

Deductible, Copay 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.

	Option I		Option II
	Community BluesM PPO	Out-of-Network	
Deductible (per calendar year)	\$250 per member, \$500 family Note: Deductible waived if service is performed in a PPO physician's office.	\$500 per member, \$1,000 family Note: Out-of-network deductible amounts also apply toward the in-network deductible.	\$250 per member, \$500 family Comprehensive Major Medical (CMM 250)
Copays:			
• Fixed dollar copays	\$10 for office visits and \$50 for emergency room visits	\$50 for emergency room visits	None
• Percent copays	10% for general services (waived if service is performed in a PPO physician's office) and 50% for mental health, substance abuse and private duty nursing	20% for general services and 50% for mental health, substance abuse and private duty nursing Note: Services without a network are covered at the in-network level.	20% for general services and 50% for mental health, substance abuse and private duty nursing
Copay Dollar Maximum:			
• Fixed dollar copays	None	None	Not applicable
• Percent copays - excludes mental health, substance abuse and private duty nursing copays	\$1,000 per member, \$2,000 family per calendar year	\$2,000 per member, \$4,000 family per calendar year Note: Out-of-network copays may also apply toward the in-network maximum.	\$1,000 family per calendar year
Dollar Maximum (per member)	\$1 million lifetime per covered specified human organ transplant type and a separate \$5 million lifetime for all other covered services and as noted for individual services	\$1 million lifetime per covered specified human organ transplant type and a separate \$5 million lifetime for all other covered services and as noted for individual services	\$1 million lifetime per covered specified human organ transplant type and a separate \$5 million lifetime for all other covered services and as noted for individual services

Prescription Drug Coverage – Preferred Rx Plan

	Options I and II	
Covered services:	Network Pharmacy: 100% of approved amount less a \$10 copay for each generic drug or a \$60 copay for each brand-name drug	
• Federal legend drugs	Non-Network Pharmacy: 75% of approved amount less a \$10 copay for each generic drug or a \$60 copay for each brand-name drug	
• State-controlled drugs	Non-Network Pharmacy: 75% of approved amount less a \$10 copay for each generic drug or a \$20 copay for each brand-name drug	
• Needles and syringes	Mail-Order (Home Delivery) Prescription Drugs: Up to a 90-day supply of medication by mail from Medco Health Prescription Solutions with a \$20 copay for each generic drug or a \$120 copay for each brand-name drug	

Note: A network pharmacy is a Preferred Rx pharmacy in Michigan or MedImpact Pharmacy outside Michigan. A non-network pharmacy is a pharmacy NOT part of the Preferred Rx or MedImpact Pharmacy networks.

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.

Medicare Supplemental Coverage

If you or a member of your family is enrolled in Medicare, you must select Option II to receive Supplemental Coverage for that person. BCBSM Supplemental Coverage, in combination with Medicare, provides the same level of benefits and services as described in this chart for Option II.

Eligibility Requirement

All MSAE members whose dues are current are eligible for BCBSM coverage.

For further information, contact the MSAE Office at
1-800-860-2272



**Health Care
Coverage Options**

MSAE

AMERICAN SOCIETY OF ASSOCIATED INSURERS



Blue Cross
Blue Shield
of Michigan

A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

Benefits	Option I		Option II
	Community Blue™ PPO		Comprehensive Major Medical (CMM 250)
	In-Network	Out-of-Network	

Note: There is a 180-day waiting period on all pre-existing conditions including voluntary sterilization and maternity care.

Preventive Care Services – *Payment for preventive services is limited to a combined maximum of \$500 per member per calendar year

Health maintenance exam – includes chest X-ray, EKG and select lab procedures	Covered – 100%*, one per calendar year	Not covered	Not covered
Annual gynecological exam	Covered – 100%*, one per calendar year	Not covered	Not covered
Pap smear screening – laboratory services only	Covered – 100%*, one per calendar year	Not covered	Covered – 80% after deductible, one every 12 months (from date of any previous pap smear)
Well-baby & child care visits	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	Not covered
Immunizations	Covered – 100%*, up through age 16	Not covered	Not covered
Fecal occult blood screening	Covered – 100%*, one per calendar year	Not covered	Not covered
Flexible sigmoidoscopy exam	Covered – 100%*, one per calendar year	Not covered	Not covered
Prostate specific antigen screening	Covered – 100%*, one per calendar year	Not covered	Not covered

Mammography

Mammography screening	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 80% after deductible, one baseline for ages 35-40, one annually at age 40 and older
	One per calendar year, no age restrictions		

Physician Office Services

Office visits, office consultations, and urgent care visits	Covered – \$10 copay	Covered – 80% after deductible, must be medically necessary	Covered – 80% after deductible
Outpatient and home visits	Covered – 90% after deductible	Covered – 80% after deductible, must be medically necessary	Covered – 80% after deductible

Emergency Medical Care

Hospital emergency room	Covered – \$50 copay	Covered – \$50 copay	Covered – 80% after deductible
	Waived if admitted or for an accidental accident		
Ambulance services – when medically necessary	Covered – 90% after deductible	Covered – 90% after deductible	Covered – 80% after deductible

Diagnostic Services

Laboratory & pathology tests	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 80% after deductible
Diagnostic tests & X-rays	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 80% after deductible
Radiation therapy	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 80% after deductible

Maternity Services Provided by a Physician or Certified Nurse Midwife

Pre-natal & post-natal care	Covered – 100%	Covered – 80% after deductible	Covered – 80% after deductible
Delivery & nursery care	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 80% after deductible

Hospital Care

Semi-private room, inpatient physician care, general nursing care, hospital services and supplies	Covered – 90% after deductible, unlimited days	Covered – 80% after deductible, unlimited days	Covered – 80% after deductible, unlimited days
Inpatient consultations	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 80% after deductible
Chemotherapy	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 80% after deductible

Alternatives to Hospital Care

Skilled nursing care	Covered – 90% after deductible	Covered – 90% after deductible	Not covered
	Covered up to 120 days per calendar year		
Hospice care	Covered – 100%	Covered – 100%	Covered – 100%, limited to lifetime dollar maximum which is adjusted periodically
	Limited to lifetime dollar maximum which is adjusted periodically		
Home health care	Covered – 90% after deductible	Covered – 90% after deductible	Covered – 80% after deductible

Surgical Services

Surgery and related surgical services	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 80% after deductible
Voluntary sterilization	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 80% after deductible

Human Organ Transplants

Specified organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program	Covered – 100%	Covered – in designated facilities only	Covered – 100%, up to \$1 million maximum per transplant type
	Covered up to \$1 million maximum per transplant type		
Bone marrow transplants – in designated cancer centers	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 80% after deductible
Kidney, cornea & skin transplants	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 80% after deductible

Mental Health Care and Substance Abuse Treatment

Inpatient mental health care	Covered – 50% after deductible, unlimited days	Covered – 50% after deductible, unlimited days	Covered – 50% after deductible, unlimited days
Inpatient substance abuse treatment	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible, up to \$15,000 annual, \$30,000 lifetime maximum per member
	Unlimited days, up to \$15,000 annual, \$30,000 lifetime maximum per member		
Outpatient mental health care	Covered – 50% after deductible (50% in physician's office)	Covered – 50% after deductible	Covered – 50% after deductible
Outpatient substance abuse treatment – in approved facilities only	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible, up to the state dollar amount which is adjusted annually
	Covered up to the state dollar amount which is adjusted annually		

Other Services

Allergy testing and therapy	Covered – 100%	Covered – 80% after deductible	Covered – 80% after deductible
Chiropractic spinal manipulation	Covered – 100%	Covered – 80% after deductible	Covered – 80% after deductible, up to 33 medically necessary visits per calendar year
Outpatient physical, speech and occupational therapy	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 80% after deductible, unlimited treatment
	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 – 90% after deductible	Covered – 90% after deductible	Covered – 80% after deductible
Prosthetic and orthotic appliances	Covered – 90% after deductible	Covered – 90% after deductible	Covered – 80% after deductible
Private duty nursing	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible

See reverse side for deductible and copay amounts