Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Usui International Corporation
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PPO - PPO Basic Plan
Effective Date: 01/01/2023
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	$750 per member $1,500 per family	$1,500 per member $3,000 per family
Copays • Fixed Dollar Copays	$30 copay for : • Office visits • Chiropractic spinal manipulations $50 copay for : • Facility Urgent care services • Professional Urgent care services $125 copay for : • Inpatient admissions $200 copay for : • Facility medical emergency	$50 copay for : • Facility Urgent care services • Professional Urgent care services $200 copay for : • Facility medical emergency $250 copay for : • Inpatient admissions
Coinsurance • Percent Coinsurance	20% up to a maximum of: $1,500 per member $3,000 per family	40% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$6,600 per member $13,200 per family Includes Deductible, Coinsurance and Copays	$13,200 per member $26,400 per family Includes Deductible and Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Covered - 60% after deductible

Benefits	In-Network	Out-of-Network
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Covered - 60% after deductible
Annual Gynecological Exam - one per benefit period, in addition to health maintenance exam	Covered - 100%	Covered - 60% after deductible
Pap Smear Screening - one per calendar year	Covered - 100%	Covered - 60% after deductible
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 60% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Covered - 60% after deductible
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 60% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Covered - 60% after deductible
Immunizations - pediatric and adult	Covered - 100%	Covered - 60% after deductible

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $30 copay	Covered - 60% after deductible
Telemedicine Visits	Covered - 100% after $30 copay	Covered - 60% after deductible
Blue Cross Online Visits Note: Services are payable when rendered through Blue Cross Online Visits℠	Covered - 100%	Not Covered
Office Consultations	Covered - 80% after deductible	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 80% after deductible	Covered - 60% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $200 copay; copay waived if admitted	Covered - 100% after $200 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Covered - 100% after $200 copay	Covered - 100% after $200 copay
Facility Urgent Care Services	Covered - 100% after $50 copay	Covered - 100% after $50 copay
Physician Urgent Care Services	Covered - 100% after $50 copay	Covered - $50 copay then 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 60% after deductible
Radiation Therapy	Covered - 80% after deductible	Covered - 60% after deductible

Benefits	In-Network	Out-of-Network
Chemotherapy	Covered - 80%	Covered - 60% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 60% after deductible
Delivery and Nursery Care excludes dependent children	Covered - 80% after deductible	Covered - 60% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - $125 copay then 80% after deductible	Covered - $250 copay then 60% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 60% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 80% after deductible	Covered - 60% after deductible
Home Health Care Limited to a maximum of 50 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible
Skilled Nursing Limited to a maximum of 60 days per calendar year	Covered - 80% after deductible	Covered - 60% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Bariatric Surgery	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 60% after deductible
Elective Abortions	Not Covered	Not Covered

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 - 80% after deductible	Covered - 60% 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 - $125 copay then 80% after deductible	Covered - $250 copay then 60% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - $30 copay then 80% after deductible	Covered - 60% after deductible
Telemedicine Mental Health Care	Covered - $30 copay then 80% after deductible	Covered - 60% after deductible
Blue Cross Online Mental Health Care	Covered - $30 copay then 80% after deductible	Not Covered

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 25 visits per calendar year	Covered - $30 copay then 80% after deductible	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 60% after deductible
Private Duty Nursing Care	Not Covered	Not Covered
Allergy Testing and Therapy	Covered - 80% after deductible	Covered - 60% after deductible
Facility Clinic Visit	Covered - 100% after same as office services	Covered - 60% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible