

# Benefits-at-a-Glance

## Gibraltar School District

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.

		Community Blue <sup>SM</sup> PPO (Plan 1)	
		In-Network	Out-of-Network
<b>Preventive Services</b>			
Health Maintenance Exam		Covered – 100%, one per calendar year, includes chest X-ray, EKG and select lab procedures *	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
<b>Mammography</b>			
Mammography Screening		Covered – 100% after deductible	Covered – 80% after deductible
		One per calendar year, no age restrictions	
<b>Physician Office Services</b>			
Office Visits		Covered – \$5 copay	Covered – 80% after deductible, must be medically necessary
Outpatient and Home Visits		Covered – 100% after deductible	Covered – 80% after deductible, must be medically necessary
Office Consultations		Covered – \$5 copay	Covered – 80% after deductible, must be medically necessary
Urgent Care Visits		Covered – \$5 copay	Covered – 80% after deductible, must be medically necessary
<b>Emergency Medical Care</b>			
Hospital Emergency Room		Covered – \$25 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% after deductible	Covered – 100% after deductible
<b>Diagnostic Services</b>			
Laboratory and Pathology Services		Covered – 100% after deductible	Covered – 80% after deductible
Diagnostic Tests and X-rays		Covered – 100% after deductible	Covered – 80% after deductible
Therapeutic Radiology		Covered – 100% after deductible	Covered – 80% after deductible

\* Unlimited

New Plan

Blue Managed Traditional First Dollar (Basic) Plan with Master Medical (MM) Option 1	Community Blue PPO (Plan 1)	
	In-Network	Out-of-Network

**Maternity Services Provided by a Physician or Certified Nurse Midwife**

Prenatal and Postnatal Care	Covered – 100%	Covered – 80% after deductible
Delivery and Nursery Care	Covered – 100% after deductible	Covered – 80% after deductible

**Hospital Care**

Semiprivate Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies Note: Nonemergency services must be rendered in a participating hospital	Covered – 100% after deductible	Covered – 80% after deductible
Inpatient Consultations	Unlimited days	
Chemotherapy	Covered – 100% after deductible	Covered – 80% after deductible

**Alternatives to Hospital Care**

Skilled Nursing Care	Covered – 100% after deductible	Covered – 100% after deductible
Hospice Care	Covered – 100%	Covered – 100%
Home Health Care	Covered – 100% after deductible	Covered – 100% after deductible

**Surgical Services**

Surgery – includes related surgical services	Covered – 100% after deductible	Covered – 80% after deductible
Voluntary Sterilization	Covered – 100% after deductible	Covered – 80% after deductible
Voluntary Abortions	Not Covered	Not Covered

**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% after deductible	Covered – in designated facilities only
Bone Marrow – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504); specific criteria applies	Covered – 100% after deductible	Covered – 80% after deductible
Kidney, Cornea and Skin	Covered – 100% after deductible	Covered – 80% after deductible

**Mental Health Care and Substance Abuse**

Inpatient Mental Health Care	Covered – 100% after deductible	Covered – 100% after deductible
Inpatient Substance Abuse Treatment	Covered – 50% after deductible	Covered – 50% after deductible
Outpatient Mental Health Care	Covered – 100% after deductible	Covered – 100% after deductible
Outpatient Substance Abuse Treatment – in approved facilities only	Covered – 50% after deductible	Covered – 50% after deductible

**Other Services**

Outpatient Diabetes Management Program (ODMP)	Covered – 100% after deductible	Covered – 80% after deductible
Allergy Testing and Therapy	Covered – 100%	Covered – 80% after deductible
Chiropractic Spinal Manipulation	Covered – 100%	Covered – 80% after deductible

New Plan

Blue Managed Traditional First Dollar (Basic) Plan with Master Medical (MM) Option 1	Community Blue PPO (Plan 1)	
	In-Network	Out-of-Network

Other Services, *continued*

Outpatient Physical, Speech and Occupational Therapy	Facility and Clinic: Covered – 100% after deductible	Facility and Clinic: Covered – 100% after deductible
	Physician's Office (excludes speech and occupational therapy): Covered – 100% after deductible	Physician's Office (excludes speech and occupational therapy): 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% after deductible	Covered – 100% after deductible
Prosthetic and Orthotic Appliances	Covered – 100% after deductible	Covered – 100% after deductible
Private Duty Nursing	Covered – 50% after deductible	Covered – 50% after deductible

Deductible, Copays and Dollar Maxin  
 Note: If you receive care from a nonpartici charge.

you may be billed for the difference between our approved amount and the provider's

Deductible (per calendar year)	\$100 per member, \$200 per family	\$250 per member, \$500 per family
Copays		
• Fixed Dollar Copays	\$5 for office visits, urgent care and \$25 for emergency room visits	\$50 for emergency room visits
• Percent Copays	100% for mental health care, 50% for 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 (per calendar year)		
• Fixed Dollar Copays	None	None
• Percent Copays – excludes mental health care, substance abuse treatment and private duty nursing copays	Not applicable	\$2,000 per member, \$4,000 per family
Dollar Maximums (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 above for individual services	