



This is intended as an easy-to-read summary. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificate and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.

	In-Network	Out-of-Network
<p>Deductible, copays and dollar maximums Note: Services from a provider for which there is no PPO network and services from a non-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. 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.</p>		
Deductible	\$750 per member, \$1,500 per family	\$1,500 per member, \$3,000 per family
<p>Copays</p> <ul style="list-style-type: none"> Fixed (does not contribute to out-of-pocket maximum) Percent 	<p>\$50 per Emergency Room Visit \$50 per Urgent Care Facility Visit (freestanding)</p> <p>0% copay on select benefits Ambulance Hospice Care Home Health Care Mammography Screening Preventive Services Private Duty Nursing Skilled Nursing Specified Human Organ Transplant</p> <p>10% copay on select benefits Cardiac Rehab Chemotherapy Delivery and Nursery Care Diagnostic Tests and X-rays Hospital Care – Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies Inpatient Consultations Inpatient Mental Health Care Inpatient Substance Abuse Care Laboratory and Pathology Tests Outpatient Diabetes Education Pre-Natal and Post-Natal Care Professional Visits for Newborn Surgical Services Therapeutic Radiation</p> <p>35% copay on select benefits Acupuncture Allergy Testing and Therapy Chiropractic Spinal Manipulation Durable Medical Equipment & Medical Supplies Massage Therapy by a Massage Therapist, Clinic, Independent Physical Therapist, M.D. or D.O. Office Visits, Outpatient and Home Medical Visits, and Office Consultations Outpatient Mental Health Care Outpatient Substance Abuse Treatment Physical Therapy, Occupational Therapy, Speech Therapy Phototherapy Light Equipment Prescription Contraceptive Devices Prosthetic and Orthotic Appliances Shoe Inserts & Lifts</p>	<p>\$50 per Emergency Room Visit \$50 per Urgent Care Facility Visit (freestanding)</p> <p>30% copay on select benefits Cardiac Rehab Chemotherapy Delivery and Nursery Care Diagnostic Tests and X-rays Inpatient Consultations Inpatient Mental Health Care Laboratory and Pathology Tests Mammography Screening Pre-Natal and Post-Natal Care Professional Visits for Newborn Hospital Care – Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies Surgical Services Therapeutic Radiation</p> <p>35% copay on select benefits Office Visits, Outpatient and Home Medical Visits, and Office Consultations Outpatient Mental Health Care Outpatient Substance Abuse Treatment Prescription Contraceptive Devices</p> <p>40% copay on select benefits Acupuncture Allergy Testing and Therapy Chiropractic Spinal Manipulation Massage Therapy by an M.D. or D.O. Physical Therapy, Occupational Therapy, Speech Therapy</p>



	In-Network	Out-of-Network
Deductible, copays and dollar maximums		
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Copay Dollar Maximums <ul style="list-style-type: none"> Fixed copays Percent copays 	None \$2,000 per member, \$4,000 per family	None \$4,000 per member, \$8,000 per family
Dollar Maximums	\$1 million lifetime per covered specified human organ transplant type and a separate \$3 million lifetime per member for all other covered services and as noted for individual services	

Preventive Services

Health Maintenance Exam Annual Gynecological Exam	Covered – 100%, One of EACH per year calendar year	Not Covered
Pap Smear Screening – Laboratory services only	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
Childhood immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics	Covered – 100%	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
Chemical Profile	Covered – 100%, one per calendar year	Not Covered
Urinalysis	Covered – 100%, one per calendar year	Not Covered
Chemistry	Covered – 100%, one per calendar year	Not Covered
Complete Blood Count	Covered – 100%, one per calendar year	Not Covered
Chest X-Ray	Covered – 100%, one per calendar year	Not Covered
EKG	Covered – 100%, one per calendar year	Not Covered
Digital Rectal Exam	Covered – 100%, one per calendar year	Not Covered
Air Contrast Barium Enema	Covered – 100%, one per calendar year	Not Covered
Proctoscopic Exam	Covered – 100%, one per calendar year	Not Covered

Mammography

Mammography Screening	Covered – 100%	Covered –70% after deductible
	One per calendar year, no age restrictions	

Physician Office Services

Office Visits	Covered – 65%	Covered – 65% after deductible
Outpatient and Home Medical Care Visits	Covered – 65%	Covered – 65% after deductible
Office Consultations	Covered – 65%	Covered – 65% after deductible



	In-Network	Out-of-Network
Emergency Medical Care		
Hospital Emergency Room – Approved diagnosis	Covered - \$50 copay	Covered - \$50 copay
	Copay waived if admitted or for an accidental injury	
Urgent Care Center (freestanding facility) If services rendered at a hospital based urgent care clinic then hospital component subject to \$50 copay. There may be an additional fee for the physician services which will be subject to deductible and copay (if applicable).	Covered - \$50 copay	Covered - \$50 copay
Ambulance Services – Medically necessary	Covered – 100%	Covered – 100%
Diagnostic Services		
Laboratory and Pathology Tests	Covered – 90% after deductible	Covered – 70% after deductible
Diagnostic Tests and X-rays	Covered – 90% after deductible	Covered – 70% after deductible
Therapeutic Radiology	Covered – 90% after deductible	Covered – 70% after deductible
Maternity Services Provided by a Physician		
Pre-Natal and Post-Natal Care	Covered – 90%	Covered – 70% after deductible
Delivery and Nursery Care	Covered – 90% after deductible	Covered – 70% after deductible
	Includes delivery provided by a certified nurse midwife	
Hospital Care		
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies Note: Non-emergency services must be rendered in a participating hospital.	Covered – 90% after deductible	Covered – 70% after deductible
	Unlimited days	
Inpatient Consultations	Covered – 90% after deductible	Covered – 70% after deductible
Chemotherapy	Covered – 90% after deductible	Covered – 70% after deductible
Alternatives to Hospital Care		
Skilled Nursing Care	Covered – 100%	Covered – 100%
	Up to 60 days per confinement	
Hospice Care	Covered – 100%	Covered – 100%
	Limited to the dollar maximum which is reviewed and adjusted periodically	
Home Health Care - medically necessary	Covered – 100%	Covered – 100%
	Unlimited visits	
Surgical Services		
Surgery, including all related surgical services, anesthesia and surgical assistance	Covered – 90% after deductible	Covered – 70% after deductible
Voluntary Sterilization	Covered – 90% after deductible	Covered – 70% after deductible
Human Organ Transplants		
Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504) (Liver, Heart, Lung, Pancreas and Heart-Lung)	Covered – 100%	Covered – 70% after deductible
	Up to \$1 million maximum per transplant type \$5,000 maximum for travel, meals, and lodging (combined) and \$30 maximum per day for meals	
Bone marrow – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504); specific criteria applies	Covered – 90% after deductible	Covered – 70% after deductible
Kidney, Cornea and Skin	Covered – 90% after deductible	Covered – 70% after deductible



	In-Network	Out-of-Network
Mental Health Care and Substance Abuse Treatment		
Inpatient Mental Health Care and Substance Abuse Care	Covered – 90% (approved facility)	Covered – 70% after deductible (approved facility)
120 days lifetime maximum per member		
Outpatient Mental Health Care <ul style="list-style-type: none"> • Facility and Clinic • Physician's Office 	Covered – 65%	Covered - 65% after deductible
Outpatient Substance Abuse Treatment - in approved facilities	Covered – 65%	Covered - 65%
Combined 40 visits per members, per calendar year		
Mental Health Services can be rendered by an M.D., D.O., Ph.D, Outpatient Psychiatric Center (OPC) or If rendered by an independent MSW, CSW, ACSW, MSSW, LLP, or MMH, or Catholic Social Services (located at 616 Shelden Ave., Suite 211, Houghton MI) covered 75% and reimbursed directly to the subscriber		
Substance Abuse services must be rendered by an approved Substance Abuse Facility		
Other Services		
Allergy Testing and Therapy	Covered – 65%	Covered – 60% after deductible
Chiropractic Spinal Manipulation	Covered – 65%	Covered – 60% after deductible
Up to 24 visits per calendar year		
Outpatient Physical, Speech and Occupational Therapy	Covered – 65%	Covered – 60% after deductible
Up to 60 visits per calendar year		
Durable Medical Equipment and Medical Supplies	Covered – 65%	Covered – 65%
Prosthetic and Orthotic Appliances	Covered – 65%	Covered – 65%
Private Duty Nursing	Covered – 100%	Covered – 100%
Acupuncture	Covered – 65%	Covered – 60% after deductible
20 visits total, per member, per calendar year Services must be rendered by an M.D. or D.O. Must be an approved diagnosis		
Shoe Inserts when shoe is not attached to a brace	Covered - 65% of approved amount	Covered - 65% of approved amount
One pair of either shoe inserts or lifts per calendar year		
Lab procedures performed in a physician's office that are not normally payable in a physician's office setting	Covered – 90% after deductible	Covered – 70% after deductible
Professional visits for a newborn in nursery	Covered – 90% after deductible	Covered – 70% after deductible
Outpatient Diabetes Education and Training	Covered - 90% after deductible Subject to a lifetime maximum of \$1,000 per member	
Phototherapy Light Equipment with Photometer (50v bulbs)	Covered - 65% of charges Subject to lifetime maximum of \$400 Replacement bulbs not covered	
Cardiac Rehabilitation Phases II & III of treatment	Covered – 90% after deductible	Covered – 70% after deductible



	In-Network	Out-of-Network
Other Services		
Massage Therapy <ul style="list-style-type: none"> • M.D., D.O. • Massage Therapist, Massage Clinic, or Independent Physical Therapist 	Covered – 65%	Covered – 60% after deductible
	Covered – 65%	Covered – 65%
20 visits total, per member, per calendar year Doctors prescription required Approved amount capped at \$40 less copay with reimbursement made to subscriber when services rendered by Massage Therapist or Massage Clinic Must be performed in the office setting		
Prescription Contraceptive Devices	Covered – 65%	Covered – 65% after deductible



**Blue Preferred RxSM Prescription Drug Coverage
Benefits-at-a-Glance**

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Note: Effective October 1, 2006, the mail order pharmacy for **specialty drugs** changed to Option Care. Specialty prescription drugs (such as Enbrel[®] and Humira[®]) are used to treat complex conditions for rheumatoid arthritis. These drugs require special handling, administration or monitoring.

Option Care will handle mail order prescriptions **only** for specialty drugs. Continue to send other mail order prescription medications to Medco. A list of specialty drugs is available on our Web site at **bcbsm.com**. If you have any questions, please call **Option Care customer service at 866-515-1355**.

Covered Services:

- Federal-legend drugs
- State-controlled drugs
- Prescription drug contraceptive medicines
- 34 day supply or 100 units of medication
 - Needles and syringes **covered 100% only when provided at the time an Insulin prescription is filled.**

- Up to a 90 day supply of almost any medication

Retail Prescription Drug Program

Preferred Rx Pharmacy (in Michigan):

- **Generic Drugs:**
 - 10% copay per prescription
 - Subject to a minimum copay of \$5 and a maximum of \$15
- **Brand Drugs:**
 - 25% copay per prescription
 - Subject to a minimum copay of \$10 and a maximum of \$30

(Outside Michigan) MedImpact Prescriptions Pharmacy Network

Non-Preferred or Non-MedImpact Pharmacy: 75% of approved amount less the appropriate 10% or 25% copay.

Mail Order Prescription Drug Program

Generic Drugs:

- **Up to a 34-day supply:**
 - 10% copay, with a \$5 minimum and \$15 maximum copayment
- **35 to 60-day supply:**
 - 10% copay, with a \$10 minimum and \$30 maximum copayment
- **61 to 90-day maximum supply:**
 - 10% copay, with a \$15 minimum and \$45 maximum copayment

Brand Drugs:

- **Up to a 34-day supply:**
 - 25% copay, with a \$10 minimum and \$30 maximum copayment
- **35 to 60-day supply:**
 - 25% copay, with a \$20 minimum and \$60 maximum copayment
- **61 to 90-day maximum supply:**
 - 25% copay, with a \$30 minimum and \$90 maximum copayment

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

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