

Your Health Care Plan

The benefit chart(s) in Your Benefits Guide are designed to provide you with a **summary** of the services covered under your health plan. You will need to reference the actual certificate(s) or rider(s) for detailed information about a benefit including any exclusions or limitations.

When you need to reference a certificate or rider, simply match the form number from the benefit chart (located to the left of the benefit) to the same form number on the navigation bar. Then double click on the form number in the navigation bar.

4656 - DC
Dependent Continuation
Dependents between the ages of 19 and 25 provided they meet all of the requirements of this rider.

Sponsored Dependents

3326 - SD

Dependent coverage for those individuals who are financially dependent on the subscriber if they meet all of the requirements of this rider.

Community Blue PPO

Benefit Chart

Deductible, Copays and Dollar Maximums - \$1 million lifetime per covered specified organ transplant type and a separate \$5 million lifetime per member for all other covered services and as noted below for individual services.

Benefits	Form	In-Network	Form	Out-of-Network
Deductible	5775	\$100 per person or \$200 for the family per calendar year	6225	\$250 per person or \$500 for the family per calendar year Note: Your out-of-network deductible amount will also be applied to your in-network requirement.
Fixed Dollar Copays	6225	\$10 copay for specific office services	6225	Not applicable
	6225	\$50 copay for emergency services, waived if admitted or for an accidental injury	6225	\$50 copay for emergency services, waived if admitted or for an accidental injury
Percent Copays	577501	10 percent copay after deductible	5769	30 percent copay after deductible
Mental Health Percent Copay	6225	50 percent copay after deductible	6225	50 percent copay after deductible
Private Duty Nursing Percent Copay	6225	50 percent copay after deductible	6225	50 percent copay after deductible
Copay Dollar Maximums	5815	\$500 per member, \$1,000 for the family per calendar year	5857	\$1,500 per member, \$3,000 for the family per calendar year

Preventive Care Service - \$500 annual maximum for covered preventive care services. (Form Number - 3742)

Benefits	Form	In-Network	Form	Out-of-Network
Health Maintenance Exam - includes chest X-ray, EKG and select lab procedures, one per member, per calendar year	6225	Covered - 100 percent of approved amount	6225	Not Covered
Gynecological Exam - one per member, per calendar year	6225	Covered - 100 percent of approved amount	6225	Not Covered

Preventive Care Service - \$500 annual maximum for covered preventive care services. (Form Number - 3742)

Pap Smear Screening, laboratory and pathology services, one per member, per calendar year	6225	Covered - 100 percent of approved amount	6225	Not Covered
Well-Baby and Child Care - 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	6225	Covered - 100 percent of approved amount	6225	Not Covered
Immunizations, up through age 16	6225	Covered - 100 percent of approved amount	6225	Not Covered
Fecal Occult Blood Screening, one per member, per calendar year	6225	Covered - 100 percent of approved amount	6225	Not Covered
Flexible Sigmoidoscopy Exam, one per member, per calendar year	6225	Covered - 100 percent of approved amount	6225	Not Covered
Prostate Specific Antigen (PSA) Screening, one per member, per calendar year	6225	Covered - 100 percent of approved amount	6225	Not Covered

Mammography

Benefits	Form	In-Network	Form	Out-of-Network
Mammography Screening, one per contract year, no age restrictions	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible

Physician Office Services

Benefits	Form	In-Network	Form	Out-of-Network
Office Visits	6225	Covered - \$10 copay for specific office services	5769	Covered - 70 percent of approved amount after deductible, must be medically necessary
Outpatient and Home Visits	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible, must be medically necessary
Office Consultations	6225	Covered - \$10 copay for specific office services	5769	Covered - 70 percent of approved amount after deductible, must be medically necessary
Urgent Care Visits	6225	Covered - \$10 copay for specific office services	5769	Covered - 70 percent of approved amount after deductible, must be medically necessary

Emergency Medical Care

Benefits	Form	In-Network	Form	Out-of-Network
Hospital Emergency Room	6225	\$50 copay for emergency services, waived if admitted or for an accidental injury	6225	\$50 copay for emergency services, waived if admitted or for an accidental injury
Ambulance Services when medically necessary	577501	Covered - 90 percent of approved amount after deductible	577501	Covered - 90 percent of approved amount after deductible

Diagnostic Services

Benefits	Form	In-Network	Form	Out-of-Network
Laboratory and Pathology Services	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible
Diagnostic Tests and X-rays	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible
Therapeutic Radiology	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible

Maternity Services Provided by a Physician

Benefits	Form	In-Network	Form	Out-of-Network
Prenatal and Postnatal Care	6225	Covered - 100 percent of approved amount	5769	Covered - 70 percent of approved amount after deductible
Delivery and Nursery Care	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible

Hospital Care

Benefits	Form	In-Network	Form	Out-of-Network
Semiprivate Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies Note: Nonemergency services must be rendered in a participating hospital	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible
Inpatient Consultations	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible
Chemotherapy	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible

Alternatives to Hospital Care

Benefits	Form	In-Network	Form	Out-of-Network
Skilled Nursing Care - Up to 120 days per member, per calendar year	577501	Covered - 90 percent of approved amount after deductible	577501	Covered - 90 percent of approved amount after deductible
Hospice Care - limited to dollar maximum which is reviewed and adjusted periodically	6225	Covered - 100 percent of approved amount	6225	Covered - 100 percent of approved amount
Home Health Care	577501	Covered - 90 percent of approved amount after deductible	577501	Covered - 90 percent of approved amount after deductible

Surgical Services

Benefits	Form	In-Network	Form	Out-of-Network
Surgery - includes related surgical services - Participating Ambulatory Surgery Facility	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible
Voluntary Sterilization	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible

Human Organ Transplants

Benefits	Form	In-Network	Form	Out-of-Network
Specified Organ Transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504), up to \$1 million lifetime maximum per transplant type	6225	Covered - 100 percent of approved amount	6225	Covered - 100 percent of approved amount in designated facilities only
Bone Marrow – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504); specific criteria applies	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible
Kidney, Cornea and Skin	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible
Specified Oncology Clinical Trials	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible

Mental Health Care and Substance Abuse Treatment

Benefits	Form	In-Network	Form	Out-of-Network
Inpatient Mental Health Care - limited to \$15,000 annually and \$30,000 lifetime.	6225	Covered - 50 percent of the approved amount after deductible	6225	Covered - 50 percent of the approved amount after deductible, if applicable
Inpatient Substance Abuse Treatment - limited to \$15,000 annually and \$30,000 lifetime.	6225	Covered - 50 percent of approved amount after deductible	6225	Covered - 50 percent of the approved amount after deductible, if applicable
Outpatient Mental Health Care - limited to \$2,000 per member annually and \$5,000 lifetime - Facility and Clinic - Physician's Office	6225	Covered - 50 percent of the approved amount after deductible	6225	Covered - 50 percent of the approved amount after deductible, if applicable
Outpatient Substance Abuse Treatment in approved facilities, up to the state dollar amount which is adjusted annually	6225	Covered - 50 percent of approved amount after deductible	6225	Covered - 50 percent of approved amount after deductible

Other Services

Benefits	Form	In-Network	Form	Out-of-Network
Outpatient Diabetes Management Program (ODMP)	577501	Covered - 90 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible
Allergy Testing and Therapy	6225	Covered - 100 percent of approved amount	5769	Covered - 70 percent of approved amount after deductible after deductible
Chiropractic Spinal Manipulation Note: Up to 24 visits per member, per calendar year	6225	Covered - 100 percent of approved amount	5769	Covered - 70 percent of approved amount after deductible
Outpatient Physical, Speech and Occupational Therapy Note: A combined 60-visit maximum per calendar year for physical therapy in the outpatient department of a hospital as well as in the physician's office - Facility and Clinic	577501	Covered - 90 percent of approved amount after deductible	577501	Covered - 90 percent of approved amount after deductible
- Physician's Office - excludes speech and occupational therapy	6225	Covered - 100 percent of approved amount after deductible	5769	Covered - 70 percent of approved amount after deductible
Durable Medical Equipment	577501	Covered - 90 percent of approved amount after deductible	577501	Covered - 90 percent of approved amount after deductible
Prosthetic and Orthotic Appliances	577501	Covered - 90 percent of approved amount after deductible	577501	Covered - 90 percent of approved amount after deductible
Private Duty Nursing	6225	Covered - 50 percent of approved amount after deductible	6225	Covered - 50 percent of approved amount after deductible

Note: Temporary benefits for hospital services – When a hospital chooses to terminate its participating contract with BCBSM, your coverage provides temporary benefits for emergency care and for certain services for up to six months from the date the hospital terminates its participating contract with Blue Cross Blue Shield of Michigan. Please refer to rider Temporary Benefits for Hospital Services (form #1700) for covered benefits under this arrangement.

Blue Preferred RX

Benefit Chart for Prescription Drug Coverage

The following benefit chart is designed to provide you with a **summary** of the services covered under your plan. You will need to reference the actual certificate(s) or rider(s) for detailed information about a benefit including any exclusions or limitations

Choosing your pharmacy

The amount you pay in out-of-pocket costs depends on whether or not you use a network or non-network pharmacy. You will have the least out-of-pocket costs when you use network pharmacies.

Important: Pharmacies outside of Michigan must use the MedImpact BIN and PC number below to verify your eligibility, not the five-digit group number on your ID card.

MedImpact Rx BIN 003585/Rx PCN 23615

If the pharmacist needs assistance, he or she may call the MedImpact Provider Help Desk at 1-800-239-1023.

Copay Requirements

Benefits	Form	Network Pharmacy	Form	Non-Network Pharmacy
Dollar Copay	2617	\$10 for each generic drug \$40 for each brand-name drug, even if the prescription is marked "DAW" or there is no generic equivalent drug available	2617	\$10 for each generic drug \$40 for each brand-name drug, even if the prescription is marked "DAW" or there is no generic equivalent drug available, plus 25 percent of the approve amount
Mail Order (Home Delivery) Prescription Drugs Note: Specialty drugs are covered through mail order such as cancer drugs, hormone, antirejection and etc.	2138	Covered - Copay is a separate copay amount for covered drugs up to 34 days supply for prescription or refill Copay is double for drugs more than a 35 up to 90 day supply for prescription or refill.	2138	Not Covered

Preferred RX Drug Plan

Benefits	Form	Network Pharmacy	Form	Non-Network Pharmacy
Federal Legend Drugs	3607	Covered - 100 percent of approved amount less plan copay	3607	Covered - 75 percent of approved amount less plan copay
State-controlled Drugs	3607	Covered - 100 percent of approved amount less plan copay	3607	Covered - 75 percent of approved amount less plan copay
Disposable Needles and Syringes – dispensed with insulin	3607	Covered - 100 percent of approved amount less plan copay for insulin	3607	Covered - 75 percent of approved amount less plan copay for insulin
Mail Order (Home Delivery) Prescription Drugs Note: Specialty drugs are covered through mail order such as cancer drugs, hormone, antirejection and etc.	2138	Covered - 100 percent of the approved amount less plan copay	2138	Not Covered

Copayment for Network and Non-Network Providers

Class of Dental Services	BCBSM Pays In-Network Providers	Your Copay In-Network	BCBSM Pays Out-of-Network Providers	Your Copayment Out-of-Network
Class I	100 percent	None	50 percent	50 percent
Class II	75 percent	25 percent	50 percent	50 percent
Class III	50 percent	50 percent	50 percent	50 percent
Class IV	50 percent	50 percent	40 percent	60 percent

These are the codes for your Certificates and Riders and are for internal use by BCBSM:

0507-MHP-E
1700-TBHD
2138AD-MOPD2X/10/40 65
261765-\$10/40 65
360765-PREFERRED RX 65
374068-INON7 PLAN3-65
408703-RDR GPC SAT II
494365-DNTLOPT CERT65
5385-CRNA
577501-CBDS100P 90/10
5857-CBCMNP1500
6502-65 OPT 2
6603-CB-PCB
MMPD65-CATASTROPHIC 65

0738-65 OPTION 1
2138AC-MOPD2X W/\$10/40
2617- \$10/\$40 RX
3607-PREFERRED RX
374003-IN-ON 7 PLAN 3
3742-CB-PCM-500
4943-DENTAL OPT CERT
5216-ECIP
5769-CBC 30% NP
5815-CB-CMP \$500/90
6225-COMM BLUE BASIC
6600-CNM
993009-GLE-1

Tracking Number 224734

Service Key	Effective Date
C186PU	07/01/2001
S1A0MT	07/01/2004

Blue Cross Blue Shield of Michigan provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

This handbook is not a contract. It is intended as a brief description of benefits. Every effort has been made to ensure the accuracy of the information within. However, if statements in this description differ from the applicable coverage documents, then the terms and conditions of those documents will prevail.

Blue Cross Blue Shield of Michigan administers the program for your employer. Blue Cross Blue Shield of Michigan does not insure the coverage. Benefits and future changes in benefits are the responsibility of your employer. Information concerning members may be reviewed by your employer and Blue Cross Blue Shield of Michigan.

The coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.

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