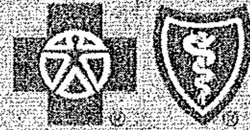

Flexible Blue^{SM} Plan 2 Medical Coverage with 20% In-Network Copay / 40% Out-of-Network Copay Benefits-at-a-Glance Genesee Mental Health Proposal

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 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.

Member's responsibility (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.

	In-network	Out-of-network
Deductibles **Note:** The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract.	$1,250 for a one-person contract or $2,500 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over) 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.	$2,500 for a one-person contract or $5,000 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)
Copays **Note:** Copays apply once the deductible has been met. • Fixed dollar copays	None	None
• Percent copays	20% of approved amount	40% of approved amount
Copay dollar maximums	$1,000 for a one-person contract or $2,000 for a family contract (2 or more members) each calendar year	$2,000 for a one-person contract or $4,000 for a family contract (2 or more members) each calendar year
Dollar maximums	$1 million lifetime maximum per covered specified human organ transplant type and a separate $5 million lifetime maximum 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 $500 per member per calendar year

	In-network	Out-of-network
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
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 – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Outpatient and home medical care visits	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Office consultations	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Urgent care visits	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible

Emergency medical care

Hospital emergency room	Covered – 80% after in-network deductible	Covered – 80% after in-network deductible
Ambulance services – must be medically necessary	Covered – 80% after in-network deductible	Covered – 80% after in-network deductible

Diagnostic services

Laboratory and pathology services	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Diagnostic tests and x-rays	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Therapeutic radiology	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible

Maternity services provided by a physician

Prenatal and postnatal care	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
	Includes care provided by a certified nurse midwife	
Delivery and nursery care	Covered – 80% after in-network deductible	Covered – 60% 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 Note: Nonemergency services must be rendered in a **participating** hospital.	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
	Unlimited days	
Inpatient consultations	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Chemotherapy	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible

	In-network	Out-of-network

Alternatives to hospital care

Skilled nursing care	Covered – 80% after in-network deductible, in participating skilled nursing facilities only Limited to 90 days per member per calendar year	
Hospice care	Covered – 80% after in-network deductible, through a participating hospice program only 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	
Home health care – must be medically necessary	Covered – 80% after in-network deductible, by a participating home health care agency only	
Home infusion therapy – must be medically necessary	Covered – 80% after in-network deductible, by participating providers only	

Surgical services

Surgery – includes presurgical consultations, related surgical services and medically necessary facility services by a participating ambulatory surgery facility	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Colonoscopy	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
	One per member per calendar year	
Voluntary sterilization	Covered – 80% after in-network deductible	Covered – 60% 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 – 80% after in-network deductible, in designated facilities only, limited to $1 million lifetime maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Specified oncology clinical trials	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Kidney, cornea and skin transplants	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible

Mental health care and substance abuse treatment

Inpatient mental health care and inpatient substance abuse treatment	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Outpatient mental health care	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible, in participating facilities only
Outpatient substance abuse treatment – in approved facilities only	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible, in approved facilities only

Other covered services

Outpatient Diabetes Management Program (ODMP)	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Allergy testing and therapy	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Osteopathic manipulative therapy Chiropractic spinal manipulation	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
	Up to 24 visits per member per calendar year	

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

Prescription drugs		

Rider FB RX-PD-GB $10/$60 Mail Order 2X	Adds $10 copay for generic and $60 for brand name drugs and doubles the copay for mail order drugs for a 35- to 90-day supply after deductible. Maximum copay applys..
Rider RX-90-2x	Expands retail coverage of prescription drugs to include 84 to 90-day supplies (prescriptions with days supply between 35 to 83-days are not covered via retail), subject to one member copay that is double the amount that would apply for a 34-day refill. Requires all **retail** 90-day supplies of medication be obtained from a "**90-Day Retail Network**" provider. You must be on your medication for at least 60 out of the past 120 days under your BCBSM coverage before using this option.