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

Benefits-at-a-Glance for U of M Premier Care Plan 65 Medicare Primary Members 2017

This is intended as an easy-to-read summary. It is not a contract. An official description of benefits is contained in applicable BCN Service Company Benefit Document and Amendments. Payment amounts are based on the Approved Amount, less any applicable deductible and/or copay 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. **Services must be provided or arranged by member's primary care physician or health plan.**

Member's Responsibility: Deductible, Copays, Coinsurance and Maximums

Deductible Note: Coinsurance and select fixed dollar copays apply once the deductible has been met.	This plan has no deductible.
Fixed dollar copays	$25 PCP office visits $30 specialist visits $25 urgent care $100 emergency room services $25 outpatient mental health/sub abuse visits $1,000 weight reduction procedures
Coinsurance	None
Out of Pocket Maximum – combined Network 1 and Network 2 – applies to deductibles, copays and coinsurance amounts for all covered services (excludes prescription drug cost sharing)	$3,000 per member $6,000 per contract per calendar year

Preventive Services

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well baby and child care	Covered – 100%
Immunizations	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%
Routine Colonoscopy	Covered – 100%
Female Sterilization	Covered – 100%

Mammography

Mammography Screening	Covered – 100%

Physician Office Services

Office Visits	Covered – $25 copay
Consulting Specialist Care – when referred	Covered – $30 copay

Emergency Medical Care

Hospital Emergency Room, waived when admitted	Covered – $100 copay
Urgent Care Center	Covered – $25 copay
Ambulance Services – medically necessary	Covered – 100%, ground and air ambulance service

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100%; Office visit copay may apply, per member per visit
Diagnostic Tests and X-rays	Covered – 100%; Office visit copay may apply, per member per visit
Radiation Therapy	Covered – 100%; Office visit copay may apply, per member per visit

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – 100%

Delivery and Nursery Care	Covered – 100%

Hospital Care

Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 100%, unlimited days (Coordinated with Medicare)

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100%; up to 120 days per calendar year
Hospice Care	Covered – 100%
Home Health Care	Covered – 100%

Surgical Services

Surgery– includes all related surgical services and anesthesia	Covered – 100%
Voluntary Sterilization	Covered – 100%
Human Organ Transplants – subject to medical criteria	Covered – 100%

Mental Health Care and Substance Abuse Treatment

Inpatient/Residential Mental Health Care and Substance Abuse Care	**Mental Health Care**: Covered – 100% when authorized **Substance Abuse Care:** Covered – 100% when authorized
Outpatient Mental Health Care	Covered – $25 copay when authorized
Outpatient Substance Abuse Care	Covered – $25 copay when authorized

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment Requires authorization	Covered – $25 copay
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18 Physical, speech and occupational therapy for autism spectrum disorder is unlimited.	Covered – $25 copay
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit

Other Services

Allergy Testing and Therapy	Covered – 100%; Office visit copay may apply per member per visit; Injections covered 100%
Chiropractic Services	Not covered
Infertility – In Vitro fertilization Requires preauthorization based on medical criteria – See Benefit Document	Limited to U of M providers only Covered 80% - 20% coinsurance up to $20,000 lifetime limit
Infertility Assessment	Covered – 100%, office visit copay may apply
Outpatient Physical, Speech and Occupational Therapy Major and minor diagnosis as defined by the Group	Covered – $25 copay per visit, Major diagnosis - limited to 60 visits per calendar year Minor diagnosis - limited to 15 visits per calendar year
Durable Medical Equipment	Covered – 100%
Prosthetic and Orthotic Appliances	Covered – 100%
Hearing Evaluation, Hearing Aid	One hearing exam, basic binaural hearing aids every 36 mos. Office visit copay may apply
Cardiac Rehabilitation	Covered – Covered 100%, limited to 36 sessions/18 week period
Transgender Surgery	Covered – 100%
Elective First Trimester Termination of Pregnancy	Covered – 100%; office visit copay may apply
Weight Reduction Procedures – when approved by BCN	Covered - $1,000 copay or 20% of Medicare allowed amount whichever is less
Male Mastectomy	Not Covered
Routine Vision Care	Covered – One routine vision exam per year (dilation is not covered)