MEDICAL BENEFIT SUMMARIES

(Chart illustrates your cost)	HMO BCN	CDHP with Access to an HSA BCBSM		PPO 1 BCBSM		PPO 2 BCBSM	
	In-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
COPAY SERVICES							
PREVENTIVE SERVICES							
Health Maintenance Exam	$0	$0	Not covered	$0	Not covered	$0	Not covered
Annual Gynecological Exam	$0	$0	Not covered	$0	Not covered	$0	Not covered
Well-Baby & Child Care	$0	$0	Not covered	$0	Not covered	$0	Not covered
Immunizations	$0	$0	Not covered	$0	Not covered	$0	Not covered
Prostate Specific Antigen (PSA) Screening	$0	$0	Not covered	$0	Not covered	$0	Not covered
Mammogram (one per year)	$0	$0	40%*	$0	40%*	$0	40%*
PHYSICIAN OFFICE SERVICES							
Office Visits	$30 copay	30%*	40%*	$30 copay	40%*	$30 copay	40%*
Specialist Visits	$40 copay	30%*	40%*	$40 copay	40%*	$40 copay	40%*
Teladoc Virtual Visits (24/7 Urgent Care)	$10 copay	30%*	40%*	$10 copay	Not covered	$10 copay	Not covered
EMERGENCY MEDICAL CARE							
Emergency Room (copay waived if admitted)	$150 copay	30%*	30%*	$150 copay	$150 copay	$150 copay	$150 copay
Urgent Care	$50 copay	30%*	40%*	$50 copay	40%*	$50 copay	40%*
Ambulance	30%*	30%*	30%*	30%*	30%*	30%*	30%*
HOSPITAL CARE (Nonemergency services must be rendered in a participating hospital)							
Hospital Visits	30%*	30%*		30%*		30%*	
Hospital – Inpatient	30%*	30%*		30%*		30%*	
Surgery	30%*	30%*		30%*		30%*	
MENTAL HEALTH & SUBSTANCE ABUSE EXPENSES (Must be provided by a participating hospital, inpatient facility, or outpatient facility)							
Inpatient	30%*	30%*		30%*		30%*	
Outpatient**	$30 copay	30%*		30%*		30%*	
DEDUCTIBLES, COINSURANCE, AND MAXIMUMS							
Deductible (See page 10 for information regarding the CDHP Deductible)	$3,000 Single $6,000 Family	$2,500 Single $5,000 Family	$5,000 Single $10,000 Family	$3,500 Single $7,000 Family	$6,000 Single $12,000 Family	$2,500 Single $5,000 Family	$5,000 Single $10,000 Family
Coinsurance	30%	30%	40%	30%	40%	30%	40%
Coinsurance Maximum (Includes coinsurance only)	$1,500 Single $3,000 Family	N/A	N/A	$2,750 Single $5,500 Family	$5,500 Single $11,000 Family	$2,000 Single $4,000 Family	$4,000 Single $8,000 Family
Annual Out-of-Pocket Maximum* (Includes deductible for office visits and prescription drugs)**	$4,500 Single $9,000 Family	$3,500 Single $7,000 Family	$7,000 Single $14,000 Family	$6,900 Single $13,800 Family	$13,800 Single $27,600 Family	$6,900 Single $13,800 Family	$13,800 Single $27,600 Family

*** After you meet the deductible.**

**** When a mental health or substance abuse service is considered an office visit, BCBSM will process the claim under the office visit benefit.**

***** The BCN HMO out of pocket maximum does not include your prescription drug copays. For details on the prescription out-of-pocket maximum, please refer to page 15.**

MEDICAL BENEFIT SUMMARIES

(Chart illustrates your cost)	HMO BCN	CDHP with Access to an HSA BCBSM		PPO 1 BCBSM		PPO 2 BCBSM	
	In-Network	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**
ALL OTHER SERVICES							
Allergy Testing/Injections	Testing and Serum 50% Injections $5 copay	30%*	40%*	$0	40%*	$0	40%*
Anesthesia	30%*	30%*	40%*	30%*	40%*	30%*	40%*
Chiropractic Care	**(30 visits per year)**	**(24 visits per year)**		**(24 visits per year)**		**(24 visits per year)**	
- Office Visit	$40 copay	30%*	40%*	$40 copay	40%*	$40 copay	40%*
- Spinal Manipulation	$40 copay	30%*	40%*	$0	40%*	$0	40%*
- X-rays	30%*	30%*	40%*	30%*	40%*	30%*	40%*
Contraceptive Devices, Implants, and Injections	$0	$0	40%*	$0	40%*	$0	40%*
Dialysis	30%*	30%*	40%*	30%*	40%*	30%*	40%*
Fertility Testing	50%*	30%*	40%*	30%*	40%*	30%*	40%*
Home Health Care	$40 copay	30%*	40%*	30%*	30%*	30%*	30%*
Hospice	$0	30%*		$0		$0	
		Limited to four 90-day periods (Respite core limited to 5 days during a 30-day period). Provided through a participating hospice program only.					
Labs and X-ray Test	Labs-$0 X-ray-30%*	30%*	40%*	30%*	40%*	30%*	40%*
Medical Equipment	50%	30%*	30%*	30%*	30%*	30%*	30%*
Medical Supplies	50%	30%*	30%*	30%*	30%*	30%*	30%*
Physical, Speech, and Occupational Therapy *Services at nonparticipating outpatient physical therapy facilities are not covered*	$40 copay	30%*	40%*	30%*	40%*	30%	40%*
- Maximum Visits	60 per calendar year	60 per calendar year		60 per calendar year		60 per calendar year	
Orthotic	50%	30%*	30%*	30%*	30%*	30%*	30%*
Maternity							
- Pre and Post Natal Care	$30 copay	$0	40%*	$0	40%*	$0	40%*
- Delivery	30%*	30%*	40%*	30%*	40%*	30%*	40%*
Prosthetic Devices	50%	30%*	30%*	30%*	30%*	30%*	30%*
Skilled Nursing Facility	30%*	30%*	40%*	30%*	30%*	30%*	30%*
- Maximum Visits	45 per calendar year	120 per calendar year		120 per calendar year		120 per calendar year	
Hearing Coverage *Audiometric exam, Hearing aid evaluation, Ordering and fitting the hearing aid (a monaural or binaural hearing aid), and Hearing aid conformity test – one every 36 months*	$0	30%*		$0		$0	
- Maximum	$3,000 for monaural hearing aids; $6,000 for binaural hearing aids every 36 months.						

*** After you meet the deductible.**