



## Flexible Blue<sup>SM</sup> Plan 3 Medical Coverage with Preventive Care and Mammography Benefits Benefits-at-a-Glance

This is intended as an easy-to-read summary. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates 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 your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

### In-network

### Out-of-network

#### Deductibles, copays and dollar maximums

**Note:** Services without a PPO network and emergency services are covered at the in-network level. **If a PPO provider refers you to a non-network provider, all covered services obtained from that non-network provider will be subject to applicable out-of-network cost-sharing.** 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.

<b>Deductibles</b> <b>Note:</b> The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract.	\$2,000 for a one-person contract or \$4,000 for a family contract (2 or more members) each calendar year ( <b>no 4<sup>th</sup> quarter carry-over</b> )	\$4,000 for a one-person contract or \$8,000 for a family contract (2 or more members) each calendar year ( <b>no 4<sup>th</sup> quarter carry-over</b> )
	Deductibles are based on amounts defined annually by the federal government for Flexible Blue-related health plans. Please call your customer service center for an annual update.	
<b>Copays</b>		
• Fixed dollar copays	None	None
• Percent copays	None	20% of approved amount
<b>Copay dollar maximums</b>		
• Fixed dollar copays	Not applicable	Not applicable
• Percent copays	Not applicable	\$1,000 for a one-person contract or \$2,000 for a family contract (2 or more members) each calendar year
<b>Dollar maximums</b>	\$1 million lifetime per covered specified human organ transplant type and a <b>separate</b> \$5 million lifetime per member for all other covered services and as noted above for individual services	

**Preventive care services** – \*Payment for preventive services is limited to a combined maximum of \$1,000 per member per calendar year

Health maintenance exam – includes chest X-ray, EKG, cholesterol screening and other select lab procedures	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Gynecological exam	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Well-baby and child care	Covered – 100% (no deductible or copay) * • 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% (no deductible or copay)*	Not covered
Fecal occult blood screening	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered

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**In-network**

**Out-of-network**

**Preventive care services, continued**

Flexible sigmoidoscopy exam	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered

**Mammography**

Mammography screening	Covered – 100% (no deductible or copay)	Covered – 80% after out-of-network deductible
One per member per calendar year, no age restriction		

**Physician office services**

Office visits	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Outpatient and home medical care visits	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Office consultations	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Urgent care visits	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible

**Emergency medical care**

Hospital emergency room	Covered – 100% after in-network deductible	Covered – 100% after in-network deductible
Ambulance services – must be medically necessary	Covered – 100% after in-network deductible	Covered – 100% after in-network deductible

**Diagnostic services**

Laboratory and pathology services	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Diagnostic tests and x-rays	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Therapeutic radiology	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible

**Maternity services provided by a physician**

Prenatal and postnatal care	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Includes care provided by a certified nurse midwife		
Delivery and nursery care	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Includes delivery provided by a certified nurse midwife		

**Hospital care**

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies <b>Note:</b> Nonemergency services must be rendered in a <b>participating</b> hospital.	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Unlimited days		
Inpatient consultations	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Chemotherapy	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible



### In-network

### Out-of-network

#### Alternatives to hospital care

Skilled nursing care	Covered – 100% after in-network deductible, in <b>participating</b> skilled nursing facilities <b>only</b> Limited to 90 days per member per calendar year	
Hospice care	Covered – 100% after in-network deductible, through a <b>participating</b> hospice program <b>only</b> Limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – must be medically necessary	Covered – 100% after in-network deductible, by a <b>participating</b> home health care agency <b>only</b>	
Home infusion therapy – must be medically necessary	Covered – 100% after in-network deductible, by <b>participating</b> providers <b>only</b>	

#### Surgical services

Surgery – includes presurgical consultations, related surgical services and medically necessary facility services by a <b>participating</b> ambulatory surgery facility	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Colonoscopy	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
	One per member per calendar year	
Voluntary sterilization	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible

#### Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100% after in-network deductible, in designated facilities <b>only</b> , limited to \$1 million <b>lifetime</b> maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Specified oncology clinical trials	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Kidney, cornea and skin	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible

#### Mental health care and substance abuse treatment

Inpatient mental health care and inpatient substance abuse treatment	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
	Limited to a <b>combined</b> maximum of 60 days per calendar year with 120 days lifetime per member	
Outpatient mental health care	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible, in <b>participating</b> facilities <b>only</b>
	Limited to a <b>combined</b> maximum of 120 visits per member per calendar year	
Outpatient substance abuse treatment – in approved facilities <b>only</b>	Covered – 100% after in-network deductible	Covered – 100% after in-network deductible, in approved facilities <b>only</b>
	Limited to annual state-dollar amount (that combines outpatient and residential substance abuse)	

#### Other covered services

Outpatient Diabetes Management Program (ODMP)	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Allergy testing and therapy	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Osteopathic & Chiropractic spinal manipulations	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
	Up to 24 visits per member per calendar year	



**In-network**

**Out-of-network**

**Other covered services, *continued***

Outpatient physical, speech and occupational therapy services – provided for rehabilitation	Covered – 100% after in-network deductible  ----- Limited to a <b>combined</b> maximum of 60 visits per member per calendar year	Covered – 80% after out-of-network deductible <b>Note:</b> Outpatient physical therapy is <b>not</b> covered at nonparticipating facilities.
Durable medical equipment	Covered – 100% after in-network deductible	Covered – 100% after in-network deductible
Prosthetic and orthotic appliances	Covered – 100% after in-network deductible	Covered – 100% after in-network deductible
Private duty nursing services	Covered – 100% after in-network deductible	Covered – 100% after in-network deductible

**Riders included**

<b>Rider FB – RM100 and Rider FB – PC500M</b>	Removes copay and deductible for mammography services provided by PPO providers. Adds coverage for preventive care benefits provided by PPO providers, up to a combined maximum of \$500 per member per calendar year. Mammography services are not included in the \$500 annual maximum. <b>Note:</b> These riders are available only as a “package” of preventive care services.
<b>Rider CI, Rider PCD2</b>	Riders CI and PCD2 are part of your medical-surgical coverage.
<b>Rider XVA</b>	Excludes benefits for voluntary abortions.
<b>Rider DC</b>	Covers dependents to the end of the year they turn 25. Cost of rider included in family rate.