calendar year	
Hospice care	Covered – 100%	Covered – 100%
	Limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – must be medically necessary	Covered – 90% after deductible	Covered – 90% after deductible
Home infusion therapy – must be medically necessary	Covered – 90% after deductible	Covered – 90% after deductible

Surgical services

Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	Covered – 90% after deductible	Covered – 70% after deductible
Presurgical consultations	Covered – 100%	Covered – 70% after deductible
Colonoscopy diagnostic	Covered – 90% after deductible	Covered – 70% after deductible
Voluntary sterilization	Covered – 90% after deductible	Covered – 70% after deductible
Bariatric Surgery	Covered – 50% after deductible	Covered – 50% after deductible



In-network

Out-of-network

Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100% Limited to \$1 million lifetime maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	Covered – in designated facilities only
Bone marrow – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 90% after deductible	Covered – 70% after deductible
Specified oncology clinical trials	Covered – 90% after deductible	Covered – 70% after deductible
Kidney, cornea and skin	Covered – 90% after deductible	Covered – 70% after deductible

Mental health care and substance abuse treatment

Inpatient mental health care	Covered – 80% after deductible 60 days per calendar year with lifetime maximum of 120 days	Covered – 80% after deductible
Inpatient substance abuse treatment	Covered – 50% after deductible 60 days per calendar year with lifetime maximum of 120 days	Covered – 50% after deductible
Outpatient mental health care • Facility and clinic • Physician's office Includes services provided by A CSM, MSW, LLP, LCSW, ACSW	Covered – 80% after deductible Covered – 80% 50 visits per calendar year with lifetime maximum of 120 visits	Covered – 80% after deductible Covered – 80% after deductible
Outpatient substance abuse treatment – in approved facilities	Covered – 50% after deductible Up to the state-dollar amount that is adjusted annually	Covered – 50% after deductible

Other covered services

Outpatient Diabetes Management Program (ODMP)	Covered – 90% after deductible	Covered – 70% after deductible
Allergy testing and therapy	Covered – 90%	Covered – 70% after deductible
Chiropractic spinal manipulation	Covered – \$20 copay Up to 24 visits per calendar year	Covered – 70% after deductible
Outpatient physical, speech and occupational therapy	Covered – 90% after deductible Limited to a combined maximum of 60 visits per member per calendar year	Covered – 70% after deductible
Durable medical equipment	Covered – 50% after deductible	Covered – 50% after deductible
Prosthetic and orthotic appliances	Covered – 50% after deductible	Covered – 50% after deductible
Private duty nursing	Covered – 50% after deductible	Covered – 50% after deductible