Blue Cross Blue Shield Blue Care Network of Michigan

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Community Blue[SM] PPO – Plan 5 Medical Coverage Benefits-at-a-Glance for Plymouth-Canton Community Schools

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 any other plan documents your group uses, 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.

Note: To be eligible for coverage, the following services require your provider to obtain approval **before** they are provided – select radiology services, inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, rehabilitation therapy and applied behavioral analyses.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals – BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician **must** contact BCBSM to request preauthorization of the drugs. If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

	In-network	**Out-of-network ***
Member's responsibility (deductibles, copays and dollar maximums)		
Deductibles	$1,450 for one member $2,900 for the family (when two or more members are covered under your contract) each calendar year **Note:** Deductible may be waived if service is performed in a PPO physician's office.	$2,900 for one member $5,800 for the family (when two or more members are covered under your contract) each calendar year
Flat dollar copays	• $15 copay for office visits $40 copay for urgent care • $150 copay for emergency room visits	$150 copay for emergency room visits
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing • 10% 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 • 30% 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.
Coinsurance maximums – applies to coinsurance amounts for all covered services – including mental health and substance abuse services – but **does not** apply to deductibles, flat dollar copays, private duty nursing amounts and prescription drug cost sharing amounts	$1,000 for one member $2,000 for two or more members each calendar year	$2,000 for one member $4,000 for two or more members each calendar year
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays and coinsurance amounts, if applicable	$6,350 for one member; $12,700 for two or more members each calendar year)	$12,700 for one member; $25,400 for two or more members each calendar year)
Lifetime dollar maximum	None	

* 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 calendar year	Not covered
Gynecological exam	100% (no deductible or copay), one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay)	70% after out-of-network deductible
Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay)	70% after out-of-network deductible
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 calendar 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 calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	70% 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 calendar year	
Colonoscopy – routine or medically necessary	100% (no deductible or copay) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	70% after out-of-network deductible
	One per member per calendar year	
Physician office services		
Office visits – must be medically necessary	$15 copay per office visit	70% after out-of-network deductible
Outpatient and home medical care visits – must be medically necessary	90% after in-network deductible	70% after out-of-network deductible
Office consultations – must be medically necessary	$15 copay per office visit	70% after out-of-network deductible
Urgent care visits – must be medically necessary	$40 copay per office visit	70% after out-of-network deductible
Emergency medical care		
Hospital emergency room	$150 copay per visit (copay waived if admitted or for an accidental injury)	$150 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	90% after in-network deductible	70% after in-network deductible

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	In-network	Out-of-network *
Diagnostic services		
Laboratory and pathology services	90% after in-network deductible	70% after out-of-network deductible
Diagnostic tests and x-rays	90% after in-network deductible	70% after out-of-network deductible
Therapeutic radiology	90% after in-network deductible	70% after out-of-network deductible
Maternity services provided by a physician		
Prenatal and postnatal care visits	100% (no deductible or copay)	70% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	90% after in-network deductible	70% 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.	90% after in-network deductible	70% after out-of-network deductible
	Unlimited days	
Inpatient consultations	90% after in-network deductible	70% after out-of-network deductible
Chemotherapy	90% after in-network deductible	70% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care – must be in a **participating** skilled nursing facility	90% after in-network deductible	90% after in-network deductible
	Limited to a maximum of 120 days per member per calendar 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	90% after in-network deductible	90% after in-network deductible
Home infusion therapy – must be medically necessary and given by **participating** home infusion therapy providers	90% after in-network deductible	90% after in-network deductible
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	90% after in-network deductible	70% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay)	70% after out-of-network deductible
Voluntary sterilization for males **Note:** See "Preventive care services" section for voluntary sterilizations for females.	90% after in-network deductible	70% after out-of-network deductible
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)	90% after in-network deductible	70% after out-of-network deductible
Specified oncology clinical trials	90% after in-network deductible	70% after out-of-network deductible
Kidney, cornea and skin transplants	90% after in-network deductible	70% after out-of-network deductible

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	In-network	Out-of-network *

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.

Inpatient mental health care	90% after in-network deductible	70% after out-of-network deductible
	Unlimited days	
Inpatient substance abuse treatment	90% after in-network deductible	70% after out-of-network deductible
	Unlimited days	
Outpatient mental health care: • Facility and clinic	90% after in-network deductible	70% after out-of-network deductible, in participating facilities **only**
• Physician's office	90% after in-network deductible **	70% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities **only**	90% after in-network deductible **	70% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

** 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.

Note: If your employer has **50 or fewer** employees (all employees, not just eligible employees), covered mental health and substance abuse services are subject to the following copay amounts. Mental health and substance abuse copays are **not** limited to a copay maximum.

	In-network	Out-of-network *

Other covered services

Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by a network provider. **Note:** Effective July 1, 2011, when you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	90% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay) for diabetes self-management training	70% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay)	70% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$15 copay per office visit	70% after out-of-network deductible
	Limited to a **combined** maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy – provided for rehabilitation	90% after in-network deductible	70% 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 calendar year	
Durable medical equipment **Note**: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by a network provider.	90% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	90% after in-network deductible	90% after in-network deductible
Private duty nursing	50% after in-network deductible	50% after in-network deductible
Prescription drugs	$10/40 copay	$10/40 copay plus 25% of the cost of the drug

* 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.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call the Plymouth-Canton Community Schools Employee Benefits Office at 734-416-4834. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/healthreform or call the number on the back of your BCBSM ID card to request a copy. Group Number 7177-024, 025

Important Questions	Answers		Why This Matters:
What is the overall deductible?	$1,450 Individual/ $2,900 Family	$2,900 Individual/ $5,800 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No		You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$6,350 Individual/ $12,700 Family	$12,700 Individual/ $25,400 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of in-network providers, see www.bcbsm.com or call the number on the back of your ID card.		This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.		This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 co-pay	30% after deductible	---none---
	Specialist visit	$15 co-pay	30% after deductible	Chiropractic care limited to 24 visits/cal yr.
	Preventive care/screening/ immunization	No charge	Coverage for mammograms & colonoscopies only – 30% after deductible	As required by the U.S. Preventive Task Force (USPSTF)
If you have a test	Diagnostic test (x-ray, blood work)	10% after deductible	30% after deductible	---none---
	Imaging (CT/PET scans, MRIs)	10% after deductible	30% after deductible	---none---
If you need drugs to treat your illness or condition More information about prescription drug coverage, call the number on the back of your BCBSM ID card.	Generic drugs	$10 co-pay for retail 30-day supply; $20 co-pay for mail order 90-day supply	$10 co-pay plus an additional 25% of BCBSM approved amount for the drug	Mail order drugs are not covered out-of-network. Generic contraceptive medications are covered at 100%
	Preferred brand drugs	$40 co-pay for retail 30-day supply; $80 co-pay for mail order 90-day supply	$40 co-pay plus an additional 25% of BCBSM approved amount for the drug	Mail order drugs are not covered out-of-network.
	Non-preferred brand drugs	$40 co-pay for retail 30-day supply; $80 co-pay for mail order 90-day supply	$40 co-pay plus an additional 25% of BCBSM approved amount for the drug	Mail order drugs are not covered out-of-network.
	Specialty drugs	$40 co-pay for retail 30-day supply; $80 co-pay for mail order 90-day supply	$40 co-pay plus an additional 25% of BCBSM approved amount for the drug	Mail order drugs are not covered out-of-network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% after deductible	30% after deductible	---none---
	Physician/surgeon fees	10% after deductible	30% after deductible	---none---
If you need immediate medical attention	Emergency room care	$150 co-pay	$150 co-pay	Co-pay waived if admitted or for accidental injury.

* For more information about limitations and exceptions, see the plan or policy document, please contact Dawn Schaller at 734-416-4834.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	10% after deductible	10% after in-network deductible	Must be medically necessary.
	Urgent care	$40 co-pay	30% after deductible	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	10% after deductible	30% after deductible	Semi-private room
	Physician/surgeon fees	10% after deductible	30% after deductible	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 co-pay	$15 co-pay	In approved facilities only for outpatient substance abuse.
	Inpatient services	10% after deductible	30% after deductible	---none---
If you are pregnant	Office visits	No charge	30% after deductible	---none---
	Childbirth/delivery professional services	10% after deductible	30% after deductible	---none---
	Childbirth/delivery facility services	10% after deductible	30% after deductible	---none---
If you need help recovering or have other special health needs	Home health care	10% after deductible	10% after in-network deductible	Must be medically necessary and provided by a participating home health care agency.
	Rehabilitation services	10% after deductible	30% after deductible	Physical, Occupational, Speech therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	Not covered	Not covered	---none---
	Skilled nursing care	10% after deductible	10% after in-network deductible	Limited to a maximum of 120 days per member. Must be in a participating skilled nursing facility.
	Durable medical equipment	10% after deductible	10% after in-network deductible	---none---
	Hospice services	No charge	No charge	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, 4, 90-day periods – provided through participating hospice program only; limited to a dollar limit that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions to individual case management).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	---none---
	Children's glasses	Not covered	Not covered	---none---
	Children's dental check-up	Not covered	Not covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Routine eye care (Adult)
- Hearing aids
- Long-term care
- Dental care (Adult)
- Weight loss programs
- Cosmetic surgery
- Routine foot care
- Infertility treatment

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (Blue Distinction Centers)
- Private duty nursing
- Chiropractic care
- Coverage provided outside the United States. See http://provider.bcbs.com

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [Michigan, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the number on the back of your BCBSM ID card.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-752-1455.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-752-1455.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-752-1455.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-752-1455.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document, please contact Dawn Schaller at 734-416-4834.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,450
Specialist *[cost sharing]*	$15
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,450
Copayments	$0
Coinsurance	$1,135
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$2,585

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,450
Specialist *[cost sharing]*	$15
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,450
Copayments	$540
Coinsurance	$595
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$2,585

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,450
Specialist *[cost sharing]*	$15
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,450
Copayments	$165
Coinsurance	$45
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,660

The plan would be responsible for the other costs of these EXAMPLE covered services.