



**Michigan Osteopathic
Association**

**Health Care Selection Guide
Options 1, 3 & 4**



**Blue Cross
Blue Shield
Blue Care Network
of Michigan**

Independent licensees of the Blue Cross and Blue Shield Association.

Traditional Health Care Coverage Options

Option 1

Options 3 & 4

Preventive Services

Health maintenance exam	Not covered	Not covered
Annual gynecological exam	Not covered	Not covered
Pap smear screening – laboratory services only	Covered at 100%, one every 12 months	Covered at 80% after deductible, one every 12 months
Well-baby and child care	Not covered	Not covered
Immunizations	Not covered	Not covered
Proctoscopic exam	Not covered	Not covered

Mammography

Mammography screening	Covered at 100%, one baseline for ages 35-40, one annually after age 40	Covered at 80% after deductible, one baseline for ages 35-40, one annually after age 40
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Physician Office Services

Office visits, including office consultations	Covered under Master Medical (MM) at 80% after deductible	Covered at 80% after deductible
Outpatient and home visits	Covered under MM at 80% after deductible	Covered at 80% after deductible

Emergency Medical Care

Hospital emergency room	Covered at 100%	Covered at 80% after deductible
Ambulance services – medically necessary	Covered under MM at 80% after deductible	Covered at 80% after deductible

Diagnostic Services

Laboratory and pathology tests	Covered at 100%	Covered at 80% after deductible
Diagnostic tests and X-rays	Covered at 100%	Covered at 80% after deductible
Radiation therapy	Covered at 100%	Covered at 80% after deductible

Maternity Services Provided by a Physician or Certified Nurse Midwife

Pre-natal and post-natal care	Covered under MM at 80% after deductible	Covered at 80% after deductible
Delivery and nursery care	Covered at 100%	Covered at 80% after deductible

Hospital Care

Semi-private room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital	Covered at 100%, up to 365 days, 60-day renewal, additional days under MM at 100%	Covered at 80% after deductible, unlimited days
Inpatient consultations	Covered at 100%	Covered at 80% after deductible
Chemotherapy	Covered at 100%	Covered at 80% after deductible

Alternatives to Hospital Care

Skilled nursing care	Not covered	Not covered
Hospice care	Covered at 100%, limited to lifetime dollar maximum which is adjusted periodically	Covered at 100%, limited to lifetime dollar maximum which is adjusted periodically
Home health care	Covered at 100%	Covered at 100%

Surgical Services

Surgery – includes related surgical services	Covered at 100%	Covered at 80% after deductible
Voluntary sterilization	Covered at 100%	Covered at 80% after deductible

Human Organ Transplants

Specified organ transplants – in designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered at 100%	Covered in designated facilities only
Up to \$1 million maximum per transplant type		

Traditional Health Care Coverage Options

Option 1

Options 3 & 4

Human Organ Transplants, *continued*

Bone marrow transplants – when coordinated through BCBSM Human Organ Transplant Program (1-800-242-3504); specific criteria applies	Covered at 100%	Covered at 80% after deductible
Kidney, cornea and skin transplants	Covered at 100%	Covered at 80% after deductible

Mental Health Care and Substance Abuse Treatment

Inpatient mental health care	Covered at 100%, up to 45 days, 60-day renewal, additional days under MM at 50% after deductible	Covered at 50% after deductible
Inpatient substance abuse care	Covered at 100%, unused mental health care days, no MM coverage	Covered at 50% after deductible
Outpatient mental health care:	Covered under MM at 50% after deductible	Covered at 50% after deductible
Outpatient substance abuse care – in approved facilities	Covered at 100%, up to the state-dollar amount which is adjusted annually	Covered at 50% after deductible, up to the state-dollar amount which is adjusted annually

Other Services

Allergy testing and therapy	Covered under MM at 80% after deductible	Covered at 80% after deductible
Chiropractic spinal manipulation	Covered under MM at 80% after deductible, up to 20 visits first 90 consecutive days, then 2 visits per month	Covered at 80% after deductible, up to 20 visits first 90 consecutive days, then 2 visits per month
Outpatient physical, speech and occupational therapy:	Covered under MM at 80% after deductible, up to 60 consecutive days of treatment per condition, additional benefits under MM at 80% after deductible	Covered at 80% after deductible, unlimited days
Durable medical equipment	Covered under MM at 80% after deductible	Covered at 80% after deductible
Prosthetic and orthotic appliances	Covered under MM at 80% after deductible	Covered at 80% after deductible
Private duty nursing	Covered under MM at 50% after deductible	Covered at 50% after deductible
Prescription drugs	Covered under MM at 80% after deductible	Not covered

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.

Deductible – per calendar year	Basic Coverage: None MM Coverage: \$100 per member, \$200 per family	Option 3: \$250 per member, \$500 per family Option 4: \$500 per member, \$1,000 per family
Copays	Basic Coverage: None MM Coverage: 20% for general services and 50% for mental health care and private duty nursing	20% for general services and 50% for mental health care, substance abuse care and private duty nursing
Copay dollar maximum – excludes mental health care, substance abuse care and private duty nursing	Basic Coverage: None MM Coverage: \$1,000 family	\$1,000 family
Dollar maximums – per member	Basic Coverage: \$1 million lifetime per covered specified organ transplant type and as noted for individual services MM Coverage: \$1million lifetime	\$1 million lifetime per covered specified organ transplant type and \$5 million lifetime for other covered services and as noted for individual services

Vision Care Program Option

A-80 Vision Care Plan

Copays:

- \$5 for eye exam
- Combined \$7.50 for lenses and frames or medically necessary contact lenses

Benefit Period: All vision benefits are covered once every 24 consecutive months. During any 24-month period, benefits are payable for either eyeglasses or contact lenses, but not both.

Participating Vision Provider: Benefits are covered at 100% of approved amount less copay.

Nonparticipating Vision Provider: If you receive services from a nonparticipating provider, you will be reimbursed 75% of approved amount less \$5 copay for vision exam and at a predetermined amount for all other benefits. You are responsible for any difference between your vision provider's charge and the approved amount.

Exams – Covers visual testing by an optometrist or ophthalmologist, including history, testing sharpness of vision, internal and external exam of the eyes, and testing for glaucoma (when necessary).

Corrective lenses – Covers one pair of glass or plastic lenses less than 65 mm in diameter. The provider may charge you for the difference in cost between standard and oversize lenses. Tinted lenses are covered when prescribed for medical reasons.

Contact lenses – Covers contact lenses that meet medical necessity criteria. If contact lenses are selected, but not medically necessary, your plan will pay a maximum of \$35. You are responsible for any difference between this amount and the provider's charge.

Frames – Covers standard plastic, metal or wire eyeglass frame, up to the approved amount. If you select more expensive frames, the provider may charge you for the difference between the usual retail charge for covered frames and the more expensive frames.

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 of Michigan certificate 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 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.

DEC 02/RE