

**Community Blue Health Plan - Current Plan**

<b>Deductible, Co-pays, and Dollar Maximums</b>		
	<i>In-Network</i>	<i>Out-of-Network</i>
Calendar Year Deductible	\$50 per member, \$100 per family	\$250 per member, \$500 per family (out-of-network deductible amounts also apply toward the in-network deductible)
Copays	• Fixed \$30 office visits, \$30 urgent care and \$50 for emergency room visits	\$250 for emergency room visits
	• Percent 20% 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	
<b>Preventive Services</b>		
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 - Routine 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
<b>Mammography</b>		
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.

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<b>Physician Office Services</b>	<i>In-Network</i>	<i>Out-of-Network</i>
Office Visits	Covered - \$30 copay	Covered - 60% after deductible, must be medically necessary
Outpatient and Home Visits	Covered - 80% after deductible	Covered - 60% after deductible, must be medically necessary
Office Consultations	Covered - \$30 copay	Covered - 60% after deductible
<b>Emergency Medical Care</b>		
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 - \$30 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 - 80% after deductible	Covered - 80% after deductible
<b>Diagnostic Services</b>		
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
<b>Maternity Services Provided by a Physician</b>		
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% - after deductible	Covered - 60% after deductible
	Includes delivery provided by certified nurse midwife	
<b>Hospital Care</b>		
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
<b>Alternatives to Hospital Care</b>		
Skilled Nursing Care	Covered - 80% after deductible	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 - 80% after deductible - Unlimited visits	Covered - 80% after deductible - Unlimited visits
<b>Surgical Services</b>		
Surgery, including all related surgical services, anesthesia, and surgical assistance	Covered - 100%	Covered - 60% after deductible
Voluntary Sterilization	Covered - 100%	Covered - 60% after deductible

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<b>Human Organ Transplants</b>	<i>In-Network</i>	<i>Out-of-Network</i>
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 - 80% after deductible	Covered - 60% after deductible
Kidney, Cornea, and Skin	Covered - 80% after deductible	Covered - 60% after deductible
<b>Mental Health Care and Substance Abuse Treatment</b>		
Inpatient Mental Health Care & Inpatient Substance Abuse Treatment	Covered - 100%	Covered - 60% after deductible
	Unlimited days	
Outpatient Mental Health Care · Facility and clinic · Physician's Office	Covered - 50% after deductible	Covered - 50% after deductible, in participating facilities only
	Covered - 50% after deductible	Covered - 50% after deductible
Outpatient Substance Abuse Treatment; in approved facilities	Covered - 50% after deductible	Covered - 50% after deductible
<b>Other Services</b>		
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 · Physician's Office - excludes speech and occupational therapy	Covered - 80% after deductible	Covered - 60% after deductible
	Covered - 80% after deductible	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 - 80% after deductible	Covered - 60% after deductible
Prosthetic and Orthotic Appliances	Covered - 80% after deductible	Covered - 60% after deductible
Private Duty Nursing	Covered - 50% after deductible	Covered - 50% after deductible
Prescription Drugs	Covered - Self Insured, 80% co-pay after Deductible	Covered - Self Insured, 80% co-pay after Deductible
	Send Receipts to American Fidelity	Send Receipts to American Fidelity

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