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	$700 per member $1,400 per family	$1,300 per member $2,600 per family
Copays • Fixed Dollar Copays	$12.50 copay for: • Retail Health visits $25 copay for: • Primary Care Physician (PCP) office visits $35 copay for: • Specialist office visits • Chiropractic spinal manipulations $50 copay for: • Facility Urgent care services • Professional Urgent care services $150 copay for: • Facility medical emergency	$50 copay for: • Facility Urgent care services • Professional Urgent care services $150 copay for: • Facility medical emergency
Plan Out of Pocket Maximum • Percent Coinsurance	20% up to a maximum of: $2,300 per member $4,600 per family Includes Deductible and Coinsurance	40% up to a maximum of: $4,500 per member $7,000 per family Includes Deductible and Coinsurance **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$9,200 per member $18,400 per family Includes Deductible, Coinsurance and Copays	None 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 Tests and lab procedures performed as part of the health maintenance exam	Covered - 100%	Covered - 60% after deductible
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%	Covered - 60% after deductible
Mammography Screening - 1 per calendar year includes 3D Mammography	Covered - 100%	Covered - 60% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - beginning 40 years of age; 1 per calendar year and 1 additional for high risk	Covered - 100%	Covered - 60% after deductible
Endoscopic Exams - beginning at age 45: • Colonoscopy: 1 every 10 years; or every 5 years when no sigmoidoscopy or Barium Enema or when no colonoscopy within 10 years • Sigmoidoscopy: 1 every 5 years when no sigmoidoscopy or Barium Enema or when no colonoscopy within 10 years • Barium Enema: 1 every 5 years when no sigmoidoscopy or Barium Enema or when no colonoscopy within 10 years • Cologuard: 1 every 3 years • Proctosigmoidoscopy: 1 per calendar year	Covered - 100%	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 • Shingrix starting at age 50 • Zoster starting at age 50	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $25 PCP copay; $35 specialist copay	Not Covered
Retail Health Visit	$12.50 Copay	Not Covered
Telemedicine Visits	Covered - 100% for visits 1-5 per member, then $10 copay for additional visits	Not Covered
Virtual Care - Online Medical Visits Note: Online Medical visits by a non-BCBSM selected vendor are not covered.	Covered - 100% for visits 1-5 per member, then $10 copay for additional visits	Not Covered
Office Consultations	Covered - 100% after $25 PCP copay; $35 specialist copay	Not Covered
Pre-Surgical Consultations	Covered - 100% after $25 PCP copay; $35 specialist copay	Not Covered

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $150 copay; copay waived if admitted	Covered - 100% after $150 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Facility Urgent Care Services	Covered - 100% after $50 copay	Covered - 100% after $50 copay
Physician Urgent Care Services	Covered - 100% after $50 copay	Covered - 100% after $50 copay
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 60% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	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 Care Visits	Covered - 100%	Not Covered
Postnatal Care Visits	Covered - 100%	Covered - 60% after deductible
Delivery and Nursery Care	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 365 days with 60-day renewal	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 Limited to lifetime maximum of 365 days	Covered - 80% after deductible	Not Covered
Home Health Care Limited to 3 days for each unused inpatient day with a 60-day renewal per calendar year	Covered - 80% after deductible	Covered - 60% after deductible
Skilled Nursing Limited to 2 days for each unused inpatient day with 60-day renewal	Covered - 80% after deductible	Covered - 60% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - $50 copay then 80% after deductible	Covered - $50 copay then 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.	Covered - 80% after deductible	Covered - 60% after deductible

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% after $25 copay	Out of Network Therapy visits-Not Covered Other Outpatient MH/SUD services: Covered – 60% after deductible
Telemedicine Mental Health Care/Substance Use Disorder	Covered - 100% for visits 1-5 per member; visits 6+ $10 copay; visits combined with Virtual Care – Online Mental Health Visits	Not Covered
Virtual Care - Online Mental Health/Substance Use Disorder Visits Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered.	Covered - 100% for visits 1-5 per member; visits 6+ $10 copay; visits combined with Telemedicine Mental Health Visits	Not Covered

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out-of-Network
Applied Behavior Analysis (ABA) **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	Not Covered
Chiropractic Spinal Manipulation Services Limited to a maximum of 24 visits per calendar year	Covered - 100% after $35 copay	Not Covered
Durable Medical Equipment	Covered - 100%	Covered - 80% up to $500 benefit maximum for DME/P&O
Prosthetic and Orthotic Devices	Covered - 100%	Covered - 80% up to $500 benefit maximum for DME/P&O
Private Duty Nursing Care	Covered - 80% after deductible	Covered - 60% after deductible
Allergy Testing and Therapy	Covered - 80% after deductible	Covered - 60% after deductible
Facility Clinic Visit Cancer related diagnosis only	Covered - 80% after deductible	Covered - 60% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy	Covered - 80% after deductible	Not Covered