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	$1,100 per member $2,200 per family	$2,200 per member $4,400 per family
Copays • Fixed Dollar Copays	$12.50 copay for: • Retail Health Center $35 copay for: • Primary Care Physician (PCP) office visits $55 copay for: • Specialist office visits • Chiropractic spinal manipulations $60 copay for: • Facility Urgent care services • Professional Urgent care services $175 copay for: • Facility medical emergency	$60 copay for • Facility Urgent care services • Professional Urgent care services $175 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	30%	50% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$3,675 per member $7,350 per family Includes Deductible and Coinsurance	$7,350 per member $14,700 per family Includes Deductible and Coinsurance
Lifetime dollar maximum	No lifetime maximum	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 2; 1 per calendar year	Covered - 100%	Not Covered
Routine Physical Related Tests and lab procedures performed as part of the health maintenance exam	Covered - 70% after deductible	Not Covered
Annual Gynecological Exam - 1 per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - 1 per calendar year	Covered - 70% after deductible	Covered - 50% after deductible
Mammography Screening includes 3D Mammography	Covered - 70% after deductible	Covered - 50% after deductible
Prostate Specific Antigen (PSA) screening - beginning 40 years of age; 1 per calendar year and 1 additional for high risk	Covered - 70% after deductible	Covered - 50% 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	Covered - 100%	Not Covered
Well Child Care Unlimited visits up to and including 24 months	Covered - 100%	Not Covered
Immunizations - pediatric and adult • Shingrix starting at age 50 • Zoster starting at age 50	Covered - 100% Covered – 70% after deductible Covered – 70% after deductible	Not Covered Covered 50% after deductible Covered 50% after deductible

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $35 pcp copay; $55 specialist copay	Not Covered
Retail Health Visits	Covered - 100% after $12.50 copay	Not covered
Telemedicine Visits	Covered - 100% for visits 1–5 per member, then $10 copay for any 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 after $10 copay for any additional visits	Not Covered
Office Consultations	Covered - 100% after $35 pcp copay; $55 specialist copay	Not Covered
Pre-Surgical Consultations	Covered - 100% after $35 pcp copay; $55 specialist copay	Not Covered

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $175 copay; copay waived if admitted	Covered - 100% after $175 copay; copay waived if admitted

Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Facility Urgent Care Services	Covered - 100% after $60 copay; waived if transferred to emergency room	Covered - 100% after $60 copay; waived if transferred to emergency room
Physician Urgent Care Services	Covered - 100% after $60 copay; waived if transferred to emergency room	Covered - 100% after $60 copay; waived if transferred to emergency room
Ambulance Services - Medically Necessary Transport	Covered - 70% after deductible	Covered - 50% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 70% after deductible	Covered - 50% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 70% after deductible	Covered - 50% after deductible
Radiation Therapy and Chemotherapy	Covered - 70% after deductible	Covered - 50% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal Care Visits	Covered - 70% after deductible	Not Covered
Postnatal Care Visits	Covered - 70% after deductible	Covered - 50% after deductible
Delivery and Nursery Care	Covered - 70% after deductible	Covered - 50% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 70% after deductible	Covered - 50% after deductible
Inpatient Medical Care	Covered - 70% after deductible	Covered - 50% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care Limited to lifetime maximum of 365 days	Covered - 70% after deductible	Not Covered
Home Health Care Limited to 3 days for each unused inpatient day per calendar year	Covered - 70% after deductible	Covered - 50% after deductible
Skilled Nursing	Covered - 70% after deductible	Covered - 50% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - $50 copay then 70% after deductible	Covered - $50 copay then 50% after deductible
Bariatric Surgery	Covered - 70% after deductible	Covered - 50% after deductible

Sterilization excludes reversal sterilization	Covered - 70% after deductible	Covered - 50% after deductible
Expanded Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	Covered - 70% after deductible	Covered - 50% 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 - 70% after deductible	Covered - 50% 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 - 70% after deductible	Covered - 50% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 100% after $35 copay	Not Covered
Telemedicine Mental Health/Substance Use Disorder Care	Covered – Visits 1-5, covered at 100%; Visits 6+, covered with $10 copay	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 - Visits 1-5, covered at 100%; Visits 6+, covered with $10 copay	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 - 70% after deductible	Covered - 50% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 70% after deductible	Covered - 50% after deductible
Nutritional Counseling	Covered - 70% after deductible	Covered - 50% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 70% after deductible	Not Covered
Chiropractic Spinal Manipulation Services Limited to a maximum of 24 visits per calendar year combined with Osteopathic manipulations	Covered - 100% after $55 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 - 70% after deductible	Covered - 50% after deductible
Allergy Testing and Therapy	Covered - 70% after deductible	Covered - 50% after deductible
Facility Clinic Visit Cancer related diagnosis only	Covered - 70% after deductible	Covered - 50% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy	Covered - 70% after deductible	Not Covered

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.