Blue Cross Blue Shield of Michigan

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Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Note: A list of services that require approval **before** they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services**.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	$500 per member $1,000 per family	$1,000 per member $2,000 per family
Copays • Fixed Dollar Copays	$25 copay for : • Primary Care Physician (PCP) office visits • Chiropractic spinal manipulations $45 copay for : • Specialist office visits $50 copay for : • Facility Urgent care services • Professional Urgent care services $150 copay for : • Facility medical emergency	$150 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	20%	40% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$3,500 per member $7,000 per family Includes Deductible, Coinsurance and Copays	$7,500 per member $14,000 per family Includes Deductible and Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; 1 per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - 2 per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - 1 per calendar year	Covered - 100%	Not Covered
Mammography Screening- preventive or medically necessary- includes 3D Mammography	Covered - 100% once per calendar year; subsequent services covered 80% after deductible	Not Covered
Contraceptive Methods and Counseling	Covered - 100%	Covered- 60% after deductible
Prostate Specific Antigen (PSA) screening- preventive or medically necessary	Covered - 100% once per calendar year; subsequent services covered 80% after deductible	Not Covered
Endoscopic Exams- preventive or medically necessary	Covered - 100% once per calendar year; subsequent services covered 80% after deductible	Not Covered
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $25 pcp copay; $45 specialist copay	Covered - 60% after deductible
Telemedicine Visits	Covered - 100% after $25 pcp copay; $45 specialist copay	Covered - 60% after deductible
Virtual Care - Online Medical Visits Note: Online Medical visits by a non-BCBSM selected vendor are not covered.	Covered - 100%	Not Covered
Office Consultations	Covered - 100% after $25 pcp copay; $45 specialist copay	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 100% after $25 pcp copay; $45 specialist copay	Covered - 60% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - $150 copay then 80% after deductible; copay waived if admitted	Covered - $150 copay then 80% after deductible; copay waived if admitted
Non-Emergency use of the Emergency Room	Covered - $150 copay then 80% after deductible	Covered - $150 copay then 60% after deductible
Facility Urgent Care Services	Covered - 100% after $50 copay	Covered - 60% after deductible

Physician Urgent Care Services	Covered - 100% after $50 copay	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 100%	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 100%	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 60% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 60% after deductible
Delivery and Nursery Care excludes dependent children	Covered - 80% after deductible	Covered - 60% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible	Covered - 60% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 60% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 100%	Covered - 100%
Home Health Care	Covered - 80% after deductible	Covered - 80% after deductible
Skilled Nursing Limited to 120 days per calendar year	Covered - 80% after deductible	Covered - 80% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Bariatric Surgery	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - male reproductive organs excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - female reproductive organs excludes reversal sterilization	Covered - 100%	Covered - 60% after deductible

Expanded Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	Not Covered	Not Covered

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 60% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 100%	Covered - 60% after deductible
Telemedicine Mental Health Care	Covered - 100%	Covered - 60% after deductible
Virtual Care - Online Mental Health Visits Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered.	Covered - 100%	Not Covered

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out-of-Network
Applied Behavior Analysis (ABA) Prior authorization required **Note:** Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).	Covered - 80% after deductible	Covered - 60% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 80% after deductible	Covered - 60% after deductible
Nutritional Counseling	Covered - 80% after deductible	Covered - 60% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation Services Limited to a maximum of $500 per calendar year	Covered - 100% after $25 copay	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 60% after deductible
Private Duty Nursing Care	Covered - 80% after deductible	Covered - 60% after deductible

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. 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.

Allergy Testing and Therapy	Covered - 80% after deductible	Covered - 60% after deductible
Facility Clinic Visit	Covered - 100% after $25 copay	Covered - 60% after deductible
Acupuncture Limited to a maximum of $500 per calendar year	Covered- 100% after $25 copay	Covered - 60% after deductible
Massage Therapy Limited to a maximum of $500 per calendar year	Covered- 100% after $25 copay	Covered - 60% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible

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