

**MEDICAL COVERAGE, LIMITATIONS AND EXCLUSIONS
NEHP RETIREES - OPTION 1**

The following is a summary of benefits and exclusions. Additional limitations and exclusions may apply to covered services. Payment amounts are based on the amount approved by the PPO network that you have selected, or reasonable and customary charges, depending on the Schedule under which you are covered, less any applicable deductible and/or co-pay amounts required by the Plan. For a document containing a fuller discussion of benefits, contact the Plan Administrator at 1-800-447-1032.

<u>Preventive Service</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Health Maintenance Exam <u>or</u> Annual Gynecological Exam	Covered - 80% after deductible	Covered - 60% after deductible
Pap Smear Screening - laboratory services only	Covered - 80% after deductible One every 12 months	Covered - 60% after deductible
Fecal Occult Blood Screening	Covered - 80% after deductible	Covered - 60% after deductible
Prostate Specific Antigen (PSA Screening)	Covered - 80% after deductible One laboratory screening test per member, per calendar year after age 40	Covered - 60% after deductible
 <u>Mammography</u>		
Mammography Screening	Covered - 80% after deductible One baseline for ages 35-40, one annually after age 40	Covered - 60% after deductible
 <u>Physician Office Services</u>		
Office Visits	Covered - \$20 copay per visit	Covered - 60% after \$20 copay per visit
Outpatient and Home Visits	Covered - \$20 copay per visit	Covered - 60% after \$20 copay per visit
Office Consultations	Covered - 80% after deductible	Covered - 60% after deductible
Urgent Care Visits	Covered - 80% after deductible	Covered - 60% after deductible
 <u>Emergency Medical Care</u>		
Hospital Emergency Room	Covered - 80% after deductible	Covered - 60% after deductible
Ambulance Services - medically necessary	Covered - 80% after deductible	Covered - 60% after deductible
 <u>Diagnostic Services</u>		
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 Includes care provided by a Certified Nurse Midwife	Covered - 60% after deductible
Delivery and Nursery Care	Covered - 80% after deductible Includes delivery provided by a Certified Nurse Midwife	Covered - 60% after deductible

Hospital Care

Except for hospitalization in connection with childbirth, you must contact the Plan Manager or the HMO or PPO as applicable to pre-certify In-Hospital medical benefits prior to being admitted to a hospital ("pre-service claim"). In an emergency, you are required to contact the Plan Manager or the HMO or PPO as applicable for pre-certification within 48 hours of your admission. If you fail to contact the Plan Manager or the HMO or PPO as applicable to pre-certify, you may lose all or part of benefits to which you would otherwise be entitled.

Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Service and Supplies	Covered - 80% after deductible Unlimited days	Covered - 60% after deductible
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% Limited to the lifetime dollar maximum which is adjusted annually by the state	Covered - 100%
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

Human Organ Transplants

Specified Organ Transplant - in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered - 100% Up to \$1 million maximum per transplant type	Covered - 100% - in designated facilities only
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
<u>Mental Health Care and Substance Abuse Treatment</u>		
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.	

Other Services

Outpatient Diabetes Management Program (ODMP)	Covered - 80% after deductible	Covered - 60% after deductible
Allergy Testing and Therapy	Covered - \$20 copay per service	Covered - 60% after \$20 copay per service
Chiropractic Spinal Manipulation	Covered - 80% after deductible Up to 20 visits first 90 consecutive days then 2 visits per month	Covered - 60% after deductible
Outpatient Physical, Speech and Occupational Therapy		
• Facility and Clinic deductible	Covered - 80% after deductible	Covered - 60% after deductible
• Physician's Office - excludes speech and occupational therapy	Covered - 80% after deductible Unlimited treatment	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 60% after deductible
Prosthetic & Orthotic Appliances	Covered - 80% after deductible	Covered - 60% after deductible
Private Duty Nursing	Covered - 50% after deductible	Covered - 50% after deductible
Prescription Drugs	\$10 Generic \$20 Brand name through the prescription Benefit Manager, which is different from the medical benefits provided. See Addendum A.	

Deductible, Copays and Dollar Maximums

Deductible	\$250 per member, \$500 family per calendar year	
Copays		
• Fixed Dollar Copays	\$20 for office visits, immunizations, allergy testing & therapy	
• Percent Coinsurance	20% in network	40% out of network
• Coinsurance Max	\$1,000 per contract	\$1,000 per contract
Dollar Maximum	\$1 million lifetime per member and as noted above for individual services	

Note: Services without a network are covered at the in-network level

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.