Comprehensive Major Medical (CMM)/PPO Coverage
Benefits-at-a-Glance for National Employees Health Plan

	In-Network	Out-of-Network
Preventive Services		
Health Maintenance Exam **or** Annual Gynecological Exam	Covered – 80% after deductible	Covered – 60% after deductible
Pap Smear Screening – laboratory services only	Covered – 80% after deductible	Covered – 60% after deductible
	One every 12 months	
Well-Baby and Child Care	Covered – $10 copay	Covered 60% after $10 copay
	Up to age 1	
Immunizations	Covered - $10 copay per service	Covered – 60% after $10 copay per service
	Through age 6	
Fecal Occult Blood Screening	Covered – 80% after deductible	Covered – 60% after deductible
Prostate Specific Antigen (PSA) Screening	Covered – 80% after deductible	Covered – 60% after deductible
	One Laboratory screening test per member, per calendar year after age 40	
Mammography		
Mammography Screening	Covered – 80% after deductible	Covered – 60% after deductible
	One baseline for ages 35-40, one annually after age 40	
Physician Office Services		
Office Visits	Covered – $10 copay per visit	Covered – 60% after $10 copay per visit
Outpatient and Home Visits	Covered – $10 copay per visit	Covered – 60% after $10 copay per visit
Office Consultations	Covered – 80% after deductible	Covered – 60% after deductible
Urgent Care Visits	Covered – 80% after deductible	Covered – 60% after deductible
Emergency Medical Care		
Hospital Emergency Room	Covered – 80% after deductible	Covered – 60% after deductible
Ambulance Services – medically necessary	Covered – 80% after deductible	Covered – 60% 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 – 80% after deductible	Covered – 60% after deductible
	Includes care provided by a Certified Nurse Midwife	
Delivery and Nursery Care	Covered – 80% after deductible	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	Not Covered	Not Covered
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 – 60% after deductible
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

	In-Network	Out-of-Network
Human Organ Transplants		
Specified Organ Transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered –100%	Covered – 100% - in designated facilities **only**
	Up to $1 million maximum per transplant type	
Bone Marrow – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504); specific criteria apply	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	Covered-50% after deductible, 20 days per calendar year per member. Lifetime maximum per member is included in the lifetime plan maximum for all benefits
Inpatient Substance Abuse Care	Covered-50% after deductible, $15,000 annual maximum per member, $30,000 lifetime maximum
Outpatient Mental Health Care	Covered – 50% after deductible, 40 visits per calendar year per member. Lifetime maximum per member is included in the lifetime plan maximum for all benefits
Outpatient Substance Abuse Care – in approved facilities	Covered – 50% after deductible, up to the state-dollar amount which is adjusted annually
	Up to the state-dollar amount which is adjusted annually

Other Services

	In-Network	Out-of-Network
Outpatient Diabetes Management Program (ODMP)	Covered –80% after deductible	Covered – 60% after deductible
Allergy Testing and Therapy	Covered –$10 copay per service	Covered – 60% after $10 copay per service
Chiropractic Spinal Manipulation	Covered –80% after deductible	Covered – 60% after deductible
	Up to 20 visits first 90 consecutive days then 2 visits per month	
Outpatient Physical, Speech and Occupational Therapy		
• Facility and Clinic	Covered –80% after deductible	Covered – 60% after deductible
• Physician's Office – **excludes speech and occupational therapy**	Covered –80% after deductible	Covered – 60% after deductible
	Unlimited treatment	
Durable Medical Equipment	Covered – 80% after deductible	Covered – 60% after deductible
Prosthetic and Orthotic Appliances	Covered – 80% after deductible	Covered – 60% after deductible
Private Duty Nursing	Covered – 50% after deductible	Covered – 50% after deductible
Prescription Drugs	$5 Generic $10 Brand Name through Caremark	

Deductible, Copays and Dollar Maximums

	In-Network	Out-of-Network
Deductible	$100 per member, $200 family per calendar year	
Copays • Fixed Dollar Copays	$10 for office visits, immunizations, & allergy testing & therapy	
• Percent coinsurance	20% in-network	40% out of network Note: Services without a network are covered at the in-network level
• Fixed Dollar Copays	$10 for office visits	None
• Out-of-Network coinsurance max	$1,000 per contract in and out of network	
Dollar Maximum	$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.*

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.

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