

REHAB SOLUTIONS, INC. BASE PLAN

What is covered

Provisions	In-Network	Out-of-Network
Deductible, Copays and Dollar Maximums Note: If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.		
Deductible	\$1,500 per member, \$3,000 per family per calendar year Note: Deductible waived if service is performed in a PPO physician's office.	\$3,000 per member, \$6,000 per family per calendar year Note: Out-of-network deductible amounts also apply toward the in-network deductible.
Copays		
• Fixed Dollar Copays	\$25 for office visits and \$100 for emergency room visits	\$100 for emergency room visits
• Percent Copays	80% for general services, waived if service is performed in a PPO physician's office , and 50% for mental health care, substance abuse treatment and private duty nursing	50% 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		
• Fixed Dollar Copays	None	None
• Percent Copays – excludes mental health care, substance abuse treatment and private duty nursing copays	\$2,500 per member, \$5,000 family per calendar year	\$5,000 per member, \$10,000 family per calendar year Note: Out-of-network copays also apply toward the in-network maximum.
Dollar Maximums	\$1 million lifetime per covered specified organ transplant type and a separate \$5 million lifetime per member for all other covered services and as noted above for individual services	
Services	In-Network	Out-of-Network
Preventive Care Services – *Payment for preventive services is limited to a combined maximum of \$500 per member per calendar year		
Health Maintenance Exam – includes chest X-ray, EKG and 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%* <ul style="list-style-type: none"> • 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

Mammography		
Mammography Screening	Covered – 80% after deductible	Covered – 50% after deductible
	One per calendar year, no age restrictions	
Physician Office Services		
Office Visits	Covered – \$25 copay	Covered – 50% after deductible, must be medically necessary
Outpatient and Home Visits	Covered – 80% after deductible	Covered – 50% after deductible, must be medically necessary
Office Consultations	Covered – \$25 copay	Covered – 50% after deductible, must be medically necessary
Urgent Care Visits	Covered – \$25 copay	Covered – 50% after deductible, must be medically necessary
Emergency Medical Care		
Hospital Emergency Room	Covered – \$100 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 – 80% after deductible	Covered – 50% after deductible
Diagnostic Services		
Laboratory and Pathology Services	Covered – 80% after deductible	Covered – 50% after deductible
Diagnostic Tests and X-rays	Covered – 80% after deductible	Covered – 50% after deductible
Therapeutic Radiology	Covered – 80% after deductible	Covered – 50% after deductible
Maternity Services Provided by a Physician		
Prenatal and Postnatal Care	Covered – 100%	Covered – 50% after deductible
	Includes care provided by a certified nurse midwife	
Delivery and Nursery Care	Covered – 80% after deductible	Covered – 50% after deductible
	Includes delivery provided by a certified nurse midwife	
Hospital Care		
Semiprivate Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 80% after deductible	Covered – 50% after deductible
Note: Nonemergency services must be rendered in a participating hospital	Unlimited days	
Inpatient Consultations	Covered – 80% after deductible	Covered – 50% after deductible
Chemotherapy	Covered – 80% after deductible	Covered – 50% after deductible
Alternatives to Hospital Care		
Skilled Nursing Care	Covered – 80% after deductible	Covered – 50% after deductible
	Up to 120 days per calendar year	
Hospice Care	Covered – 100%	Covered – 100%
	Limited to dollar maximum which is adjusted periodically	

Home Health Care	Covered – 80% after deductible	Covered – 80% after deductible
	Unlimited visits	
Surgical Services	In-Network	Out-of-Network
Surgery – includes related surgical services	Covered – 80% after deductible	Covered – 50% after deductible
Voluntary Sterilization	Covered – 80% after deductible	Covered – 50% after deductible
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%	Covered – in designated facilities only
	Up to \$1 million lifetime maximum per transplant type	
Bone Marrow – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504); specific criteria applies	Covered – 80% after deductible	Covered – 50% after deductible
Kidney, Cornea and Skin	Covered – 80% after deductible	Covered – 50% after deductible
Mental Health Care and Substance Abuse Treatment		
Inpatient Mental Health Care	Covered – 50% after deductible	Covered – 50% after deductible
	Unlimited days	
Inpatient Substance Abuse Treatment	Covered – 50% after deductible	Covered – 50% after deductible
	Unlimited days, up to \$15,000 annual, \$30,000 lifetime maximum	
Outpatient Mental Health Care		
• Facility and Clinic	Covered – 50% after deductible	Covered – 50% after deductible
• Physician's Office	Covered – 50%	Covered – 50% after deductible
Outpatient Substance Abuse Treatment – in approved facilities	Covered – 50% after deductible	Covered – 50% after deductible
	Up to the state-dollar amount which is adjusted annually	
Other Services		
Outpatient Diabetes Management Program (ODMP)	Covered – 80% after deductible	Covered – 50% after deductible
Allergy Testing and Therapy	Covered – 100%	Covered – 80% after deductible
Chiropractic Spinal Manipulation	Covered – \$25 copay	Covered – 50% after deductible
	Up to 24 visits per calendar year	
Outpatient Physical, Speech and Occupational Therapy		
• Facility and Clinic	Covered – 80% after deductible	Covered – 50% after deductible
• Physician's Office – excludes speech and occupational therapy	Covered – 100%	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 – 80% after deductible	Covered – 50% after deductible
Prosthetic and Orthotic Appliances	Covered – 80% after deductible	Covered – 50% after deductible

Private Duty Nursing	Covered – 50% after deductible	Covered – 50% after deductible
Prescription Drugs	See Prescription Drugs Page	
Optional Riders Included		
Rider CBC-MT, Copay Requirement for Manipulative Treatment \$25	Imposes the same fixed dollar copay requirement for chiropractic and osteopathic manipulative treatment by a network provider as is required for all network physician office visits	