



PPO Versatile Plan 1 with RX Plan 6 Benefits-at-a-Glance WmHIP

The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This BAAG is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

In-Network

Out-of-Network

Deductible, Copays/Coinsurance and Dollar Maximums

	In-Network	Out-of-Network
Deductible - per calendar year	\$250 per member \$500 per family	\$ 500 per member \$1,000 per family
Copays/Coinsurance • Fixed Dollar Copays	\$10 copay for: • Office visits • Urgent Care Visits \$25 copay for: • Non-emergency visits in emergency room	\$25 copay for: • Non-emergency visits in emergency room
• Percent Coinsurance	10%	30% Note: Services without a network are covered at the in-network level.
Out-of-Pocket Maximum – per calendar year • Percent Coinsurance <i>Excludes Deductible</i>	\$1,000 per member \$2,000 per family	\$2,000 per member \$4,000 per family
Lifetime Maximum		Unlimited

Preventive Services

Health Maintenance Exam – beginning age 16, one per calendar year; includes related X-rays, EKG, and lab procedures performed as part of the physical exam	Covered – 100%	Not Covered
Annual Gynecological Exam - one per calendar year	Covered – 100%	Not Covered
Pap Smear Screening – one per calendar year; laboratory services only.	Covered – 100%	Not Covered
Prostate Specific Antigen (PSA) Screening - one per calendar year.	Covered – 100%	Not Covered
Fecal Occult Blood Test – one per calendar year	Covered – 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered – 100%	Not Covered
Well-Baby and Child Care - through age 15; 6 visits birth through age 1, 2 visits per year age 2 through 3, 1 visit per year age 4 through 15	Covered – 100%	Not Covered
Immunizations - pediatric and adult	Covered – 100%	Not Covered
Hearing Exam – one per calendar year	Covered – 100%	Not Covered
Colonoscopy – routine or medically necessary	100% for routine colonoscopy (no deductible or copay) Note: Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	80% after out-of-network deductible
	One routine colonoscopy per member per calendar year	
Routine mammogram and related reading	100% (no deductible or copay) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	80% after out-of-network deductible Note: Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
	One per member per calendar year	



Physician Office Services

Office Visits Includes: <ul style="list-style-type: none"> • Primary Care Physicians and Specialists • Presurgical consultations ◆ Initial visit to determine pregnancy 	Covered – 100% after \$10 copay One copay applies to the office visit exam and all services performed during the office visit (e.g., lab, x-rays, etc.)	Covered – 70% after deductible
Facility Based Urgent Care Centers	Covered – 100% after \$10 copay	Covered – 70% after deductible

Emergency Medical Care

Hospital Emergency Room Qualified Medical Emergency & First Aid Services	Covered – 90% after deductible	Covered – 90% after deductible
Non-Emergency use of the Emergency Room	Covered - \$25 copay then 90% after deductible	Covered - \$25 copay then 90% after deductible
Ambulance Services – medically necessary transport	Covered – 90% after deductible	Covered – 90% after deductible

Diagnostic Services

MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered – 90% after deductible	Covered – 70% after deductible
Independent Laboratory	Covered – 100%, deductible waived	Covered – 70% after deductible
Other Diagnostic Tests, X-rays, Laboratory & Pathology	Covered – 90% after deductible	Covered – 70% after deductible
Radiation Therapy	Covered – 90% after deductible	Covered – 70% after deductible

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – 90% after deductible	Covered – 70% after deductible
Delivery and Nursery Care	Covered – 90% after deductible	Covered – 70% after deductible

Hospital Care

Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 90% after deductible	Covered – 70% after deductible
	Unlimited days	
Inpatient Medical Care	Covered – 90% after deductible	Covered – 70% after deductible
Chemotherapy	Covered – 90% after deductible	Covered – 70% after deductible

Alternatives to Hospital Care

Skilled Nursing Facility	Covered – 90% after deductible	Covered – 90% after deductible
	Limited to 120 days per calendar year	
Hospice care – must be provided through a participating hospice program	Covered – 90% after deductible	Covered – 90% after deductible
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home Health Care	Covered – 90% after deductible	Covered – 90% after deductible

Outpatient Surgical Services

Surgery – includes related surgical services	Covered – 90% after deductible	Covered – 70% after deductible
Dental surgery and related anesthesia for the removal of wisdom teeth	Covered – 90% after deductible	Covered – 70% after deductible
Voluntary Abortion	Not Covered	Not Covered
Voluntary Sterilization – <i>excludes reversal sterilization</i>	Covered – 90% after deductible	Covered – 70% after deductible

Human Organ Transplants

Specified Organ Transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered - 100%	Not Covered
	Unlimited dollar maximum per transplant type	
Kidney, Cornea, Bone Marrow and Skin	Covered – 90% after deductible	Covered – 70% after deductible



Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care	Covered – 90% after deductible	Covered – 70% after deductible
Inpatient Substance Abuse Care	Covered – 90% after deductible	Covered – 70% after deductible
Outpatient Mental Health Care	Covered – 90% after deductible**	Covered – 70% after deductible
Outpatient Substance Abuse Care	Covered – 90% after deductible**	Covered – 70% after deductible

** Mental health and substance abuse procedures that are the equivalent of an office visit (consultative services rendered in the physician's office) will be treated and processed like an office visit, subject to the fixed dollar office visit copay

Other Services

Cardiac Rehabilitation	Covered – 90% after deductible	Covered – 70% after deductible
Acupuncture - Performed by MD, DO and other select provider specialties	Covered – 90% after deductible	Covered – 70% after deductible
Allergy Testing and Therapy	Covered – 90% after deductible	Covered – 70% after deductible
Chiropractic Care	Covered – 90% after deductible	Covered – 90% after deductible
	Limited to 24 spinal manipulation visits per calendar year	
Outpatient Physical, Speech and Occupational Therapy	Covered – 90% after deductible	Covered – 70% after deductible
	Limited to 60 combined visits per calendar year. Services are covered when performed in the outpatient department of the hospital, or approved freestanding facility. Physical therapy is also covered in an independent therapist's office.	
Massage Therapy rendered by MD, DO, or Chiropractor	Covered – 90% after deductible	Covered – 70% after deductible
Hot/Cold Packs rendered by Chiropractor	Limited to 24 visits per calendar year	
Durable Medical Equipment/Medical Supplies	Covered – 90% after deductible	Covered – 90% after deductible
Prosthetic and Orthotic Appliances	Covered – 90% after deductible	Covered – 90% after deductible
Private Duty Nursing	Covered – 90% after deductible	Covered – 90% after deductible
Hearing Aids	Covered - 100% of the approved amount. Hear aids must be purchased from an approved hearing aid provider	

Prescription Drugs

Retail – 34 day supply	<p>\$ 0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D)</p> <p>\$10 copay – Generic drugs</p> <p>\$40 copay – Brand name drugs</p> <p>Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.</p>
Mail Order - 90-day supply	<p>\$ 0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D)</p> <p>\$20 copay – Generic drugs</p> <p>\$80 copay – Brand name drugs</p>
Additional Services: Oral & Injectable Contraceptives Smoking Cessation Drugs Weight Loss Drugs Impotency Drugs Infertility Drugs	<p>Covered</p> <p>Covered</p> <p>Covered</p> <p>Covered – limited to 12 doses per month</p> <p>Covered</p>



This is intended as an easy-to-read guide. It is not a contract. An official description of benefits is contained in applicable Blue Cross Blue Shield of Michigan coverage documents.