

# Community Blue<sup>SM</sup> PPO (Revised 7-1-09)

## Benefits-at-a-Glance for Ann Arbor Public Schools – Office Professionals (OP) Only Plan B

|   | In-Network  | Out-of-Network |
|---|---|----------------|
| <b>Preventive Services</b>  |   |                |
| Health Maintenance Exam – includes chest X-ray, EKG and select lab procedures | Covered – 100%, one per calendar year   | Not Covered    |
| Annual Gynecological Exam   | Covered – 100%, one per calendar year   | Not Covered    |
| Pap Smear Screening – laboratory services only                                | Covered – 100%, one per calendar year   | Not Covered    |
| Well-Baby and Child Care  | Covered – 100% <ul style="list-style-type: none"> <li>• 6 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 2 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> <li>• 1 visit per birth year, 48 months through age 15</li> </ul> | Not Covered    |
| Immunizations   | Covered – 100%, up through age 16   | 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    |

### Mammography

|  |                |                                |
|--|----------------|--------------------------------|
| Mammography Screening                      | Covered – 100% | Covered – 80% after deductible |
| One per calendar year, no age restrictions |                |                                |

### Physician Office Services

|                            |                      |   |
|----------------------------|----------------------|---|
| Office Visits              | Covered – \$20 copay | Covered – 80% after deductible, must be medically necessary |
| Outpatient and Home Visits | Covered – 100%       | Covered – 80% after deductible, must be medically necessary |
| Office Consultations       | Covered – \$20 copay | Covered – 80% after deductible, must be medically necessary |
| Urgent Care Visits         | Covered – \$20 copay | Covered – 80% after deductible, must be medically necessary |

### Emergency Medical Care

|  |  |  |
|--|--|--|
| Hospital Emergency Room                  | Covered – \$50 copay, waived if admitted or for an accidental injury | Covered – \$50 copay, waived if admitted or for an accidental injury |
| Ambulance Services – medically necessary | Covered – 100%   | Covered – 100%   |

### Diagnostic Services

|                                |                |                                |
|--------------------------------|----------------|--------------------------------|
| Laboratory and Pathology Tests | Covered – 100% | Covered – 80% after deductible |
| Diagnostic Tests and X-rays    | Covered – 100% | Covered – 80% after deductible |
| Radiation Therapy              | Covered – 100% | Covered – 80% after deductible |

### Maternity Services Provided by a Physician

|                               |   |                                |
|-------------------------------|---|--------------------------------|
| Pre-Natal and Post-Natal Care | Covered – 100%  | Covered – 80% after deductible |
|                               | Includes care provided by a Certified Nurse Midwife     |                                |
| Delivery and Nursery Care     | Covered – 100%  | Covered – 80% after deductible |
|                               | Includes delivery provided by a Certified Nurse Midwife |                                |

### Hospital Care

|  |                |                                |
|--|----------------|--------------------------------|
| Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies<br>Note: Nonemergency services must be rendered in a <b>participating</b> hospital | Covered – 100% | Covered – 80% after deductible |
|  | Unlimited days |                                |
| Inpatient Consultations  | Covered – 100% | Covered – 80% after deductible |
| Chemotherapy   | Covered – 100% | Covered – 80% after deductible |

### Alternatives to Hospital Care

|                      |   |                |
|----------------------|---|----------------|
| Skilled Nursing Care | Covered – 100%  | Covered – 100% |
|                      | Up to 120 days per calendar year                                      |                |
| Hospice Care         | Covered – 100%  | Covered – 100% |
|                      | Limited to the lifetime dollar maximum which is adjusted periodically |                |
| Home Health Care     | Covered – 100%  | Covered – 100% |
|                      | Unlimited visits  |                |

### Surgical Services

|  |                |                                |
|--|----------------|--------------------------------|
| Surgery – includes related surgical services | Covered – 100% | Covered – 80% after deductible |
| Voluntary Sterilization                      | Covered – 100% | Covered – 80% after deductible |

### Human Organ Transplants

|   |                |  |
|---|----------------|--|
| Specified Organ Transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) | Covered – 100% | Covered – in designated facilities <b>only</b> |
| Up to \$1 million maximum per transplant type   |                |  |
| Bone Marrow – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504); specific criteria applies                     | Covered – 100% | Covered – 80% after deductible                 |
| Kidney, Cornea and Skin   | Covered – 100% | Covered – 80% after deductible                 |

### Mental Health Care and Substance Abuse Treatment

|  |  |                                |
|--|--|--------------------------------|
| Inpatient Mental Health Care   | Covered – 80%  | Covered – 80% after deductible |
| Unlimited days   |  |                                |
| Inpatient Substance Abuse Treatment  | Covered – 80%  | Covered – 80% after deductible |
| Unlimited days, up to \$15,000 annual, \$30,000 lifetime maximum               |  |                                |
| Outpatient Mental Health Care<br>• Facility and Clinic<br>• Physician’s Office | Covered – 80%  | Covered – 80%                  |
|  | Covered – 80%  | Covered – 80% after deductible |
| Outpatient Substance Abuse Treatment – in approved facilities                  | Covered – 80%  | Covered – 80%                  |
|  | Up to the state-dollar amount which is adjusted annually |                                |

### Other Services

|   |   |   |
|---|---|---|
| Outpatient Diabetes Management Program (ODMP)   | Covered – 100%  | Covered – 80% after deductible  |
| Allergy Testing and Therapy   | Covered – 100%  | Covered – 80% after deductible  |
| Chiropractic Spinal Manipulation  | Covered – \$20 copay  | Covered – 80% after deductible  |
| Up to 24 visits per calendar year   |   |   |
| Outpatient Physical, Speech and Occupational Therapy<br>• Facility and Clinic<br>• Physician’s Office – <b>excludes speech and occupational therapy</b> | Covered – 100%  | Covered – 100%  |
|   | Covered – 100%  | Covered – 80% after deductible  |
|   | 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    |   |
| Durable Medical Equipment   | Covered – 100%  | Covered – 100%  |
| Prosthetic and Orthotic Appliances  | Covered – 100%  | Covered – 100%  |
| Private Duty Nursing  | Covered – 50%   | Covered – 50%   |
| Prescription Drugs  | \$15 for each generic drug; \$30 for each brand name drug. Two times copay for 90 day supply, retail and mail order. Contraceptive coverage included. | \$15 for each generic drug; \$30 for each brand name drug. Two times copay for 90 day supply, retail and mail order. Contraceptive coverage included. |

### Deductible, Copays and Dollar Maximums

**Note:** 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>Deductible</b>  | None  | \$250 per member, \$500 family per calendar year  |
| <b>Copays</b><br>• Fixed Dollar Copays<br><br>• Percent Copays   | \$20 for office visits and \$50 for emergency room visits   | \$50 for emergency room visits  |
|  | 50% for private duty nursing  | 20% for general services and for mental health care, substance abuse treatment and 50% for private duty nursing<br><b>Note:</b> Services without a network are covered at the in-network level. |
| <b>Copay Dollar Maximums</b><br>• Fixed Dollar Copays<br>• Percent Copays – excludes mental health care, substance abuse treatment and private duty nursing copays | None  | None  |
|  | Not Applicable  | \$2,000 per member, \$4,000 family per calendar year  |
| <b>Dollar Maximums</b>   | \$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 above for individual services |   |

### Additional Riders Included

|   |  |
|---|--|
| <b>ASCMOD2215</b>                                       | Adds benefit for hair prostheses (wigs), when obtained from an accredited P&O provider. Lifetime maximum of \$300.   |
| <b>Rider HC-A, Hearing Care</b>                         | Adds specific hearing care benefits, including binaural hearing aids, when provided by participating providers.  |
| <b>Rider EBMT, Experimental Bone Marrow Transplants</b> | Establishes the criteria and clarifies which conditions are payable for experimental bone marrow transplants. Donors must meet genetic marker criteria. Requires prior approval by Blue Cross-Blue Shield. |

This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield certificate and riders. Payment amounts are based on the Blue Cross Blue Shield approved amount, less any applicable deductible and/or copay amounts required by the plan. This 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.