



## Community Blue<sup>SM</sup> PPO – Plan 14/0% Jackson Community College 68238/004

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.

**Effective 6/1/09**

**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.

<b>Deductible</b>	\$1,500 for one member, \$3,000 for the family (when two or more members are covered under your contract) each calendar year <b>Note: Deductible waived if service is performed in a PPO physician’s office.</b>	\$3,000 for one member, \$6,000 for the family (when two or more members are covered under your contract) each calendar year <b>Note:</b> Out-of-network deductible amounts also apply toward the in-network deductible.
<b>Copays</b>		
• Fixed dollar copays	\$10 for office visits and \$50 for emergency room visits	\$50 for emergency room visits
• Percent copays	20% for mental health care, substance abuse treatment and 50% for private duty nursing	20% for general services, mental health care, substance abuse treatment and 50% for private duty nursing
<b>Copay dollar maximums</b>		
• Fixed dollar copays	None	None
• Percent copays – <b>excludes</b> mental health care, substance abuse treatment and private duty nursing copays	Not applicable	\$5,000 for one member, \$10,000 for two or more members each calendar year
<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	

### 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
<b>Childhood immunizations</b> as recommended by the Advisory Committee on Immunization Practices and the American Academy of Pediatrics <b>Adult immunizations</b> as recommended by The Advisory Committee on Immunization Practices (ACIP).	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



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

**In-network**

**Out-of-network**

**Mammography**

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

**Physician office services**

Office visits	Covered – \$10 copay per office visit	Covered – 80% after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 100% after deductible	Covered – 80% after deductible, must be medically necessary
Office consultations	Covered – \$10 copay per office visit	Covered – 80% after deductible, must be medically necessary
Urgent care visits	Covered – \$10 copay per office visit	Covered – 80% after deductible, must be medically necessary

**Emergency medical care**

Hospital emergency room	Covered – \$50 copay per visit, waived if admitted or for an accidental injury	Covered – \$50 copay per visit, waived if admitted or for an accidental injury
Ambulance services – must be medically necessary	Covered – 100% after deductible	Covered – 100% after deductible

**Diagnostic services**

Laboratory and pathology services	Covered – 100% after deductible	Covered – 80% after deductible
Diagnostic tests and x-rays	Covered – 100% after deductible	Covered – 80% after deductible
Therapeutic radiology	Covered – 100% after deductible	Covered – 80% after deductible

**Maternity services provided by a physician**

Prenatal and postnatal care	Covered – 100%	Covered – 80% after deductible
Includes care provided by a certified nurse midwife		
Delivery and nursery care	Covered – 100% after deductible	Covered – 80% after deductible
Includes delivery provided by a certified nurse midwife		

**Hospital care**

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies <b>Note:</b> Nonemergency services must be rendered in a <b>participating</b> hospital.	Covered – 100% after deductible	Covered – 80% after deductible
Unlimited days		
Inpatient consultations	Covered – 100% after deductible	Covered – 80% after deductible
Chemotherapy	Covered – 100% after deductible	Covered – 80% after deductible

**Alternatives to hospital care**

Skilled nursing care	Covered – 100% after deductible	Covered – 100% 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 – 100% after deductible	Covered – 100% after deductible
Home infusion therapy – must be medically necessary	Covered – 100% after deductible	Covered – 100% after deductible

**Surgical services**

Surgery – includes related surgical services and medically necessary facility services by a <b>participating</b> ambulatory surgery facility	Covered – 100% after deductible	Covered – 80% after deductible
Presurgical consultations	Covered – 100%	Covered – 80% after deductible
Colonoscopy	Covered – 100% after deductible	Covered – 80% after deductible
Voluntary sterilization	Covered – 100% after deductible	Covered – 80% after deductible



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**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 <b>lifetime</b> maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	Covered – in designated facilities <b>only</b>
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100% after deductible	Covered – 80% after deductible
Specified oncology clinical trials	Covered – 100% after deductible	Covered – 80% after deductible
Kidney, cornea and skin transplants	Covered – 100% after deductible	Covered – 80% after deductible

**Mental health care and substance abuse treatment**

Inpatient mental health care	Covered – 80% after deductible Unlimited days	Covered – 80% after deductible
Inpatient substance abuse treatment	Covered – 80% after deductible	Covered – 80% after deductible
Outpatient mental health care • Facility and clinic • Physician's office	Covered – 80% after deductible Covered – 80%	Covered – 80% after deductible Covered – 80% after deductible
Outpatient substance abuse treatment – in approved facilities	Covered – 80% after deductible Up to the state-dollar amount that is adjusted annually	Covered – 80% after deductible

**Other covered services**

Outpatient Diabetes Management Program (ODMP)	Covered – 100% after deductible	Covered – 80% after deductible
Allergy testing and therapy	Covered – 100%	Covered – 80% after deductible
Chiropractic manipulation treatment and osteopathic manipulation treatment	Covered – 100% after deductible Up to a maximum of 24 visits per member per calendar year	Covered – 80% after deductible
Outpatient physical, speech and occupational therapy	Covered – 100% after deductible Limited to a <b>combined</b> maximum of 60 visits per member per calendar year	Covered – 80% after deductible
Durable medical equipment	Covered – 100% after deductible	Covered – 100% after deductible
Hearing Care	Covered- Audiometric Exam, and Monaural Hearing Aid covered when provided by a par provider. Hearing Care benefits renew every 36 months	Not a covered benefit.
Prosthetic and orthotic appliances	Covered – 100% after deductible	Covered – 100% after deductible
Private duty nursing	Covered – 50% after deductible	Covered – 50% after deductible
Prescription drugs	\$10/20 MOPD2X with Contraceptives	\$10/20 MOPD2X with Contraceptives