



Michigan Osteopathic  
Association

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## Health Care Selection Guide Option 6



Blue Cross  
Blue Shield  
Blue Care Network  
of Michigan

Independent licensees of the Blue Cross and Blue Shield Association.

# Community Blue<sup>SM</sup> PPO

## Benefits-at-a-Glance

### Plan 8

#### In-Network

#### Out-of-Network

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

Health Maintenance Exam – includes chest X-ray, EKG and select lab procedures	Covered – 100%, one per calendar year	Not Covered
Annual Gynecological Exam	Covered – 100%, one per calendar year	Not Covered
Pap Smear Screening – laboratory services only	Covered – 100%, one per calendar year	Not Covered
Well-Baby and Child Care	Covered – 100% • 6 visits per year through age 1 • 2 visits per year, age 2 through 3 • 1 visit per year, age 4 through 15	Not Covered
Immunizations	Covered – 100%, up through age 16	Not Covered
Fecal Occult Blood Screening	Covered – 100%, one per calendar year	Not Covered
Flexible Sigmoidoscopy Exam	Covered – 100%, one per calendar year	Not Covered
Prostate Specific Antigen (PSA) Screening	Covered – 100%, one per calendar year	Not Covered

#### Mammography

Mammography Screening	Covered – 80% after deductible	Covered – 60% after deductible
	One per calendar year, no age restrictions	

#### Physician Office Services

Office Visits	Covered – \$20 copay	Covered – 60% after deductible, must be medically necessary
Outpatient and Home Visits	Covered – 80% after deductible	Covered – 60% after deductible, must be medically necessary
Office Consultations	Covered – \$20 copay	Covered – 60% after deductible, must be medically necessary
Urgent Care Visits	Covered – \$20 copay	Covered – 60% after deductible, must be medically necessary

#### Emergency Medical Care

Hospital Emergency Room – approved diagnosis	Covered – \$50 copay, waived if admitted or for an accidental injury	Covered – \$50 copay, waived if admitted or for an accidental injury
Ambulance Services – medically necessary	Covered – 80% after deductible	Covered – 80% after deductible

#### Diagnostic Services

Laboratory and Pathology Tests	Covered – 80% after deductible	Covered – 60% after deductible
Diagnostic Tests and X-rays	Covered – 80% after deductible	Covered – 60% after deductible
Radiation Therapy	Covered – 80% after deductible	Covered – 60% after deductible

#### Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – 100%, includes care provided by a Certified Nurse Midwife	Covered – 60% after deductible, includes care provided by a Certified Nurse Midwife
Delivery and Nursery Care	Covered – 80% after deductible, includes delivery provided by a Certified Nurse Midwife	Covered – 60% after deductible, includes delivery provided by a Certified Nurse Midwife

#### Hospital Care

Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 80% after deductible	Covered – 60% after deductible
	Unlimited days	
Inpatient Consultations	Covered – 80% after deductible	Covered – 60% after deductible
Chemotherapy	Covered – 80% after deductible	Covered – 60% after deductible

#### Alternatives to Hospital Care

Skilled Nursing Care	Covered – 80% after deductible	Covered – 80% after deductible
	Up to 120 days per calendar year	
Hospice Care	Covered – 100%	Covered – 100%
	Limited to the lifetime dollar maximum which is adjusted annually by the state	
Home Health Care	Covered – 80% after deductible	Covered – 80% after deductible
	Unlimited visits	

**In-Network**

**Out-of-Network**

**Surgical Services**

Surgery – includes related surgical services	Covered – 80% after deductible	Covered – 60% after deductible
Voluntary Sterilization	Covered – 80% after deductible	Covered – 60% after deductible

**Human Organ Transplants**

Specified Organ Transplants – in designated facilities	Covered – 80% after deductible	Covered – 60% after deductible
	Up to \$1 million maximum per transplant	
Bone Marrow – in designated cancer centers	Covered – 80% after deductible	Covered – 60% after deductible
Kidney, Cornea and Skin	Covered – 80% after deductible	Covered – 60% after deductible

**Mental Health Care and Substance Abuse Treatment**

Inpatient Mental Health Care and Substance Abuse Care	Covered – 50% after deductible	Covered – 50% after deductible
	Unlimited days	
Outpatient Mental Health Care • Facility and Clinic • Physician's Office	Covered – 50% after deductible	Covered – 50% after deductible
	Covered – 50%	Covered – 50% after deductible
Outpatient Substance Abuse Care	Covered – 50% after deductible	Covered – 50% after deductible
	Up to the state-dollar amount which is adjusted annually	

**Other Services**

Allergy Testing and Therapy	Covered – 100%	Covered – 60% after deductible
Chiropractic Spinal Manipulation	Covered – 100%	Covered – 60% after deductible
Outpatient Physical, Speech and Occupational Therapy	Up to 24 visits per calendar year	
	Covered – 80% after deductible	Covered – 60% after deductible
Durable Medical Equipment	Up to 60 visits per calendar year	
	Covered – 80% after deductible	Covered – 80% after deductible
Prosthetic and Orthotic Appliances	Covered – 80% after deductible	Covered – 80% after deductible
Private Duty Nursing	Covered – 50% after deductible	Covered – 50% after deductible

**Deductible, Copays & Dollar Maximums**

<b>Deductible</b>	\$500 per member, \$1,000 family per calendar year <b>Note:</b> Deductible waived if service is performed in a PPO physician's office.	\$1,000 per member, \$2,000 family per calendar year <b>Note:</b> Out-of-network deductible amounts also apply toward the in-network deductible.
<b>Copays</b> • Fixed Dollar Copays  • Percent Copays	\$20 for office visits and \$50 for emergency room visits  20% for general services, waived if service is performed in a PPO physician's office, and 50% for mental health care, substance abuse care and private duty nursing *	\$50 for emergency room visits  40% for general services and 50% for mental health care, substance abuse care and private duty nursing * <b>Note:</b> Services without a network are covered at the in-network level.
<b>Copay Dollar Maximums</b> • Fixed Dollar Copays • Percent Copays – excludes mental health care, substance abuse care and private duty nursing copays	None \$2,500 per member, \$5,000 family per calendar year	None \$3,000 per member, \$6,000 family per calendar year <b>Note:</b> Out-of-network copays also apply toward the in-network maximum.
<b>Dollar Maximums</b>	\$5 million lifetime per member for all covered individual services	as noted above for services

\* *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.*

## Blue Preferred Rx Prescription Drug Coverage

Covered Services	Network Pharmacy	Non-Network Pharmacy
Federal Legend Drugs	Covered – 100% less plan copay	Covered – 75% less plan copay
State-controlled Drugs	Covered – 100% less plan copay	Covered – 75% less plan copay
Needles and Syringes – dispensed with insulin	Covered – 100% less plan copay	Covered – 75% less plan copay
Mail Order Prescription Drugs – 90-day supply of medication by mail from Merck-Medco Services	Covered – 100% less plan copay	Not Covered

Copays	Network Pharmacy	Non-Network Pharmacy
• Percent Copay	50% for each prescription, but not less than \$5 or more than \$100	50% for each prescription, but not less than \$5 or more than \$100
• Fixed Dollar Copay	\$25 for each prescription through mail order program	Not Applicable
• Out-of-Network Copay	Not Applicable	25%
Copay Dollar Maximum	None	None

**Note:** A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a Merck-Medco Managed Care PAID Prescriptions (PAID) Coordinated Care Network-Level III (CCN-III) pharmacy outside Michigan. A **non-network** pharmacy is a pharmacy not part of the Preferred Rx or PAID CCN-III networks.

## Blue Vision Coverage

Blue Vision benefits are provided by Vision Service Plan, the largest provider of vision care in the nation. Members can receive services from one of VSP's over 23,000 member doctor locations or a nonparticipating provider. To find a VSP member doctor, call 1-800-877-7195 or visit VSP's Web site at [www.vsp.com](http://www.vsp.com).

Eye examination	VSP member doctor	Nonparticipating provider
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	Covered – \$5 copay, up to \$35
	Once every 12 months	

Frames	Network Pharmacy	Non-Network Pharmacy
A wide selection of quality frames is fully covered by the VSP frame allowance. Members should ask their doctor which frames are covered in full. Members may select a more expensive frame and pay a cost-controlled price difference.	Covered – \$10 copay	Covered – \$10 copay, up to predetermined amount
	One frame every 12 months	

Lenses	Network Pharmacy	Non-Network Pharmacy
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 61mm. Pink lens tints (for glare reduction) are also covered in full.	Covered – \$10 copay	Covered – \$10 copay, up to predetermined amount
	One pair every 12 months	

**Contacts:** Members may obtain either eyeglasses or contact lenses, but not both.

Elective contacts may be chosen instead of spectacle lenses and a frame.	Covered – \$105 applied toward contact lens fitting, evaluation and materials, member responsible for difference
	Once every 12 months
Therapeutic Contact Lenses (medically necessary)	Covered – \$210 maximum, member responsible for difference
	Once every 12 months

Copays	Network Pharmacy	Non-Network Pharmacy
• Exams	\$5 copay	\$5 copay
• Frames, lenses or medically necessary contacts	A combined \$10 copay	Member responsible for difference between approved amount and provider's charge, less \$10 copay

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 certificate and riders. Payment amounts are based on the Blue Cross Blue Shield 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.