Community Blue Health Plan - Current Plan

Deductible, Co-pays, and Dollar Maximums	*In-Network*	*Out-of-Network*
Calendar Year Deductible	None	$250 per member, $500 per family (out-of-network deductible amounts also apply toward the in-network deductible)
Copays • Fixed	$20 office visits, $20 urgent care and $50 for emergency room visits	$250 for emergency room visits
• Percent	10% for general services	40% for general services
Copay Dollar Maximums • Fixed	None	None
• Percent	$1,000 per member / $2,000 per family	$2,000 per member, $4,000 per family (out-of-network copays also apply toward the in-network maximum)
Dollar Maximums	Unlimited	

Preventive Services		
Dollar Maximum	Unlimited	Not Covered
Health Maintenance Exam - includes chest X-ray, EKG, cholesterol screening, and other select lab procedures	Covered - 100%, one per calendar year	Not Covered
Gynecological Exam	Covered - 100%, one per calendar year	Not Covered
Pap Smear Screening - laboratory and pathology services	Covered - 100%, one per calendar year	Not Covered
Well-Baby and Child Care	Covered - 100% ♦ 6 visits per year, birth through 35 months ♦ 2 visits per year, 36 months through 47 months ♦ 1 visit per year beyond 47 months	Not Covered
Immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics	Covered - 100%	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
Colonoscopy - Rountine or Medically Necessary	Covered 100% - No Deductible or Copay. Subsequent subject to deductible and co insurance	Covered 60% after deductible
Prostate Specific Antigen (PSA) Screening	Covered - 100%, one per calendar year	Not Covered

Mammography		
Mammography Screening	Covered - 100%	Covered - 60% after deductible
	One per calendar year, no age restrictions	

For illustrative purposes only; not intended to be a complete comparison of plans. At the request of the client the above explanation of benefits was developed as a guide for discussion purposes only. The official description of benefits will be the District's Summary Plan Descriptions which would be developed by Blue Cross Blue Shield of MI and/or American Fidelity.

Community Blue Health Plan - Current Plan

Physician Office Services	*In-Network*	*Out-of-Network*
Office Visits	Covered - $20 copay	Covered - 60% after deductible
Outpatient and Home Visits	Covered - 90%	Covered - 60% after deductible, must be medically necessary
Office Consultations	Covered - $20 copay	Covered - 60% after deductible, must be medically necessary
Emergency Medical Care		
Hospital Emergency Room - approved diagnosis	Covered - $50 copay, waived if admitted or for accidental injury	Covered - $250 copay, waived if admitted or for accidental injury
Urgent Care Center	Covered - $20 copay, waived if a medical emergency or accidental injury	Covered - 60% after deductible, waived if a medical emergency or accidental injury
Ambulance Services - medically necessary	Covered - 90%	Covered - 60% after deductible
Diagnostic Services		
Laboratory and Pathology Tests	Covered - 100%	Covered - 60% after deductible
Diagnostic Tests and X-rays	Covered - 100%	Covered - 60% after deductible
Therapeutic Radiology	Covered - 100%	Covered - 60% after deductible
Maternity Services Provided by a Physician		
Pre-Natal and Post-Natal Care	Covered - 100%	Covered - 60% after deductible
	Includes care provided by certified nurse midwife	
Delivery and Nursery Care	Covered - 100%	Covered - 60% deductible
	Includes delivery provided by certified nurse midwife	
Hospital Care		
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 100%	Covered - 60% after deductible
	Unlimited Days	
Inpatient Consultations	Covered - 100%	Covered - 60% after deductible
Chemotherapy	Covered - 100%	Covered - 60% after deductible
Alternatives to Hospital Care		
Skilled Nursing Care	Covered - 100%	Covered - 80% after deductible
	Up to 120 days per calendar year	
Hospice Care	Covered - 100%	Covered - 100%
	Limited to the dollar maximum which is adjusted periodically	
Home Health Care	Covered - 100% - Unlimited visits	Covered - 80% after deductible - Unlimited visits
Surgical Services		
Surgery, including all related surgical services, anesthesia, and surgical assistance	Covered - 100%	Covered - 60% after deductible
Voluntary Sterilization	Covered - 100%	Covered - 60% after deductible

For illustrative purposes only; not intended to be a complete comparison of plans. At the request of the client the above explanation of benefits was developed as a guide for discussion purposes only. The official description of benefits will be the District's Summary Plan Descriptions which would be developed by Blue Cross Blue Shield of MI and/or American Fidelity.

Community Blue Health Plan - Current Plan

Human Organ Transplants	*In-Network*	*Out-of-Network*
Specified Organ Transplants; must be pre-approved at designated facilities Liver, Heart, Lung Pancreas & Heart-Lung	Covered - 100%	Covered - 60% (in designated facilities only)
Bone Marrow; specific criteria applies	Covered - 90%	Covered - 60% after deductible
Kidney, Cornea, and Skin	Covered - 90%	Covered - 60% after deductible
Mental Health Care and Substance Abuse Treatment		
Inpatient Mental Health Care & Inpatient Substance Abuse Treatment	Covered - 100%	Covered - 50% after deductible
	Unlimited days	
Outpatient Mental Health Care · Facility and clinic · Physician's Office	Covered - 90% after in-network deductible Covered - $20.00 Office Visit CoPay	Covered - 50% after deductible, in participating facilities only Covered - 50% after deductible
Outpatient Substance Abuse Treatment; in approved facilities	Covered - 90%	Covered - 50% after deductible
Other Services		
Allergy Testing and Therapy	Covered - 100%	Covered - 60% after deductible
Chiropractic Spinal Manipulation	Covered - 100%	Covered - 60% after deductible
	Up to 24 visits per calendar year	
Outpatient Physical, Speech, and Occupational Therapy • Facility and Clinic	Covered - 100%	Covered - 60% 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 - 90%	Covered - 60% after deductible
Prosthetic and Orthotic Appliances	Covered - 100%	Covered - 80% after deductible
Private Duty Nursing	Covered - 90%	Covered - 50% after deductible
Prescription Drugs	$10 Generic / $60 Brand	$10 Generic / $60 Brand
	Send Receipts to American Fidelity. Brand Reimbursed back to $10.	Send Receipts to American Fidelity. Brand Reimbursed back to $10.

For illustrative purposes only; not intended to be a complete comparison of plans. At the request of the client the above explanation of benefits was developed as a guide for discussion purposes only. The official description of benefits will be the District's Summary Plan Descriptions which would be developed by Blue Cross Blue Shield of MI and/or American Fidelity.