



**Michigan Osteopathic  
Association**

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Health Care Selection Guide  
Option 5



Blue Cross  
Blue Shield  
Blue Care Network  
of Michigan

# Community Blue<sup>SM</sup> PPO with Prescription Drugs and Vision

## In-Network

## Out-of-Network

*Services without a network are covered at the in-network level.*

### Preventive Services – Limited to \$250 per member per calendar year

Health maintenance exam – includes select lab and diagnostic procedures	Covered at 100%, one per calendar year	Not covered
Annual gynecological exam	Covered at 100%, one per calendar year	Not covered
Pap smear screening – laboratory services only	Covered at 100%, one per calendar year	Not covered
Well-baby and child care	Covered at 100% <ul style="list-style-type: none"> <li>• 6 visits per year through age 1</li> <li>• 2 visits per year, age 2 through 3</li> <li>• 1 visit per year, age 4 through 15</li> </ul>	Not covered
Immunizations	Covered at 100%, up through age 16	Not covered
Fecal occult blood screening	Covered at 100%, one per calendar year	Not covered
Flexible sigmoidoscopy exam	Covered at 100%, one per calendar year	Not covered
Prostate specific antigen (PSA) screening	Covered at 100%, one per calendar year	Not covered

### Mammography

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

### Physician Office Services

Office visits, including office consultations	Covered less \$10 copay	Covered at 80% after deductible, must be medically necessary
Outpatient and home visits	Covered at 100%	Covered at 80% after deductible, must be medically necessary
Urgent care visits	Covered less \$10 copay	Covered at 80% after deductible, must be medically necessary

### Emergency Medical Care

Hospital emergency room	Covered less \$50 copay, waived if admitted or for an accidental injury	Covered less \$50 copay, waived if admitted or an accidental injury
Ambulance services – medically necessary	Covered at 100%	Covered at 100%

### 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 at 100%	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	Covered at 100%	Covered at 80% after deductible
<b>Note:</b> Nonemergency services must be rendered in a participating hospital	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	Covered at 100%	Covered at 100%
Up to 120 days per calendar year		
Home care	Covered at 100%	Covered at 100%
Limited to lifetime dollar maximum which is adjusted periodically		
Home health care	Covered at 100%, unlimited visits	Covered at 100%, unlimited visits

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## In-Network

## Out-of-Network

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### 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 <b>only</b>
Up to \$1 million maximum per transplant type		
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 and substance abuse care	Covered at 50%	Covered at 50% after deductible
Unlimited days		
Outpatient mental health care: • Facility and clinic • Physician's office	Covered at 50%	Covered at 50%
	Covered at 50%	Covered at 50% after deductible
Outpatient substance abuse care – in approved facilities	Covered at 50%	Covered at 50% after deductible
Up to the state-dollar amount which is adjusted annually		

### Other Services

Allergy testing and therapy	Covered at 100%	Covered at 80% after deductible
Chiropractic spinal manipulation	Covered at 100%	Covered at 80% after deductible
Up to 24 visits per calendar year		
Outpatient physical, speech and occupational therapy: • Facility and clinic • Physician's office – <b>excludes speech and occupational therapy</b>	Covered at 100%	Covered at 100%
	Covered at 100%	Covered at 80% after deductible
A combined 60-visit maximum per calendar year for physical therapy in the outpatient department of a hospital as well as in the physician's office		
Durable medical equipment	Covered at 100%	Covered at 100%
Prosthetic and orthotic appliances	Covered at 100%	Covered at 100%
Private duty nursing	Covered at 50%	Covered at 50%

### 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.

<b>Deductible</b> – per calendar year	None	\$250 per member, \$500 per family
<b>Copay</b> • Fixed dollar copay	\$10 for office visits and \$50 for emergency room visits	\$50 for emergency room visits
• Percent copay	50% for mental health care, substance abuse care and private duty nursing	20% for general services and 50% for mental health care, substance abuse care and private duty nursing
<b>Copay dollar maximum</b> – per calendar year • Fixed dollar copay	None	None
• Percent copay – excludes mental health care, substance abuse care and private duty nursing copays	Not applicable	\$2,000 per member, \$4,000 per family
<b>Dollar maximums</b> – per member	\$1 million lifetime per covered specified organ transplant type and \$5 million lifetime for other covered services and as noted for individual services	

## Prescription Drug Coverage Option

<p><b>Preferred Rx Prescription Drug Plan</b></p> <p>Covers:</p> <ul style="list-style-type: none"> <li>• Federal-legend drugs</li> <li>• State-controlled drugs</li> <li>• Needles and syringes</li> </ul>	<p><b>Copay:</b> \$10 copay for each generic drug or \$40 copay for each brand-name drug, even if the prescription is marked DAW or there is no generic equivalent drug available</p> <p><b>Payment of Benefits:</b></p> <ul style="list-style-type: none"> <li>• Network Pharmacy – 100% of approved amount less copay</li> <li>• Non-Network Pharmacy – 75% of approved amount less copay</li> </ul>
<p>Mail order prescription drugs</p>	<p>Up to a 90-day supply of prescribed medication by mail from Medco Health Solutions with a \$10 copay for each generic drug or a \$40 copay for each brand-name drug, even if the prescription is marked DAW or there is no generic equivalent drug available</p>

A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a Medco Health Prescription Solutions pharmacy outside Michigan. A **non-network** pharmacy is a pharmacy not part of the Preferred Rx or Medco Health networks.

## Vision Care Program Option

<p><b>A-80 Vision Care Plan</b></p> <p><b>Copays:</b></p> <ul style="list-style-type: none"> <li>• \$5 for eye exam</li> <li>• Combined \$7.50 for lenses and frames <u>or</u> medically necessary contact lenses</li> </ul> <p><b>Frequency:</b> All vision benefits are covered once every 24 consecutive months. During any 24-month period, benefits are payable for either eyeglasses <u>or</u> contact lenses, but not both.</p> <p><b>Participating Vision Provider:</b> Benefits are covered at 100% of approved amount less copay.</p> <p><b>Nonparticipating Vision Provider:</b> 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.</p>	<p><b>Exams</b> – 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).</p> <p><b>Corrective lenses</b> – 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.</p> <p><b>Contact lenses</b> – 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.</p> <p><b>Frames</b> – 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.</p>
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*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.*