

Individual Care BlueSM

PPO Benefits-at-a-Glance

	In-Network	Out-of-Network
Deductible, copays and dollar maximums		
Deductible	None	None
Copays	30 percent of the BCBSM-approved amount	50 percent of the BCBSM-approved amount
Copay dollar maximums – excludes prescription drug copays	\$2,500 per family	None
Dollar maximums	None except as noted below	

Note: Nonparticipating provider may be billed for the difference between our approved amount and the provider's charge, even when referred

Mammography		
Mammography screening – one baseline ages 35-40, one annually at age 40 and older	Covered – 100 percent with no deductible	Covered – 100 percent with no deductible

Emergency medical care		
Medical emergency or accidental injury	Covered – 70 percent	Covered – 70 percent
Emergency ambulance services	Covered – 70 percent	Covered – 70 percent

Diagnostic services		
Laboratory and pathology services	Covered – 70 percent	Covered – 50 percent
Diagnostic tests and X-rays	Covered – 70 percent	Covered – 50 percent
Therapeutic radiology	Covered – 70 percent	Covered – 50 percent

Maternity services – hospital and physician services		
Prenatal and postnatal care	Not covered	Not covered
Delivery and nursery care	Covered – 70 percent	Covered – 50 percent

Surgical services		
Surgery – includes related surgical services	Covered – 70 percent	Covered – 50 percent
Voluntary sterilization	Covered – 70 percent	Covered – 50 percent

Hospital care – non-emergency services must be rendered in a participating hospital		
Semiprivate room – up to 120 days with a 60-day renewal period	Covered – 70 percent	Covered – 50 percent
Inpatient consultations	Covered – 70 percent	Covered – 50 percent
Chemotherapy	Covered – 70 percent	Covered – 50 percent

	In-Network	Out-of-Network
Mental health and substance abuse care – in a participating facility		
Inpatient mental health care – up to 30 days with a 60-day renewal period	Covered – 70 percent	Covered – 50 percent
Residential and outpatient substance abuse care – up to the state-mandated benefit	Covered – 70 percent	Covered – 50 percent
Outpatient mental health care	Not covered	Not covered

Alternatives to hospital care		
Skilled nursing care	Not covered	Not covered
Hospice care – Covered up to the dollar maximum, which is adjusted periodically	Covered – 100 percent after in-network deductible, through a participating hospice program only	Covered – 100 percent after in-network deductible, through a participating hospice program only
Home health care	Covered – 70 percent	Covered – 50 percent

Human organ transplants – approved facilities only		
Specified organ transplants – up to \$1 million lifetime maximum per transplant type	Covered – 100 percent	Covered – 100 percent in designated facilities only
Bone marrow transplants	Covered – 70 percent	Covered – 50 percent
Kidney, cornea and skin (does not have to be coordinated through the transplant program)	Covered – 70 percent	Covered – 50 percent

Note: Specified organ and bone marrow transplants must be coordinated through the BCBSM transplant program.

Other Services		
Outpatient diabetes management program and supplies	Covered – 70 percent	Covered – 50 percent
Office visits	Covered – 70 percent 2 visits per year	Not covered
Outpatient presurgical second opinion consultations	Covered - 100%	Not covered
Preventive care services	In-network services are covered up to a combined maximum of \$500 per member, per calendar year. Services include: health maintenance exam, sigmoidoscopy, gynecological exams, routine Pap smear, fecal occult blood screening, prostate specific antigen screening, routine laboratory and radiology services, well-baby care and immunizations	Not covered
Allergy testing and therapy	Not covered	Not covered
Chiropractic spinal manipulation	Not covered	Not covered
Outpatient physical, speech and occupational therapy – up to 60 consecutive days per condition	Covered – 70 percent	Covered – 50 percent
Durable medical equipment	Not covered	Not covered
Prosthetic appliances	Covered – 70 percent	Covered – 50 percent

Prescription drug coverage	Network Pharmacy	Out-of-Network Pharmacy
Benefits include: <ul style="list-style-type: none"> • Drugs that require a prescription and state-controlled drugs • Injectable insulin • Needles and syringes dispensed with insulin or chemotherapeutic drugs • Contraceptive medication and injections 	50 percent with a minimum copay of \$10 and a maximum of \$100 per prescription	50 percent with a minimum copay of \$10 and a maximum of \$100 per prescription plus an additional 25 percent copay
	Benefits are covered up to an annual maximum of \$2,500 per member, per calendar year	

This is intended to be 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.