2024 Medical Benefit Summaries

(Chart illustrates your cost)	HMO BCN	CDHP with Access to an HSA BCBSM		PPO 1 BCBSM		PPO 2 BCBSM	
	In-Network ONLY	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—pediatric and adult	$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% *
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% *
Prescription Drugs (Applies to In-Network Pharmacies Only)							
Retail (Up to a 34-day supply) Generic Brand Preferred Brand Non-Preferred Specialty Generic/Brand Preferred Specialty Brand Non-Preferred	$20 $60 50% ($80 Minimum/ $100 Maximum) 20% ($200 Max) 25% ($300 Max)	30% *		$20 $60 50% ($80 Minimum/ $100 Maximum) 20% ($200 Max) 25% ($300 Max)		$20 $60 50% ($80 Minimum/ $100 Maximum) 20% ($200 Max) 25% ($300 Max)	
Retail 90 and Mail Order (Up to a 90-day supply)	2x Retail Copay	30% *		2x Retail Copay		2x Retail Copay	
Deductibles Coinsurance and Maximums							
Deductible (See page 5 for information regarding the CDHP Deductible)	$2,500 Single $5,000 Family	$2,000 Single $4,000 Family	$4,000 Single $8,000 Family	$3,000 Single $6,000 Family	$6,000 Single $12,000 Family	$2,000 Single $4,000 Family	$4,000 Single $8,000 Family
Coinsurance	30%	30%	40%	30%	40%	30%	40%
Coinsurance Maximum (includes coinsurance only)	$1,500 Single $3,000 Family	NA	NA	$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, coinsurance, and copays (office visits and prescription drugs)	$6,350 Single $12,700 Family	$3,000 Single $6,000 Family	$6,000 Single $12,000 Family	$6,350 Single $12,700 Family	$12,700 Single $25,400 Family	$6,350 Single $12,700 Family	$12,700 Single $25,400 Family

**Indicates the deductible applies.*

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(Chart illustrates your cost)	HMO BCN	CDHP with Access to an HSA BCBSM		PPO Plan 1 BCBSM		PPO 2 BCBSM	
	In-Network ONLY	In- Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
HOSPITAL CARE (Nonemergency services must be rendered in a participating hospital)							
Hospital Visits	30% *	30% *	40% *	30% *	40% *	30% *	40% *
Hospital—Inpatient	30% *	30% *	40% *	30% *	40% *	30% *	40% *
Surgery	30% *	30% *	40% *	30% *	40% *	30% *	40% *
MENTAL HEALTH & SUBSTANCE ABUSE EXPENSES (Must be provided by a participating hospital, inpatient facility or outpatient facility)							
Inpatient	30% *	30% *	40% *	30% *	40% *	30% *	40% *
Outpatient**	$30 copay	30% *	40% *	30% *	40% *	30% *	40% *
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			
		Limited to four 90-day periods (Respite care 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	
Orthotics	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.						

**Indicates the deductible applies.*

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