Group Number: 50002403-02
Effective Date: 1-1-2019

IN NETWORK ONLY!

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	BCBSM Community Blue PPO Plan 15	Milan Area Schools Transportation & Secretaries CB PPO Plan	Employer Subsidized Amounts
	"BCBSM Pays"	"Employee's Portion"	"Employer Pays"
Deductible, Copays and Dollar Maximums			
Deductible Note: Deductible is waived if service is performed in a PPO physician's office	$5000 per member. $10000 Family per calendar year	$50 per member. $100 Family per calendar year	$4950 per member, $9900 Family per calendar year
Copays			
Fixed Dollar Copays	$40 for office visits and $250 for emergency room visits	$20 for office visits and $50 for emergency room visits	$20 for office visits and $200 for emergency room visits
Percent Copays	80% for general services, waived if service is performed in a PPO physician's office, and 50% for mental health care, substance abuse care and private duty nursing	20% for general services, waived if service is performed in a PPO physician's office, and 50% for mental health care, substance abuse care and private duty nursing	20% for general services
Copays Dollar Maximums			
Fixed Dollar Copays	None	None	None
Percent Copays- excludes mental health care, substance abuse care and private duty nursing copays	$1350 per member, $2700 family per calendar year	$1000 per member, $2000 per family per calendar year	$350 per member, $700 per family per calendar year
For groups of 51 or more employees (including seasonal and part-time) that are subject to the MHP law, copays for mental health and substance abuse treatment are subject to a separate copay maximum	$1350 per member, $2700 family per calendar year	$1000 per member, $2000 family per calendar year	None
Dollar Maximums	Unlimited	Unlimited	None

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Preventive Services			
Health Maintenance Exam	Covered- 100%, one per calendar year	Covered- no cost, one per calendar year	None
Annual Gynecological Exam	Covered- 100%, one per calendar year	Covered- no cost, one per calendar year	None
Pap Smear Screening- Laboratory services only	Covered- 100%, one per calendar year	Covered- no cost, one per calendar year	None
Well-Baby and Child Care	Covered- 100%	Covered- no cost	None
Immunizations	Covered- 100%, up through* See Age Breakdown	Covered- no cost, up through* See Age Breakdown	None
Fecal Occult Blood Screening	Covered- 100%, one per calendar year	Covered- no cost, one per calendar year	None
Flexible Sigmoidoscopy Exam	Covered- 100%, one per calendar year	Covered- no cost, one per calendar year	None
Prostate Specific Antigen (PSA) Screening	Covered- 100%, one per calendar year	Covered- no cost, one per calendar year	None
Mammography			
Mammography Screening	Covered- 100%	Covered- no cost	* Reference Deductible & Dollar Maximums
Physician Office Services			
Office Visits	Covered- $40 copay	Covered- $20 copay	$20 Copay
Outpatient and Home Visits	Covered- 80% after deductible	Covered- 20% after deductible	* Reference Deductible & Dollar Maximums
Office Consultations	Covered- $40 copay	Covered- $20 copay	$20 Copay
Urgent Care Visits	Covered- $40 copay	Covered- $20 copay	$20 Copay
Emergency Medical Care			
Hospital Emergency Room (waived if admitted or for accidental injury)	Covered- $250 copay	Covered- $50 copay	$200 copay
Ambulance Services- medically necessary	Covered- 80% after deductible	Covered- 20% after deductible	* Reference Deductible & Dollar Maximums
Diagnostic Services			
Laboratory and Pathology Tests	Covered- 100%	Covered- no cost	* Reference Deductible & Dollar Maximums
Diagnostic Tests and X-rays	Covered- 100%	Covered- no cost	* Reference Deductible & Dollar Maximums
Radiation Therapy	Covered- 100%	Covered- no cost	* Reference Deductible & Dollar Maximums

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Maternity Services Provided by Physician			
Pre-Natal and Post-Natal Care	Covered- 100% includes care by a certified Nurse Midwife	Covered- no cost, includes care by a certified Nurse Midwife	None
Delivery and Nursing Care	Covered- 100% after deductible, includes care by a certified Nurse Midwife	Covered- no cost after deductible, includes care by a certified Nurse Midwife	* Reference Deductible & Dollar Maximums
Hospital Care			
Semi-Private room, Impatient Physician Care, General	Covered- 100%	Covered- no cost	* Reference Deductible & Dollar Maximums
Nursing Care, Hospital Services and Supplies	Unlimited Days	Unlimited Days	None
Inpatient Consultations	Covered- 100%	Covered- no cost	* Reference Deductible & Dollar Maximums
Chemotherapy	Covered- 100%	Covered- no cost	* Reference Deductible & Dollar Maximums
Alternatives to Hospital Care			
Skilled Nursing	Covered- 80%, after deductible, up to 120 days per cal. year	Covered- 20%, after deductible, up to 120 days per cal. year	* Reference Deductible & Dollar Maximums
Hospice Care	Covered- 100%, limited to the lifetime amount by state	Covered- no cost, limited to the lifetime amount by state	None
Home Health Care	Covered- 80%, after deductible, unlimited visits	Covered- 20%, after deductible, unlimited visits	* Reference Deductible & Dollar Maximums
Surgical Services			
Surgery- includes all related surgical services	Covered- 100%	Covered- no cost	* Reference Deductible & Dollar Maximums
Voluntary Sterilization	Covered- 100%	Covered- no cost	* Reference Deductible & Dollar Maximums
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- no cost	None
Bone Marrow- when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) specific criteria applies	Covered- 80%, after deductible	Covered- 20%, after deductible	None
Kidney, Cornea and Skin	Covered- 80% after deductible	Covered- 20% after deductible	* Reference Deductible & Dollar Maximums

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Mental Health Care and Substance Abuse			
Inpatient Mental Health Care	Covered- 100%	Covered- no cost	* Reference Deductible & Dollar Maximums
Inpatient Substance Abuse Treatment	Covered- 100%	Covered- no cost	* Reference Deductible & Dollar Maximums
Outpatient Mental Health Care			
Facility and Clinic	Covered- 50% after deductible	Covered- 50% after deductible	* Reference Deductible & Dollar Maximums
Physician's Office	Covered- 50% after deductible	Covered- 50% after deductible	* Reference Deductible & Dollar Maximums
Outpatient Substance Abuse Care	Covered- 50% after deductible	Covered- 50% after deductible	* Reference Deductible & Dollar Maximums
Other Services			
Allergy Testing and Therapy	Covered- 100%	Covered- no cost	None
Chiropractic Spinal Manipulation	Covered- 100%	Covered- no cost	None
Outpatient Physical, Speech, and Occupational Therapy Facility and Clinic	Covered- 80% after deductible	Covered- 20% after deductible	* Reference Deductible & Dollar Maximums
Physician's Office- excludes speech and occup. Therapy	Covered- 80% after deductible, up to 60 visits per cal. year	Covered- 20% after deductible, up to 60 visits per cal. year	* Reference Deductible & Dollar Maximums
Durable Medical Equipment	Covered- 80% after deductible	Covered- 20% after deductible	* Reference Deductible & Dollar Maximums
Prosthetic and Orthotic Appliances	Covered- 80% after deductible	Covered- 20% after deductible	* Reference Deductible & Dollar Maximums
Private Duty Nursing	Covered- 50% after deductible	Covered- 50% after deductible	Deductible Only