



**Blue Cross  
Blue Shield  
of Michigan**

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

## Kent County

**Group Number: 71401 Package Code(s): 012**

**Section Code(s): 1000, 1100, 1200**

**PPO - Kent County Wellness PPO Plan 2**

**Effective Date: 01/01/2020**

## 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
<b>Deductibles</b> - per calendar year	\$300 per member \$600 per family	\$600 per member \$1,200 per family
<b>Copays</b> • Fixed Dollar Copays	\$25 copay for : • Office visits \$40 copay for : • Urgent care services \$125 copay for : • Facility medical emergency	\$125 copay for : • Facility medical emergency
<b>Coinsurance</b> • Percent Coinsurance	15%	35% <b>Note:</b> Services without a network are covered at the in-network level.
<b>Annual out-of-pocket maximums</b>	\$3,150 per member \$6,300 per family Includes Deductible, Coinsurance and Copays	\$6,300 per member \$12,600 per family Includes Deductible and Coinsurance
<b>Lifetime dollar maximum</b>	Unlimited	

Preventive Care Services		
Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Covered - 65% after deductible
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Covered - 65% after deductible
Annual Gynecological Exam - one per calendar year, in addition to health maintenance exam	Covered - 100%	Covered - 65% after deductible
Pap Smear Screening - one per calendar year	Covered - 100%	Covered - 65% after deductible

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Benefits	In-Network	Out-of-Network
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 65% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Covered - 65% after deductible
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 65% after deductible
Well Child Care <ul style="list-style-type: none"> <li>• 8 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 6 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> </ul> Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Covered - 65% after deductible
Immunizations - pediatric and adult	Covered - 100%	Covered - 65% after deductible

## Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after \$25 copay	Covered - 65% after deductible
Online Visits Note: Services are payable when rendered by American Well providers through Blue Cross Online Visits <sup>SM</sup> or BCBS providers	Covered - 100% after \$25 copay	Covered - 65% after deductible
Office Consultations	Covered - 100% after \$25 copay	Covered - 65% after deductible
Pre-Surgical Consultations	Covered - 100% after \$25 copay	Covered - 65% after deductible

## Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after \$125 copay; copay waived if admitted	Covered - 100% after \$125 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Urgent Care Services	Covered - 100% after \$40 copay	Covered - 65% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 85% after deductible	Covered - 85% after deductible

## Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 85% after deductible	Covered - 65% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 85% after deductible	Covered - 65% after deductible
Radiation Therapy and Chemotherapy	Covered - 85% after deductible	Covered - 65% after deductible

## Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 100%
Delivery and Nursery Care	Covered - 85% after deductible	Covered - 65% after deductible

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## Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 85% after deductible	Covered - 65% after deductible
Inpatient Medical Care	Covered - 85% after deductible	Covered - 65% after deductible

## Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 85% after deductible	Covered - 85% after deductible
Home Health Care	Covered - 85% after deductible	Covered - 85% after deductible
Skilled Nursing Limited to a maximum of 120 days per calendar year	Covered - 85% after deductible	Covered - 85% after deductible

## Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 85% after deductible	Covered - 65% after deductible
Bariatric Surgery	Covered - 85% after deductible	Covered - 65% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 100%	Covered - 65% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 65% after deductible

## 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 - 85% after deductible	Covered - 65% after deductible
Kidney, Cornea, Bone Marrow and Skin	Covered - 85% after deductible	Covered - 65% 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 - 85% after deductible	Covered - 65% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment • Online Mental Health Visits	Covered - 85% after deductible Covered - 85% after deductible	Covered - 65% after deductible Covered - 65% after deductible

## Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 85% after deductible	Covered - 65% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 24 visits per calendar year	Covered - 85% after deductible	Covered - 65% after deductible
Durable Medical Equipment	Covered - 85% after deductible	Covered - 65% after deductible
Prosthetic and Orthotic Devices	Covered - 85% after deductible	Covered - 65% after deductible
Private Duty Nursing Care	Covered - 50%	Covered - 50%
Allergy Testing and Therapy	Covered - 85% after deductible	Covered - 65% after deductible

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## 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 - 85% after deductible	Covered - 65% after deductible