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Young Member Blue PPOSM Benefits-at-a-Glance

Effective for plan year beginning January 1, 2011

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.

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 deductibles, coinsurances and copays.

	In-Network	Out-of-Network*
Member's responsibility (deductibles, copays, coinsurances, and dollar maximums)		
Annual deductible	\$1,000 combined deductible each calendar year	
Fixed dollar copays	None	None
Percent coinsurances Note: Coinsurances apply once the deductible has been met.	30% of the approved amount for most covered services See "mental health care and substance abuse treatment" section for mental health and substance abuse coinsurances.	50% of the approved amount for most covered services See "mental health care and substance abuse treatment" section for mental health and substance abuse coinsurances.
Annual coinsurance dollar maximums – applies to coinsurances for all covered services, except mental health and substance abuse percent coinsurances.	\$2,500 each calendar year for one member (only one-member contracts are allowed on the Young Member Blue PPO plan)	None
Lifetime dollar maximum	None	

Preventive care services

Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Well-baby and child care visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> • 6 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 	Not covered
Adult and childhood preventive services and Immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

In-Network

Out-of-Network*

Preventive care services (continued)

Routine mammogram and related reading	100% (no deductible or copay/coinsurance) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	50% 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		
Colonoscopy – routine or medically necessary	100% for routine colonoscopy (no deductible or copay/coinsurance) Note: Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	50% after out-of-network deductible
One routine colonoscopy per member per calendar year		

Physician office services

Office visits	Not covered	Not covered
Outpatient and home medical visits	Not covered	Not covered
Office consultations	Not covered	Not covered
Pre-surgical consultation	100% (no deductible or copay/coinsurance)	50% after deductible

Emergency medical care

Hospital emergency room	70% after deductible	70% after deductible
Urgent care center	70% after deductible	70% after deductible
Physician’s office	70% after deductible	70% after deductible
Ambulance services – must be medically necessary	70% after deductible	70% after deductible

Diagnostic services

Laboratory and pathology services	70% after deductible	40% after deductible. An additional 30% coinsurance is applied toward non-standard laboratory tests performed in a non-participating PLUS laboratory. Additional 30% coinsurance is not subject to coinsurance dollar maximum.
Diagnostic tests and x-rays	70% after deductible	50% after deductible
Therapeutic radiology	70% after deductible	50% after deductible

Maternity services provided by a physician

Prenatal and postnatal care	Not covered	Not covered
Delivery and nursery care	Not covered	Not covered

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	70% after deductible	50% after deductible
	Up to 120 days; 60 day renewal period	
Inpatient consultations	70% after deductible	50% after deductible
Chemotherapy	70% after deductible	50% after deductible

Alternatives to hospital care

Skilled nursing care	Not covered	Not covered
Hospice care – must be provided through a participating hospice program	100% (no deductible or copay/coinsurance)	Not covered
	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 – must be medically necessary and provided by a participating home health care agency	70% after deductible	70% after deductible
Home infusion therapy	70% after deductible	70% after deductible

In-Network

Out-of-Network*

Surgical services

Surgery – includes related surgical services, anesthesia and surgical assistance	70% after deductible	50% after deductible
Voluntary sterilization	70% after deductible	50% after deductible

Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	Not covered
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	70% after deductible	Not covered
Kidney, cornea and skin transplants	70% after deductible	Not covered
Specified oncology clinical trials	70% after deductible	Not covered

Mental health care and substance abuse treatment

Inpatient mental health care and substance abuse care	70% after deductible	50% after deductible
	Up to 30 days; 60-day renewal	
Outpatient mental health care	Not covered	Not covered
Outpatient substance abuse care <ul style="list-style-type: none"> • Acute care and specialty hospital • Freestanding substance abuse facilities 	70% after deductible	50% after deductible
	70% after deductible	70% after deductible
	Up to the state-dollar amount which is adjusted annually	

Other covered services

Allergy testing and therapy	Not covered	Not covered
Chiropractic spinal manipulation	Not covered	Not covered
Durable medical equipment	Not covered	Not covered
Outpatient Diabetes Management Program	70% after deductible for diabetic medical supplies; 100% (no deductible or copay/coinsurance) for diabetic self-management training	50% after deductible
Outpatient physical, speech and occupational therapy	70% after deductible	50% after deductible
	Limited to 60 consecutive days of treatment per condition per calendar year	
Prosthetic appliances	70% after deductible	50% after deductible
Orthotic devices	Not covered	Not covered
Private duty nursing	Not covered	Not covered

Prescription drug coverage

Prescription drug plan	Not covered	Not covered
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*Services from a provider for which there is no Michigan 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. Cost-sharing may differ when you obtain covered services outside of Michigan. 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.

NOTE: A 365-day waiting period is applied to members age 19 and older for pre-existing medical conditions, removal of tonsils and/or adenoids, and voluntary sterilization.

This is intended as an easy-to-read summary. It is not a contract. An official description of benefits is contained in applicable Blue Cross Blue Shield certificate and riders. Payment amounts are based on the Blue Cross Blue Shield approved amount, less any applicable deductible and/or copay and coinsurance 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.