Blue Cross
Blue Shield
Blue Care Network
of Michigan

Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

CITY of JACKSON #007000992-0019

Community Blue℠ PPO LG – CBPPO5000 HRA Medical Coverage

Effective July 1, 2014

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/coinsurance. 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.

Preauthorization for Select Services – Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

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.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)	In-network	Out-of-network *
Deductibles	$5,000 for one member $10,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** See attached Deductible Reimbursement Guidelines & Claim Form outlining Employer payment of $4500/person, $9000/family of stated deductible requirement.	$10,000 for one member $20,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $10 copay for office visits and office consultations • $10 copay for chiropractic services and osteopathic manipulative therapy • $50 copay for emergency room visits	$50 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 care	• 50% of approved amount for private duty nursing care • 20% of approved amount for mental health care and substance abuse treatment • 20% of approved amount for most other covered services
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if applicable	$6,350 for one member $12,700 for two or more members each calendar year	$15,000 for one member $30,000 for two or more members each calendar year **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

* Services from a provider for which there is no Michigan PPO network and services from an out-of-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.

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	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/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	80% 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/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 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/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent or medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Colonoscopy	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent or medically necessary colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible
	One per member per calendar year	

Physician office services		
Office visits – must be medically necessary	$10 copay per office visit	80% after out-of-network deductible
Outpatient and home medical care visits – must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations – must be medically necessary	$10 copay per office visit	80% after out-of-network deductible
Urgent care visits – must be medically necessary	$10 copay per office visit	80% after out-of-network deductible

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	In-network	Out-of-network *
Emergency medical care		
Hospital emergency room	$50 copay per visit (copay waived if admitted or for an accidental injury)	$50 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	100% after in-network deductible	100% after in-network deductible
Diagnostic services		
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% after out-of-network deductible
Maternity services provided by a physician or certified nurse midwife		
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Delivery and nursery care	100% after in-network deductible	80% after out-of-network deductible
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care – must be in a **participating** skilled nursing facility	100% after in-network deductible	100% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
	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 • must be provided by a **participating** home health care agency	100% after in-network deductible	100% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization – consult with your doctor	100% after in-network deductible	100% after in-network deductible

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	In-network	Out-of-network *
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see **"Preventive care services."**	100% after in-network deductible	80% after out-of-network deductible
Human organ transplants		
Specified human organ transplants – must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) – in designated facilities **only**
Bone marrow transplants – must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	100% after in-network deductible	80% after out-of-network deductible
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

Mental health care and substance abuse treatment

Note: Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health and substance abuse service is considered by BCBSM to be comparable to an office visit, you pay only for an office visit as described in your certificate or related riders.

This means when these services are performed by an in-network provider, you will have no in-network deductible. You will be responsible for the flat-dollar member copay that applies to office visits. When these services are performed by an out-of-network provider, you will be responsible for your annual out-of-network deductible and the coinsurance amount that applies to covered out-of-network services.

Inpatient mental health care and **inpatient** substance abuse treatment	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Outpatient mental health care: • Facility and clinic	100% after in-network deductible	100% after in-network deductible, in participating facilities **only**
• Physician's office	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities **only**	100% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

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	In-network	Out-of-network *
Autism spectrum disorders, diagnoses and treatment		
Applied behavioral analysis (ABA) treatment – when rendered by an approved board-certified behavioral analyst – is limited to a maximum of 25 hours of direct line therapy per week per member, through age 18 **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment. ABA and AAEC services are not available outside of Michigan.	100% after in-network deductible	100% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is limited to the same annual **combined** limit as for physical, speech and occupational therapy for other diagnoses	
Other covered services, including mental health services, for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible
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 an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	100% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay/coinsurance) for diabetes self-management training	80% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$10 copay per office visit	80% 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	100% after in-network deductible	80% 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 (visits are **combined** with therapies for autism spectrum disorder)	
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 an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	100% after in-network deductible	100% after in-network deductible
Prescription Drugs – See Next Page(s)	$10/20/40	$10/20/40
Prosthetic and orthotic appliances	100% after in-network deductible	100% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

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BLUE CROSS BLUE SHIELD OF MICHIGAN

Procedure Code Guidelines – COMMUNITY BLUE PPO – Effective 1/1/2011

Preventative Benefits*

Referrals NOT eligible=Payable In Network only;

Payable at 100% IF billed with ***ROUTINE** Diagnosis

The following procedure codes are accepted through Michigan claims processing system:

I. ROUTINE/PREVENTATIVE PROCEDURES:

HEALTH MAINTENANCE EXAM – One per calendar year
- Codes 99384 to 99387; Codes 99394 to 99397; Code G0344

ANNUAL GYNECOLOGICAL EXAM – One per calendar year
- Code G0101, S0610, S0612, S0613

ROUTINE PAP SMEAR – One per calendar year
- Codes G0123, G0124, G0141 to G0143, G0144, G0145, G0147, G0148, P3000, P3001 (Panel Lab Only*)
- Codes Q0091, 87620, 87621, 88141-88143, 88147, 88148, 88150, 88152, 88155, 88164, 88167, 88174, 88175

ROUTINE MAMMOGRAM / ROUTINE COLONOSCOPY – One per calendar year

WELL BABY AND CHILD CARE – Through Age 15
(6 visits=birth thru 12 mos; 6 visits=13 mos thru 23 mos; 2 visits=24 mos thru 35 mos; 2 visits=36 mos thru 47 mos; and 1 visit per birth year=48 mos thru age 15)
- Codes 99381 to 99384, 99391 to 99394

IMMUNIZATIONS – Through Age 16
(+Adult Immunization as recommended by the Advisory Committee on Immunization Practices)
(DTP-5 dose; Polis-6 dose; MMR-2 dose; HIB-4 dose; Hepatitis B-3 dose; ChickenPox)
- Codes 90465, 90466, 90471, 90472, 90632, 90633, 90634, 90645 to 90648, 90649, 90655, 90656, 90657, 90658, 90660, 90669, 90680, 90700, 90702 to 90708, 90710, 90713, 90714, 90715, 90716; 90718, 90721, 90723, 90732; 90740, 90743, 90744, 90746, 90747, 90748

FLEXIBLE SIGMOIDOSCOPY – One per calendar year
- Code G0104

FECAL OCCULT BLOOD SCREENING – One per calendar year
- Code 82270 & 82274, G0107, G0328

CHOLESTEROL TEST/SCREENING – One per calendar year
- Code 83718 - Lipoprotein (Panel Lab Only*)
- Code 80061 - Lipid Panel – must include Cholesterol, serum #82465; Lipoprotein-HDL #83718; and Triglyceride #84478 (Panel Lab Only*)

CHEMICAL/LAB PROFILES – One per calendar year
- Codes 80050, 80051, 80053, 80061 (Panel Lab Only*)

CHEMISTRY – One per calendar year
- Codes 83655, 83718 (Panel Lab Only*)

URINALYSIS – One per calendar year
- Code 81000-81003

COMPLETE BLOOD COUNT (CBC) – One per calendar year
- Code 85004, 85013, 85014, 85018, 85025, 85027, G0306, G0307

EKG – One per calendar year
- Codes 93000, 93010, 93005,G0366, G0367, G0368

CHEST X-RAY – One per calendar year
- Code 71020

PROSTATE SPECIFIC ANTIGEN (PSA) – One per calendar year
- Code 84153, 84154, G0103

PLEASE NOTE THAT THE ABOVE LIST OF PROCEDURE CODES REPRESENT THOSE CPT CODES RECOGNIZED THROUGH MICHIGAN BLUE CROSS BLUE SHIELD CLAIM SYSTEMS AS PART OF THE COMMUNITY BLUE CERTIFICATE OF BENEFITS & THE AFFORDABLE CARE ACT of 2010. FOR DETAILED NARRATIVE AND DESCRIPTION PLEASE REFER TO CPT CODE MANUALS.

*Panel Labs are independent labs that have contracted with the PLUS Lab Program for PPO members.

Blue Cross Blue Shield of Michigan and Blue Care Network HMO's are independent licensees of the Blue Cross Blue Shield Association.

CITY OF JACKSON – DEDUCTIBLE REIMBURSEMENT FORM CBPPO

REQUEST FOR REIMBURSEMENT
(Deductible Payment to PROVIDERS)

Employee Name		Employee Ph#
Street Address		
City	State	Zip

The undersigned participant in the City of Jackson's CBPPO HRA/deductible reimbursement benefit plan certifies that all expenses, for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the City of Jackson's health benefit plan. The undersigned fully understands that he or she cannot submit a claim for reimbursement or payment unless the claim has ***first been submitted to Blue Cross***, and a copy of the Blue Cross Explanation of Benefits (***EOB***), including the "Detail of Services" is ***attached*** to this claim form. The undersigned understands that expenses for non-covered benefits under the applicable Blue Cross health insurance plan are not eligible for reimbursement under this deductible reimbursement plan. Checks will be mailed, as appropriate, to the service provider or to the employee at the address on file. ***Remember to retain a personal copy of this form and any documents submitted to substantiate expenses.***

HEALTH EXPENSES ELIGIBLE FOR EMPLOYEE REIMBURSEMENT OR PAYMENT TO PROVIDER

1. Check "Pay Provider" and *include the original itemized bill or statement from the Provider showing their name/address*. Also attach a *complete copy of Explanation of Benefits form (EOB) from BCBS*. BOTH documents must be attached in order to pay for any deductible amounts exceeding the $500/person or $1000/family initial employee responsibility. Please note: You will need to submit ALL claims applied to the Blue Cross deductible, including the initial $500/$1000 even though that will remain your payment responsibility. We MUST receive those deductible claims in order to record/register that you have met your initial $500/$1000 deductible liability.

☐ **Pay Provider**

☐ Complete EOB Attached. (**Must** include the 'Detail' description of individual claim data-not just the summary page.)

☐ Statement or bill from Provider. (**Must** include name and address of provider.)

Signature:	Date:

Provide completed form and supporting documentation to:

JFP Benefit Management, Inc.
Phone: (517) 784-0535; or (800) 589-7660;
Fax: (517) 784-0821
Mail: P.O. Box 189 - Jackson, Michigan 49204
Delivery: 100 S. Jackson, Suite 200, Jackson, MI 49201.

Questions – JFP Benefit Management, Inc.
Mindy Warren or Donna Pelham

CITY OF JACKSON
120 W. Michigan Avenue, Jackson MI 49201
Health/Deductible Reimbursement Arrangement – Community Blue PPO
Effective 7-01-2014

Your employer has implemented a Health Reimbursement Arrangement (HRA) plan to help offset your deductible healthcare expenses. JFP Benefit Management, Inc., a Third Party Administrator (TPA) has been retained to process claims for this plan.

Outlined below are the specifics of the plan and how to get reimbursed for eligible benefits that have been applied to your deductible.

Benefit of the Health Reimbursement Arrangement (HRA) Plan designed to pay the following *DEDUCTIBLE's:

1. Single Coverage: $5000.00 w/ $4500 Reimbursed by Employer – after $500 Employee Responsibility
2. 2 Person/Family Coverage: $10,000.00 w/ $9000 Reimbursed by Employer – after $1000 Employee Responsibility

**NOTE: Once the $5000/$10,000 deductible amount has been met, Blue Cross Blue Shield will reimburse hospital-medical/surgical services at 100% for the remainder of the year. EXCEPTION: Services with flat copays (OV, Chiropractic Adjustment, ER, Rx) do NOT apply to deductible/coinsurance requirement. Thus the Employee is responsible for such copays both prior to and after deductible has been met. See attached Benefit Chart for complete detail.*

Expenses eligible for reimbursement: Medical expenses applied to your deductible by BCBSM

How to submit a claim:

1. Use Attached claim form (Obtain add'l claim forms from your Human Resources Department or JFP.)
2. Complete the claim form with supporting documentation (Explanation of Benefits from Blue Cross Blue Shield of Michigan, Provider Statement) for each expense that has been applied to your deductible.
3. You can submit your claims by fax, mail or in person:
   a. Fax - (517) 784-0821
   b. Mail - JFP Benefit Management, Inc., P.O. Box 189, Jackson, MI 49204
   c. Person - JFP Benefit Management, Inc., 100 S. Jackson, Ste 200, Jackson, MI 49201
4. Claims received prior to 2:00 p.m. will be processed that day. Claims received after 2:00 p.m. will be processed the next business day.
5. Reimbursements will be made as directed on the claim form directly to the Provider.

Additional information:

1. Questions about processing claims for payment and reimbursement can be directed to the claims department at JFP Benefit Management, Inc. Please ask for Mindy Warren or Donna Pelham.
2. CBPPO Plan (Deductible) year is on a calendar year basis – January 1 through December 31.
3. Claims can be submitted up to 90 days after the end of the plan year for service during the preceding plan year.