

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

In-Network

Out-of-Network

Preventive Services

| | | |
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| Health Maintenance Exam <u>or</u> Annual Gynecological Exam | Covered – 100% after deductible | Covered – 80% after deductible |
| Pap Smear Screening – laboratory services only | Covered – 100% after deductible | Covered – 80% after deductible |
| | One every 12 months | |
| Well-Baby and Child Care | Covered - \$25 copay | Covered – 80% after \$25 copay |
| | Up to age 1 | |
| Immunizations | Covered - \$25 copay per service | Covered 80% after \$25 copay per service |
| | Through age 6 | |
| Fecal Occult Blood Screening | Covered – 100% after deductible | Covered – 80% after deductible |
| Prostate Specific Antigen (PSA) Screening | Covered – 100% after deductible | Covered – 80% after deductible |
| | One Laboratory screening test per member, per calendar year after age 40 | |

Mammography

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| Mammography Screening | Covered – 100% after deductible | Covered – 80% after deductible |
| | One baseline for ages 35-40, one annually after age 40 | |

Physician Office Services

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|----------------------------|---------------------------------|--|
| Office Visits | Covered – \$25 copay per visit | Covered – 80% after \$25 copay per visit |
| Outpatient and Home Visits | Covered – \$25 copay per visit | Covered – 80% after \$25 copay per visit |
| Office Consultations | Covered – 100% after deductible | Covered – 80% after deductible |
| Urgent Care Visits | Covered – 100% after deductible | Covered – 80% after deductible |

Emergency Medical Care

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|--|---------------------------------|--------------------------------|
| Hospital Emergency Room | Covered – 100% after deductible | Covered – 80% after deductible |
| Ambulance Services – medically necessary | Covered – 100% after deductible | Covered – 80% after deductible |

Diagnostic Services

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|--------------------------------|---------------------------------|--------------------------------|
| Laboratory and Pathology Tests | Covered – 100% after deductible | Covered – 80% after deductible |
| Diagnostic Tests and X-rays | Covered – 100% after deductible | Covered – 80% after deductible |
| Radiation Therapy | Covered – 100% after deductible | Covered – 80% after deductible |

Maternity Services Provided by a Physician

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

Hospital Care

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|---|---------------------------------|--------------------------------|
| Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies | Covered-100% after deductible | Covered – 80% after deductible |
| | Unlimited days | |
| Inpatient Consultations | Covered – 100% after deductible | Covered – 80% after deductible |
| Chemotherapy | Covered –100% after deductible | Covered – 80% after deductible |

Alternatives to Hospital Care

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|----------------------|--|--------------------------------|
| 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 – 100% after deductible | Covered – 80% after deductible |

Surgical Services

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|--|---------------------------------|--------------------------------|
| Surgery – includes related surgical services | Covered – 100% after deductible | Covered – 80% after deductible |
| Voluntary Sterilization | Covered – 100% after deductible | Covered – 80% after deductible |

In-Network

Out-of-Network

Human Organ Transplants

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|---|---|---|
| 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 –100% after deductible | Covered – 80% after deductible |
| Kidney, Cornea and Skin | Covered – 100% after deductible | Covered – 80% after deductible |

Mental Health Care and Substance Abuse Treatment

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| 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

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| Outpatient Diabetes Management Program (ODMP) | Covered –100% after deductible | Covered – 80% after deductible |
| Allergy Testing and Therapy | Covered – \$25 copay per service | Covered – 80% after \$25 copay per service |
| Chiropractic Spinal Manipulation | Covered –100% after deductible | Covered – 80% after deductible |
| | Up to 20 visits first 90 consecutive days then 2 visits per month | |
| Outpatient Physical, Speech and Occupational Therapy • Facility and Clinic • Physician’s Office – excludes speech and occupational therapy | Covered –100% after deductible | Covered – 80% after deductible |
| | Covered –100% after deductible | Covered – 80% after deductible |
| | Unlimited treatment | |
| Durable Medical Equipment | Covered – 100% after deductible | Covered – 80% after deductible |
| Prosthetic and Orthotic Appliances | Covered – 100% after deductible | Covered – 80% after deductible |
| Private Duty Nursing | Covered – 50% after deductible | Covered – 50% after deductible |
| Prescription Drugs | \$15 Generic \$30 Brand Name through Caremark | |

Deductible, Copays and Dollar Maximums

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|---|--|--|
| Deductible | \$500 per member, \$1,000 family per calendar year | |
| Copays • Fixed Dollar Copays • Percent Coinsurance | \$25 for office visits, immunizations 7 allergy testing & therapy | |
| | None | 20% out of network Note: Services without a network are covered at the in-network level |
| • Out-of-Network Coinsurance max | Not applicable | \$1,000 per contract per calendar year |
| 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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