

Community Blue PPO Benefit Summary for CS/FM/PS and CP/LE

This is not a full description of coverage. It is a comparison intended to highlight the coverage of the health plans. If you have questions before making a plan selection, you may contact the plan's Member Services Department.

Blue Cross Blue Shield of Michigan: 877-257-9703 • 800-637-2227 • 248-486-8666 • bcbsm.com | Vision Service Plan: 800-877-7195 • vsp.com

Benefits	Community Blue PPO CS/FM/PS		Community Blue PPO Option 1 CP/LE		Community Blue PPO Option 2 CP/LE	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospital Services						
Number of Days of Care	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Semi-Private Room or Intensive Care	Covered – 100%	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
Surgery and All Related Surgical Services	Covered – 100%	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
Anesthesia	Covered – 100%	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
Laboratory Tests and X-rays	Covered – with limitations ¹	Covered – 80% after deductible, with limitations ¹	Covered – 90% after deductible, with limitations ¹	Covered – 70% after deductible, with limitations ¹	Covered – 100%, with limitations ¹	Covered – 80% after deductible, with limitations ¹
Medicines and Drugs	Covered – 100%	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
In Hospital Physician Care	Covered – 100%	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
Outpatient Services						
Office Visit (for illness or injury)	Covered – \$10 copay	Covered – 80% after deductible, must be medically necessary	Covered – \$15 copay	Covered – 70% after deductible, must be medically necessary	Covered – \$10 copay	Covered – 80% after deductible, must be medically necessary
Specialist Office Visit	Covered – \$10 copay	Covered – 80% after deductible, must be medically necessary	Covered – \$15 copay	Covered – 70% after deductible, must be medically necessary	Covered – \$10 copay	Covered – 80% after deductible, must be medically necessary
Routine Physical Examination	Covered – 100%, one per calendar year	Not covered	Covered – 100%, one per calendar year	Not covered	Covered – 100%, one per calendar year	Not covered
Dermatology Services	Covered – \$10 copay	Covered – 80% after deductible	Covered – \$15 copay	Covered – 70% after deductible	Covered – \$10 copay	Covered – 80% after deductible
Allergy Services	Covered – with limitations ¹	Covered – 80% after deductible, with limitations ¹	Covered – with limitations ¹	Covered – 70% after deductible, with limitations ¹	Covered – with limitations ¹	Covered – 80% after deductible, with limitations ¹
Chiropractic Services	Covered – 100%, up to 24 visits per calendar year	Covered – 80% after deductible	Covered – 100%, up to 24 visits per calendar year	Covered – 70% after deductible, up to 24 visits per calendar year	Covered – 100%, up to 24 visits per calendar year	Covered – 80% after deductible, up to 24 visits per calendar year
Immunizations	Covered – 100% (through age 16)	Not covered	Covered – 100% (through age 16)	Not covered	Covered – 100% (through age 16)	Not covered
Outpatient Surgery	Covered – 100%	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
Occupational Therapy, Physical Therapy, Speech Therapy	Covered – 100%, up to 60 visits per calendar year	Covered – 80% after deductible, up to 60 visits per calendar year	Covered – 90%, up to 60 visits per calendar year	Covered – 70% after deductible, up to 60 visits per calendar year	Covered – 100%, up to 60 visits per calendar year	Covered – 80% after deductible, up to 60 visits per calendar year
Voluntary Family Planning Services	Covered – with limitations ¹	Not covered	Covered – 90% after deductible, with limitations ¹	Not covered	Covered – with limitations ¹	Not covered
Infertility Treatment and Procedures	Covered – with limitations ¹	Not covered	Covered – 90% after deductible, with limitations ¹	Not covered	Covered – with limitations ¹	Not covered
Voluntary Sterilization	Covered – 100%	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
Pregnancy Termination	Covered – 100%	Covered – with applicable deductible and coinsurance	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible

**Community Blue PPO
CS/FM/PS**

**Community Blue PPO Option 1
CP/LE**

**Community Blue PPO Option 2
CP/LE**

Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic and Therapeutic Procedures						
Laboratory Tests	Covered – 100%	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
Radiation Therapy	Covered – 100%	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
Diagnostic X-rays and Tests	Covered – with limitations ¹	Covered – 80% after deductible, with limitations ¹	Covered – 90% after deductible, with limitations ¹	Covered – 70% after deductible, with limitations ¹	Covered – with limitations ¹	Covered – 80% after deductible, with limitations ¹
Chemotherapy	Covered – 100%	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
Routine Pap Smear Test	Covered – 100%, one per calendar year (laboratory test only)	Not covered	Covered – 100%, one per calendar year (lab test only)	Not covered	Covered – 100%, one per calendar year (lab test only)	Not covered
Mammogram	Covered – 100%, one per calendar year, no age restriction	Covered – 80% after deductible, one per calendar year, no age restriction	Covered – 100%, one per calendar year, no age restriction	Covered – 70% after deductible, one per calendar year, no age restriction	Covered – 100%, one per calendar year, no age restriction	Covered – 80% after deductible, one per calendar year, no age restriction
Hospital Emergency Room Services						
At participating Hospitals	Covered – \$50 copay, waived if admitted or for an accidental injury	Covered – \$50 copay, waived if admitted or for an accidental injury	Covered – \$50 copay, waived if admitted or for an accidental injury	Covered – \$50 copay, waived if admitted or for an accidental injury	Covered – \$50 copay, waived if admitted or for an accidental injury	Covered – \$50 copay, waived if admitted or for an accidental injury
At Non Participating Hospitals in Plan Service Area	Covered – \$50 copay, waived if admitted or for an accidental injury	Covered – \$50 copay, waived if admitted or for an accidental injury	Covered – \$50 copay, waived if admitted or for an accidental injury	Covered – \$50 copay, waived if admitted or for an accidental injury	Covered – \$50 copay, waived if admitted or for an accidental injury	Covered – \$50 copay, waived if admitted or for an accidental injury
Ambulance Service	Covered – 100%, must be medically necessary	Covered – 100%, must be medically necessary	Covered – 100%, must be medically necessary	Covered – 100%, must be medically necessary	Covered – 100%, must be medically necessary	Covered – 100%, must be medically necessary
Maternity Services						
Prenatal and Post Partum Care	Covered – 100%	Covered – 80% after deductible	Covered – 100%	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
Delivery in Hospital	Covered – 100%	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
Newborn Examination(Inpatient)	Covered – 100%	Covered – 80% after deductible	Covered – 90% after deductible	Not covered	Covered – 100%	Not covered
Well-Baby Care (Outpatient)	Covered – 100%	Not covered	Covered – 100%	Not covered	Covered – 100%	Not covered
Other Medical Services						
Durable Medical Equipment	Covered – with limitations ¹	Covered – with limitations ¹	Covered – 90% after deductible, with limitations ¹	Covered – 70% after deductible, with limitations ¹	Covered – with limitations ¹	Covered – with limitations ¹
Prosthetic/Orthotic Devices	Covered – with limitations ¹	Covered – with limitations ¹	Covered – 90% after deductible, with limitations ¹	Covered – 70% after deductible, with limitations ¹	Covered – with limitations ¹	Covered – with limitations ¹
Home Health Care (Professional Services only)	Covered – 100%	Covered – 100%	Covered – 90% after deductible	Covered – 90% after deductible	Covered – 100%	Covered – 100%
Hospice Care	Covered – 100%, limited to lifetime dollar maximum which is adjusted annually by the State	Covered – 100%, limited to lifetime dollar maximum which is adjusted annually by the State	Covered – 100%, limited to lifetime dollar maximum which is adjusted annually by the State	Covered – 100%, limited to lifetime dollar maximum which is adjusted annually by the State	Covered – 100%, limited to lifetime dollar maximum which is adjusted annually by the State	Covered – 100%, limited to lifetime dollar maximum which is adjusted annually by the State
Skilled Nursing Facility	Covered – 100%, limited to 120 days per calendar year	Covered – 100%, limited to 120 days per calendar year	Covered – 100%, limited to 120 days per calendar year	Covered – 100%, limited to 120 days per calendar year	Covered – 100%, limited to 120 days per calendar year	Covered – 100%, limited to 120 days per calendar year
Hearing Services	Covered – \$10 copay per visit (exams, tests, hearing aid once every 36 months when provided by participating providers)	Not covered	Covered – \$15 copay per visit (exams, tests, hearing aid once every 36 months when provided by participating providers)	Not covered	Covered – \$10 copay per visit (exams, tests, hearing aid once every 36 months when provided by participating providers)	Not covered

**Community Blue PPO
CS/FM/PS**

**Community Blue PPO Option 1
CP/LE**

**Community Blue PPO Option 2
CP/LE**

Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Vision Services						
Eye Exam	Covered – \$5 copay. Once every 24 months, covers a complete eye exam including refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient	Covered – \$5 copay, up to \$35. Once every 24 months, covers a complete eye exam including refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient	Covered – \$5 copay up to \$35. Once every 24 months, covers a complete eye exam including refraction, glaucoma testing and other test necessary to determine the overall visual health of the patient	Covered – \$5 copay, up to \$35. Once every 24 months, covers a complete eye exam including refraction, glaucoma testing and other test necessary to determine the overall visual health of the patient	Covered – \$5 copay, up to \$35. Once every 24 months, covers a complete eye exam including refraction, glaucoma testing and other test necessary to determine the overall visual health of the patient	Covered – \$5 copay, up to \$35. Once every 24 months, covers a complete eye exam including refraction, glaucoma testing and other test necessary to determine the overall visual health of the patient
Frames	Covered – \$10 copay. One frame every 24 months. A wide selection of quality frames is fully covered by VSP frame allowance. Members should ask which frames are covered in full. Members may select a more expensive frame and pay a cost controlled price difference.	Covered – \$10 copay, up to predetermined amount. One frame every 24 months. A wide selection of quality frames is fully covered by VSP frame allowance. Members should ask which frames are covered in full. Members may select a more expensive frame and pay a cost controlled price difference.	Covered – \$10 copay. One frame every 24 months. (A wide selection of quality frames is fully covered by VSP frame allowance. Members should ask which frames are covered in full. Members may select a more expensive frame and pay a cost controlled price difference.)	Covered – \$10 copay, up to predetermined amount. One frame every 24 months. (A wide selection of quality frames is fully covered by VSP frame allowance. Members should ask which frames are covered in full. Members may select a more expensive frame and pay a cost controlled price difference.)	Covered – \$10 copay. One frame every 24 months. (A wide selection of quality frames is fully covered by VSP frame allowance. Members should ask which frames are covered in full. Members may select a more expensive frame and pay a cost controlled price difference.)	Covered – \$10 copay, up to predetermined amount. One frame every 24 months. (A wide selection of quality frames is fully covered by VSP frame allowance. Members should ask which frames are covered in full. Members may select a more expensive frame and pay a cost controlled price difference.)
Lenses	Covered – \$10 copay. One pair every 24 months. Single vision, bifocal and lenticular lenses are covered in full by the plan. Patients can choose glass or plastic lenses, as well as oversized lenses up to 61 mm. Pink lens tint (for glare reduction) are also covered in full.	Covered – \$10 copay, up to predetermined amount. One pair every 24 months. Single vision, bifocal and lenticular lenses are covered in full by the plan. Patients can choose glass or plastic lenses, as well as oversized lenses up to 61 mm. Pink lens tint (for glare reduction) are also covered in full.	Covered – \$10 copay. One pair every 24 months. Single vision, bifocal and lenticular lenses are covered in full by the plan. Patients can choose glass or plastic lenses, as well as oversized lenses up to 61 mm. Pink lens tint (for glare reduction) are also covered in full.	Covered – \$10 copay, up to predetermined amount. One pair every 24 months. Single vision, bifocal and lenticular lenses are covered in full by the plan. Patients can choose glass or plastic lenses, as well as oversized lenses up to 61 mm. Pink lens tint (for glare reduction) are also covered in full.	Covered – \$10 copay. One pair every 24 months. Single vision, bifocal and lenticular lenses are covered in full by the plan. Patients can choose glass or plastic lenses, as well as oversized lenses up to 61 mm. Pink lens tint (for glare reduction) are also covered in full.	Covered – \$10 copay, up to predetermined amount. One pair every 24 months. Single vision, bifocal and lenticular lenses are covered in full by the plan. Patients can choose glass or plastic lenses, as well as oversized lenses up to 61 mm. Pink lens tint (for glare reduction) are also covered in full.
Contacts	Covered – \$120 applied toward contact lens, fitting, evaluation and materials, member responsible for difference. Once every 24 months, members may obtain either eyeglasses or contact lenses, but not both.	Covered – \$120 applied toward contact lens, fitting, evaluation and materials, member responsible for difference. Once every 24 months, members may obtain either eyeglasses or contact lenses, but not both.	Covered – \$120 applied toward contact lens fitting, evaluation and materials, member responsible for difference. Once every 24 months. Members may obtain either eyeglasses or contact lenses, but not both.	Covered – \$120 applied toward contact lens fitting, evaluation and material, member responsible for difference. Once every 24 months. Members may obtain either eyeglasses or contact lenses, but not both.	Covered – \$120 applied toward contact lens fitting, evaluation and materials, member responsible for difference. Once every 24 months. Members may obtain either eyeglasses or contact lenses, but not both.	Covered – \$120 applied toward contact lens fitting, evaluation and material, member responsible for difference. Once every 24 months. Members may obtain either eyeglasses or contact lenses, but not both.
Therapeutic Contact Lenses	Covered – 100% after \$10 copay, must be medically necessary and VSP providers must receive prior approval.	Covered – \$210 maximum, member responsible for difference (must be medically necessary)	Covered – 100% after \$10 copay, must be medically necessary and VSP Providers must receive prior approval	Covered – \$210 maximum, member responsible for difference (must be medically necessary)	Covered – 100% after \$10 copay; must be medically necessary and VSP Providers must receive prior approval	Covered – \$210 maximum, member responsible for difference (must be medically necessary)
Prescriptions						
Retail Prescription Drugs	Covered – \$10 for generic, \$20 for brand name	Covered – 75% of approved amount, plus copay	Covered – \$10 for generic, \$20 for Preferred brand-name drugs listed on the BCBSM Custom Formulary, \$30 for Nonpreferred brand-name drugs not listed on the BCBSM Custom Formulary	Covered – 75% of approved amount less copay	Covered – \$10 for generic, \$20 for Preferred brand-name drugs listed on the BCBSM Custom Formulary, \$30 for Nonpreferred brand-name drugs not listed on the BCBSM Custom Formulary	Covered – 75% of approved amount less copay
Mail Order Drugs²	Covered - 90 day supply with one copayment	N/A	Covered – 90 day supply, \$30 for generic, \$60 for Preferred brand-name drugs listed on the BCBSM Custom Formulary, \$90 for Nonpreferred brand-name drugs not listed on the BCBSM Custom Formulary. Mandatory mail order for maintenance drugs after third refill is strongly recommended.	N/A	Covered – 90 day supply, \$30 for generic, \$60 for Preferred brand-name drugs listed on the BCBSM Custom Formulary, \$90 for Nonpreferred brand-name drugs not listed on the BCBSM Custom Formulary. Mandatory mail order for maintenance drugs after third refill is strongly recommended.	N/A
Birth Control Pills	Covered – \$10 for generic, \$20 for brand name	Covered – 75% of approved amount, plus copay	Covered – \$10 for generic, \$20 for Preferred brand-name drugs listed on the BCBSM Custom Formulary, \$30 for Nonpreferred brand-name drugs not listed on the BCBSM Custom Formulary	Covered – 75% of amount billed then copay	Covered – \$10 for generic, \$20 for Preferred brand-name drugs listed on the BCBSM Custom Formulary, \$30 for Nonpreferred brand-name drugs not listed on the BCBSM Custom Formulary	Covered – 75% of amount billed then copay
Birth Control Devices	Covered – 100%	Covered – 80% after deductible	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible

**Community Blue PPO
CS/FM/PS**

**Community Blue PPO Option 1
CP/LE**

**Community Blue PPO Option 2
CP/LE**

Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health Care						
Inpatient Psychiatric Services	Covered – 80%, limited to 60 days annually, 120 days lifetime	Covered – 80%, limited to 60 days annually, 120 days lifetime	Covered – 80%, limited to 60 days annually, 120 days lifetime	Covered – 80% after deductible, limited to 60 days annually, 120 days lifetime	Covered – 80%, limited to 60 days annually, 120 days lifetime	Covered – 80% after deductible, limited to 60 days annually, 120 days lifetime
Outpatient Visits	Covered – 80%, facility and clinic; Covered – 80%, physician's office	Covered – 80%, facility and clinic; Covered – 80%, physician's office, after deductible	Covered – 80%, facility and clinic; Covered – 80%, physician's office	Covered – 80%, facility and clinic; Covered – 80%, physician's office, after deductible	Covered – 80%, facility and clinic; Covered – 80%, physician's office	Covered – 80%, facility and clinic; Covered – 80%, physician's office, after deductible
Alcoholism and Substance Abuse						
Inpatient Services	Covered – 80%, limited to 60 days annually, 120 days lifetime	Covered – 80% after deductible, limited to 60 days annually, 120 days lifetime	Covered – 80%, limited to 60 days annually, 120 days lifetime	Covered – 80% after deductible, limited to 60 days annually, 120 days lifetime	Covered – 80%, limited to 60 days annually, 120 days lifetime	Covered – 80% after deductible, limited to 60 days annually, 120 days lifetime
Detoxification	Included in inpatient services above	Included in inpatient services above	Included in inpatient services above	Included in inpatient services above	Included in inpatient services above	Included in inpatient services above
Outpatient Services	Covered – 80%, facility and clinic; Covered – 80%, physician's office	Covered – 80%, facility and clinic; Covered – 80%, physician's office, after deductible	Covered – 80%, facility and clinic; Covered – 80%, physician's office	Covered – 80%, facility and clinic; Covered – 80%, physician's office, after deductible	Covered – 80%, facility and clinic; Covered – 80%, physician's office	Covered – 80%, facility and clinic; Covered – 80%, physician's office, after deductible
Miscellaneous						
Deductible	None	Covered – \$250 per member, \$500 per family	Covered – \$250 per member, \$500 per family	Covered – \$500 per member, \$1,000 per family	None	Covered – \$250 per member, \$500 per family
Coinsurance	Copays as noted	Covered – 20% out-of-network, copays as noted	Covered – 10% in-network; maximum: \$500 per member, \$1,000 per family	Covered – 30% out-of-network; maximum: \$2,500 per member, \$5,000 per family	None	Covered – 20% out-of-network; maximum: \$2,000 per member, \$4,000 per family
Claim Forms	None	Nonparticipating providers only	None	Nonparticipating providers only	None	Nonparticipating providers only
Conversion Option	Yes	Yes	Yes	Yes	Yes	Yes
Pre-Existing Condition	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Dependent Coverage	Covered – up to age 19. Family Continuation Rider ages 19-25, unmarried, and IRS dependent. Sponsored Dependent at least 19 years of age or older, related by blood or marriage, IRS dependent.	Covered – up to age 19. Family Continuation Rider ages 19-25, unmarried, and IRS dependent. Sponsored Dependent at least 19 years of age or older, related by blood or marriage, IRS dependent.	Covered – up to age 19. Family Continuation Rider ages 19-25, unmarried, and IRS dependent. Sponsored Dependent at least 19 years of age or older, related by blood or marriage, IRS dependent.	Covered – up to age 19. Family Continuation Rider ages 19-25, unmarried, and IRS dependent. Sponsored Dependent at least 19 years of age or older, related by blood or marriage, IRS dependent.	Covered – up to age 19. Family Continuation Rider ages 19-25, unmarried, and IRS dependent. Sponsored Dependent at least 19 years of age or older, related by blood or marriage, IRS dependent.	Covered – up to age 19. Family Continuation Rider ages 19-25, unmarried, and IRS dependent. Sponsored Dependent at least 19 years of age or older, related by blood or marriage, IRS dependent.

Footnotes

¹ Contact Customer Service for additional information at 800-637-2227 (8:30 a.m.–12:00 p.m., 1:00 p.m. - 5:00 p.m., Monday – Friday).

² When a member obtains a brand-name drug (preferred or nonpreferred), the copay for Tier 2 or 3 still applies even if the prescription indicates "Dispense as Written" (DAW) or the brand name medication has no generic equivalent.