



Michigan Osteopathic
Association

Health Care Selection Guide Option 7



Blue Cross
Blue Shield
Blue Care Network
of Michigan

Blue Managed Traditional Comprehensive Major Medical Plan Benefits-at-a-Glance

Preventive Services

Health Maintenance Exam	Not Covered
Annual Gynecological Exam	Not Covered
Pap Smear Screening – laboratory services only	Covered – 80% after deductible, one every 12 months
Well-Baby and Child Care	Not Covered
Immunizations	Not Covered
Proctoscopic Exam	Not Covered

Mammography

Mammography Screening	Covered – 80% after deductible, one baseline for ages 35-40, one annually at age 40 and older
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Physician Office Services

Office Visits	Covered – 80% after deductible
Outpatient and Home Visits	Covered – 80% after deductible
Office Consultations	Covered – 80% after deductible
Urgent Care Visits	Covered – 80% after deductible

Emergency Medical Care

Hospital Emergency Room – approved diagnosis	Covered – 80% after deductible
Ambulance Services – medically necessary	Covered – 80% after deductible

Diagnostic Services

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

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – 80% 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

Hospital Care

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

Alternatives to Hospital Care

Skilled Nursing Care	Not Covered
Hospice Care	Covered – 100%, limited to the lifetime dollar maximum which is adjusted annually by the state
Home Health Care	Covered – 80% after deductible, unlimited days
Individual Case Management	Covered

Surgical Services

Surgery – includes all related surgical services	Covered – 80% after deductible
Voluntary Sterilization	Not Covered

Human Organ Transplants

Specified Organ Transplants – in designated facilities	Covered – 100%, up to \$1 million maximum per transplant
Bone Marrow	Covered – 80% after deductible
Kidney, Cornea, and Skin	Covered – 80% after deductible

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	Mental Health Care: Covered – 50% after deductible Substance Abuse Care: Covered – 50% after deductible, up to \$15,000 annual, \$30,000 lifetime maximum per member
Outpatient Mental Health Care	Covered – 50% after deductible
Outpatient Substance Abuse Care	Covered – 50% after deductible, up to the state-dollar amount which is adjusted annually

Other Services

Allergy Testing and Therapy	Covered – 80% after deductible
Chiropractic Spinal Manipulation	Covered – 80% after deductible, up to 38 medically necessary visits per calendar year
Outpatient Physical, Speech and Occupational Therapy	Covered – 80% after deductible, unlimited treatment
Durable Medical Equipment	Covered – 80% after deductible
Prosthetic and Orthotic Appliances	Covered – 80% after deductible
Private Duty Nursing	Covered – 50% after deductible
Prescription Drugs	Not Covered

Deductible, Copays and Dollar Maximums

Deductible	\$1,500 per member, \$3,000 family per calendar year
Copays	20% for general services and 50% for mental health care, substance abuse care and private duty nursing *
Copay Dollar Maximums – excludes mental health care, substance abuse care and private duty nursing copays	\$1,000 family per calendar year
Dollar Maximums	\$5 million lifetime per member and as noted above for individual 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

	Network Pharmacy	Non-Network Pharmacy
Covered Services		
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		
• 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.

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

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

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

• 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.