

**MEDICAL COVERAGE, LIMITATIONS AND EXCLUSIONS
NEHP RETIREES - OPTION 2**

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 HMO 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.

Preventive Service

Health Maintenance Exam <u>or</u> Annual Gynecological Exam	Covered - 100% after \$15 copayment per visit
Pap Smear Screening - laboratory services only	Covered - 100% - one per year
Fecal Occult Blood Screening	Covered - 100% after \$15 copayment per visit
Prostate Specific Antigen (PSA Screening)	Covered - 100% after \$15 copayment per visit

Mammography

Mammography Screening One baseline for ages 35-40, one annually after age 40	Covered - 100%
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Physician Office Services

Office Visits	Covered - 100% after \$15 copayment per visit
Outpatient and Home Visits	Covered - 100% after \$15 copayment per visit
Office Consultations	Covered - 100% after \$15 copayment per visit
Urgent Care Visits	Covered - 100% after \$15 copayment per visit

Emergency Medical Care

Hospital Emergency Room	Covered - After \$50 copayment per occurrence, Plan pays as specified on individual HMO schedule
Ambulance Service - medically necessary	Covered - After \$50 copayment per occurrence, Plan pays as specified on individual HMO schedule

Diagnostic Services

Laboratory and Pathology Tests	Covered - 100%
Diagnostic Tests and X-rays	Covered - 100%
Radiation Therapy	Covered - 100%

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care Covered - 100% after \$15 copayment per visit. Includes care provided by a Certified Nurse Midwife

Delivery and Nursery Care Covered - 100% after \$15 copayment per visit. Includes delivery provided by a Certified Nurse Midwife

Hospital Care

Except for hospitalization in connection with childbirth, you must contact the Plan Manager or the HMO 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 as applicable for pre-certification within 48 hours of your admission. If you fail to contact the Plan Manager or the HMO 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 individual HMO Covered - Plan pays as specified in

Inpatient Consultations Covered - Plan pays as specified in individual HMO

Chemotherapy Covered - Plan pays as specified in individual HMO

Alternatives to Hospital Care

Skilled Nursing Care Not covered

Hospice Care Covered - 100% on up to 210 days per lifetime

Home Health Care Covered - 100% on up to 210 days per lifetime

Surgical Services

Surgery - includes related surgical services Covered - 100%

Voluntary Sterilization Covered - 100%

Human Organ Transplants

Specified Organ Transplant – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) Covered - Plan pays as specified in individual HMO

Bone Marrow - when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504); specific criteria apply Covered - Plan pays as specified in individual HMO

Kidney, Cornea and Skin Covered - Plan pays as specified in individual HMO

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care Covered – Plan pays as specified in individual HMO

Inpatient Substance Abuse Care	Covered – Plan pays as specified in individual HMO
Outpatient Mental Health Care	Covered – Plan pays as specified in individual HMO
Outpatient Substance Abuse Care - in approved facilities	Covered – Plan pays as specified in individual HMO

Other Services

Outpatient Diabetes Management Program (ODMP)	Covered - Plan pays as specified in individual HMO
Allergy Testing and Therapy	Covered - Plan pays as specified in individual HMO
Chiropractic Spinal Manipulation	Covered - Plan pays as specified in individual HMO Up to 20 visits first 90 consecutive days then 2 visits per month
Outpatient Physical, Speech and Occupational Therapy	
<ul style="list-style-type: none"> • Facility and Clinic • Physician Office - excludes speech and occupational therapy 	Covered - Plan pays as specified in individual HMO
	Covered - Plan pays as specified in individual HMO Unlimited treatment
Durable Medical Equipment	Covered - Plan pays as specified in individual HMO
Prosthetic & Orthotic Appliances	Covered - Plan pays as specified in individual HMO
Private Duty Nursing	Covered - Plan pays as specified in individual HMO
Prescription Drugs	Generic or Brand name - \$10 copay

Deductible, Copays and Dollar Maximums

Deductible	\$0.00
Copays	
<ul style="list-style-type: none"> • Fixed Dollar Copays • Percent Coinsurance • Coinsurance Max 	<p>\$15 for office visits; \$50 for emergency</p> <p>Not applicable</p> <p>Not applicable</p>
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 charge.