

White Pigeon Schools Community BlueSM PPO 1 (MEBS Wrap) Rx \$10/\$20 BCBSM Benefits-at-a-Glance

In-Network

Out-of-Network

Preventive Services – Limited to \$500 per calendar year

Health Maintenance Exam – includes chest X-ray, EKG and select lab procedures	Covered – 100%, one per calendar year	Not covered
Annual Gynecological Exam	Covered – 100%, one per calendar year	Not covered
Pap Smear Screening – laboratory services only	Covered – 100%, one per calendar year	Not covered
Well-Baby and Child Care	Covered – 100%* • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Not covered
Immunizations	Covered – 100%, up through age 16	Not covered
Fecal Occult Blood Screening	Covered – 100%, one per calendar year	Not covered
Flexible Sigmoidoscopy Exam	Covered – 100%, one per calendar year	Not covered
Prostate Specific Antigen (PSA) Screening	Covered – 100%, one per calendar year	Not covered

Mammography

Mammography Screening	Covered – 100%	Covered – 80% after deductible
One per calendar year, no age restrictions		

Physician Office Services

Office Visits	Covered – \$10 copay	Covered – 80% after deductible, must be medically necessary
Outpatient and Home Visits	Covered – 100%	Covered – 80% after deductible, must be medically necessary
Office Consultations	Covered – \$10 copay	Covered – 80% after deductible, must be medically necessary
Urgent Care Visits	Covered – \$10 copay	Covered – 80% after deductible, must be medically necessary

Emergency Medical Care

Hospital Emergency Room	Covered – \$50 copay, waived if admitted or for an accidental injury	Covered – \$50 copay, waived if admitted or for an accidental injury
Ambulance Services – medically necessary	Covered – 100%	Covered – 100%

Diagnostic Services

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

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – 100%	Covered – 80% after deductible
Includes care provided by a certified nurse midwife		
Delivery and Nursery Care	Covered – 100%	Covered – 80% 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 Note: Nonemergency services must be rendered in a participating hospital	Covered – 100%	Covered – 80% after deductible
Unlimited days		
Inpatient Consultations	Covered – 100%	Covered – 80% after deductible
Chemotherapy	Covered – 100%	Covered – 80% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100%	Covered – 100%
Up to 120 days per calendar year		
Hospice Care	Covered – 100%	Covered – 100%
Limited to lifetime dollar maximum which is adjusted periodically		
Home Health Care	Covered – 100%	Covered – 100%
Unlimited visits		

Surgical Services

Surgery – includes related surgical services	Covered – 100%	Covered – 80% after deductible
Voluntary Sterilization	Covered -- 100%	Covered – 80% 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 – 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 applies	Covered – 100%	Covered – 80% after deductible
Kidney, Cornea and Skin	Covered – 100%	Covered – 80% after deductible

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care	Covered – 90%	Covered – 90% after deductible
Inpatient Substance Abuse Treatment	Covered – 50%	Covered – 50% after deductible
	Up to 60 days per calendar year with a lifetime maximum of 120 days for inpatient mental health care and inpatient and residential substance abuse treatment	
Outpatient Mental Health Care • Facility and Clinic • Physician’s Office	Covered – 90%	Covered – 90% after deductible
	Covered – 90%	Covered – 90% after deductible
Outpatient Substance Abuse Treatment – in approved facilities	Covered – 50%	Covered – 50%
	Up to the state-dollar amount which is adjusted annually	

Other Services

Outpatient Diabetes Management Program (ODMP)	Covered – 100%	Covered – 80% after deductible
Allergy Testing and Therapy	Covered – 100%	Covered – 80% after deductible
Chiropractic Spinal Manipulation	Covered – 100%	Covered – 80% after deductible
	Up to 24 visits per calendar year	
Outpatient Physical, Speech and Occupational Therapy • Facility and Clinic • Physician’s Office – excludes speech and occupational therapy	Covered – 100%	Covered – 100%
	Covered – 100%	Covered – 80% after deductible
	A combined 60-visit maximum per calendar year for physical therapy in the outpatient department of a hospital as well as in the physician’s office	
Durable Medical Equipment	Covered – 100%	Covered – 100%
Prosthetic and Orthotic Appliances	Covered – 100%	Covered – 100%
Private Duty Nursing	Covered – 50%	Covered – 50%
Prescription Drugs	\$10 / \$20 with Contraceptives	Not covered

Deductible, Copays and Dollar Maximums

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.

Deductible	None	\$250 per member, \$500 family per calendar year
Copays • Fixed Dollar Copays • Percent Copays	\$10 for office visits and \$50 for emergency room visits	\$50 for emergency room visits
	10% for mental health care, 50% substance abuse treatment and private duty nursing	20% for general services and 50% for mental health care, substance abuse treatment and private duty nursing Note: Services without a network are covered at the in-network level.
Copay Dollar Maximums • Fixed Dollar Copays • Percent Copays – excludes mental health care, substance abuse treatment and private duty nursing copays	None	None
	Not applicable	\$2,000 per member, \$4,000 family per calendar year
Dollar Maximums	\$5 million lifetime per member for all covered services and as noted above for individual services	

Rider XVA, Excludes Voluntary Abortions	Excludes benefits for voluntary abortions.

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 of Michigan certificate and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan 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.