Community Blue℠ PPO
Benefits-at-a-Glance Hope College 46629/200-206 Orange Plan

The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This BAAG is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits, please see the applicable BCBSM certificates and riders if your group is underwritten or your summary plan description if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

	In-network	Out-of-network *
Member's responsibility (deductibles, copays and dollar maximums)		
Deductibles	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each plan year (July 1 through June 30) **Note:** Deductible may be waived if service is performed in a PPO physician's office.	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each plan year (July 1 through June 30) **Note:** Out-of-network deductible amounts also apply toward the in-network deductible.
Fixed dollar copays	• $25 copay for office visits • $100 copay for emergency room visits • $50 copay for ambulance service	• $100 copay for emergency room visits • $50 copay for ambulance service
Percent copays **Note:** Copays apply once the deductible has been met.	• 50% of approved amount for private duty nursing, durable medical equipment, prosthetic and orthotic appliances, and bariatric surgery • 20% of approved amount for most other covered services (copay waived if service is performed in a PPO physician's office) See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.	50% of approved amount for private duty nursing, durable medical equipment, prosthetic and orthotic appliances, and bariatric surgery • 40% of approved amount for most other covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.
Annual copay dollar maximums – applies to copays for all covered services – including mental health and substance abuse services – but **does not** apply to fixed dollar copays and private duty nursing percent copays	$2,500 for one member, $5,000 for two or more members each plan year (July 1 through June 30)	$3,000 for one member, $6,000 for two or more members each plan year (July 1 through June 30) **Note:** Out-of-network copays also apply toward the in-network maximum.
Lifetime dollar maximum	None	

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

* Services from a provider for which there is no Michigan 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. Cost-sharing may differ when you obtain covered services outside of Michigan. 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.

	In-network	Out-of-network *
Preventive care services		
Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay), one per member per plan year	Not covered
Gynecological exam	100% (no deductible or copay), one per member per plan year	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay), one per member per plan year	Not covered
Well-baby and child care visits	100% (no deductible or copay) • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per plan year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay)	Not covered
Fecal occult blood screening	100% (no deductible or copay), one per member per plan year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay), one per member per plan year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay), one per member per plan year	Not covered
Routine mammogram and related reading	100% (no deductible or copay) **Note:** Subsequent medically necessary mammograms performed during the same plan year are subject to your deductible and percent copay.	60% after out-of-network deductible **Note:** Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
	One per member per plan year	
Colonoscopy – routine or medically necessary	100% for the first billed colonoscopy (no deductible or copay) **Note:** Subsequent colonoscopies performed during the same plan year are subject to your deductible and percent copay.	60% after out-of-network deductible
	One per member per plan year	
Physician office services		
Office visits	$25 copay per office visit	60% after out-of-network deductible, must be medically necessary
Outpatient and home medical care visits	80% after in-network deductible	60% after out-of-network deductible, must be medically necessary
Office consultations	$25 copay per office visit	60% after out-of-network deductible, must be medically necessary
Urgent care visits	$25 copay per office visit	60% after out-of-network deductible, must be medically necessary

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Emergency medical care		
Hospital emergency room	$100 copay per visit (copay waived if admitted or for an accidental injury)	$100 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	Covered-$50 copay	Covered-$50 copay
Diagnostic services		
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible
Maternity services provided by a physician		
Prenatal and postnatal care	100% (no deductible or copay)	60% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible
	Includes covered services 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.	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care – must be in a **participating** skilled nursing facility	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per plan year	
Hospice care	100% (no deductible or copay)	100% (no deductible or copay)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care – must be medically necessary and provided by a **participating** home health care agency	80% after in-network deductible	80% after in-network deductible
Home infusion therapy – must be medically necessary and given by **participating** home infusion therapy providers	80% after in-network deductible	80% after in-network deductible
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay)	60% after out-of-network deductible
Voluntary sterilization	80% after in-network deductible	60% after out-of-network deductible
Bariatric Surgery	50% after in-network deductible	50% after out-of-network deductible

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	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 (1-800-242-3504)	100% (no deductible or copay)	100% (no deductible or copay) – in designated facilities **only**
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Mental health care and substance abuse treatment

Note: If your employer has **51 or more** employees (including seasonal and part-time) and is subject to the MHP law, covered mental health and substance abuse services are subject to the following copays. Mental health and substance abuse copays are included in the annual copay dollar maximums for all covered services. See “Annual copay dollar maximums” section for this amount. If you receive your health care benefits through a collectively bargained agreement, please contact your employer and/or union to determine when or if this benefit level applies to your plan.

	In-network	Out-of-network *
Inpatient mental health care	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Inpatient substance abuse treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Outpatient mental health care • Facility and clinic	80% after in-network deductible	80% after in-network deductible, in participating facilities **only**
• Physician’s office	80% after in-network deductible **	60% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities **only**	80% after in-network deductible **	80% after in-network deductible

** Effective 1/1/2011, mental health and substance abuse procedures that are the equivalent of an office visit (consultative services rendered in the physician’s office) will be treated and processed like an office visit, subject to the fixed dollar office visit copay.

Other covered services

	In-network	Out-of-network *
Outpatient Diabetes Management Program (ODMP)	80% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$25 copay per office visit	60% after out-of-network deductible
	Limited to a **combined** maximum of 24 visits per member per plan year	
Outpatient physical, speech and occupational therapy – provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** maximum of 60 visits per member per plan year	
Durable medical equipment	50% after in-network deductible	50% after in-network deductible
Prosthetic and orthotic appliances	50% after in-network deductible	50% after in-network deductible
Private duty nursing	50% after in-network deductible	50% after in-network deductible

Selected rider

Rider XVA, excludes voluntary abortions	Excludes benefits for voluntary abortions.

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