

# Community Blue<sup>SM</sup> PPO Plan 18 with Prescription Drugs Benefits-at-a-Glance – MI Association of REALTORS<sup>®</sup>

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 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.

**Note:** Except for pregnancy, there is a 180-day waiting period on all pre-existing conditions. The waiting period may be waived if you and/or your children meet certain requirements.

	In-network	Out-of-network
<b>Member's responsibility (deductibles, copays and dollar maximums)</b>		
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.		
<b>Deductibles</b>	\$750/mbr, \$1,500/fam (when two + members covered under contract) per/cal. yr. <b>Note:</b> Deduct waived if serv. perf. in PPO phys off..	\$1,500/mbr, \$3,000/fam (when two + members covered under contract) per/cal. yr. <b>Note:</b> Out-of-network deduct.amts. apply toward in-network deduct.
<b>Copays</b>		
• Fixed dollar copays	• \$40 copay for office visits • \$250 copay for emergency room visits	\$250 copay for emergency room visits
• Percent copays	• 40% apprvd. amt for gen. serv. (copay waived if serv. performed in PPO physician's office) • 50% apprvd amt. mental health care, substance abuse treatment/private duty nursing	• 50% of approved amt. for general services • 50% of approved amt. for mental health care, substance abuse treatment/private duty nursing
<b>Copay dollar maximums</b>		
• Fixed dollar copays	None	None
• Percent copays – excl. mental health care, substance abuse trtmnt/priv. duty nursing copays	\$5,000/member, \$10,000/two or more members each calendar year	\$10,000/mbr, \$20,000/two + mbrs cal.yr. <b>Note:</b> Out-of-network copays apply toward in-ntwrk max.
<b>Dollar maximums</b>	\$1 million lifetime per covered specified human organ transplant type and a <b>separate</b> \$5 million lifetime per member for all other covered services and as noted for individual services	
<b>Preventive care services – *Payment for preventive services is limited to a combined maximum of \$500 per calendar year per member</b>		
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 – lab & pathology serv.	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 mos. through age 15	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunization Practices and the American Academy of Pediatrics	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
Prostate specific antigen (PSA) screening	Covered – 100%*, one per calendar year	Not covered
<b>Mammography</b>		
Mammography screening	Covered – 60% after deductible	Covered – 50% after deductible
One per calendar year, no age restrictions		
<b>Physician office services</b>		
Office visits	Covered – \$40 copay per office visit	Covered – 50% after deduct; medically necessary.
Limited to a maximum of two visits per calendar year per member, <b>combined</b> with office consultations and urgent care visits		
Outpatient and home medical care visits	Covered – 60% after deductible	Covered – 50% after deduct; medically necessary.
Office consultations	Covered – \$40 copay per office visit	Covered – 50% after deduct; medically nec..
Limited to a maximum of two visits per calendar year per member, <b>combined</b> with office visits and urgent care visits		
Urgent care visits	Covered – \$40 copay per office visit	Covered – 50% after deduct; medically nec.
Limited to a maximum of two visits per calendar year per member, <b>combined</b> with office visits and office consultations		
<b>Emergency medical care</b>		
Hospital emergency room	Covered – \$250 copay/visit (waived if admitted or for an accidental injury)	Covered – \$250 copay/ visit ( waived if admitted or for an accidental injury)
Ambulance services –medically necessary	Covered – 60% after deductible	Covered – 60% after deductible
<b>Diagnostic services</b>		
Laboratory and pathology services	Covered – 60% after deductible	Covered – 50% after deductible
Diagnostic tests and x-rays	Covered – 60% after deductible	Covered – 50% after deductible
Therapeutic radiology	Covered – 60% after deductible	Covered – 50% after deductible

	In-network	Out-of-network
<b>Maternity services provided by physician</b>		
Prenatal and postnatal care	Covered – 100%	Covered – 50% after deductible
Includes care provided by a certified nurse midwife		
Delivery and nursery care	Covered – 60% after deductible	Covered – 50% after deductible
Includes delivery provided by a certified nurse midwife		
<b>Hospital care</b>		
Semiprivate room, inpatient physician care, gen. nursing care, hospital services/supplies	Covered – 60% after deductible	Covered – 50% after deductible
<b>Note:</b> Non-emergency services must be rendered in a <b>participating</b> hospital.	Unlimited days	
Inpatient consultations	Covered – 60% after deductible	Covered – 50% after deductible
Chemotherapy	Covered – 60% after deductible	Covered – 50% after deductible
<b>Alternatives to hospital care</b>		
Skilled nursing care	Covered – 60% after deductible	Covered – 60% after deductible
Up to 120 days per calendar year per member		
Hospice care	Covered – 100%	Covered – 100%
Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a <b>participating</b> hospice program <b>only</b> ; limited to dollar maximum that is reviewed and adjusted periodically		
Home health care –medically necessary	Covered – 60% after deductible	Covered – 60% after deductible
Home infusion therapy –medically necessary	Covered – 60% after deductible	Covered – 60% after deductible
<b>Surgical services</b>		
Surgery – incl. related surgical services/ medically nec. facility services by <b>participating</b> ambulatory surgery facility	Covered – 60% after deductible	Covered – 50% after deductible
Pre-surgical consultations	Covered – 100%	Covered – 50% after deductible
Colonoscopy	Covered – 60% after deductible	Covered – 50% after deductible
Voluntary sterilization	Covered – 60% after deductible	Covered – 50% after deductible
<b>Human organ transplants</b>		
Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100%	Covered – in designated facilities <b>only</b>
	Limited to \$1 million <b>lifetime</b> maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 60% after deductible	Covered – 50% after deductible
Specified oncology clinical trials	Covered – 60% after deductible	Covered – 50% after deductible
Kidney, cornea and skin transplants	Covered – 60% after deductible	Covered – 50% after deductible
<b>Mental health care and substance abuse treatment</b>		
Inpatient mental health care	Covered – 50% after deductible	Covered – 50% after deductible
Unlimited days		
Inpatient substance abuse treatment	Covered – 50% after deductible	Covered – 50% after deductible
Unlimited days, up to \$15,000 annual, \$30,000 lifetime maximum		
Outpatient mental health care		
• Facility and clinic	Covered – 50% after deductible	Covered – 50% after deductible
• Physician's office	Covered – 50%	Covered – 50% after deductible
Outpatient substance abuse treatment – in approved facilities <b>only</b>	Covered – 50% after deductible	Covered – 50% after deductible
Up to the state-dollar amount that is adjusted annually		
<b>Other covered services</b>		
Outpatient Diabetes Mgmt Program (ODMP)	Covered – 60% after deductible	Covered – 50% after deductible
Allergy testing and therapy	Covered – 100%	Covered – 50% after deductible
Chiropractic /osteopathic manipulation treatment	Not covered	Not covered
Outpatient physical/speech/occupational. therapy	Covered – 60% after deductible	Covered – 50% after deductible
Limited to a <b>combined</b> maximum of 60 visits per calendar year per member		
Durable medical equipment	Covered – 60% after deductible	Covered – 60% after deductible
Prosthetic and orthotic appliances	Covered – 60% after deductible	Covered – 60% after deductible
Private duty nursing	Covered – 50% after deductible	Covered – 50% after deductible
Voluntary Abortions	Not covered	Not covered
<b>Blue Preferred® Rx Drug Coverage</b>		
<b>Deductible (deductible applies to brand name drugs)</b>	<b>Combined \$250/member, \$500/family (2+members covered under your contract) for brand name prescription drugs each calendar year</b>	
	<b>Network Pharm./Mail Order Provider</b>	<b>Non-Network Pharmacy</b>
\$10 gen (Tier 1);\$40 form. brand (Tier 2);\$80 non-form brand (Tier 3) copays;retail/ mail order	Covered - \$100% less copay after deductible <b>Check Benefit Guide (online) for complete details</b>	Covered – 75% less plan copay after deductible <b>Check Benefit Guide (online) for complete details</b>
<b>Annual Benefit Maximum</b>	<b>Combined \$2,500/member, \$5,000/family (2+members covered under your contract). After annual benefit max is met, NO coverage for balance of year. <b>Check Benefit Guide (online)for complete details</b></b>	