

Value BlueSM

PPO Benefits-at-a-Glance

	In-Network	Out-of-Network
Benefit		
Deductible*	\$1,000 individual/ \$2,000 family	\$1,000 individual/ \$2,000 family
Copayment	30% in-network	50% out-of-network unless there is no network
Copay dollar maximums**	\$2,500	\$2,500
Preventive Services		
Mammography	Covered – 70% after deductible	Covered – 50% after deductible
Hospital Care at Participating Hospitals		
Covered up to 120 days; 60-day renewal, semi-private room	Covered – 70% after deductible	Covered – 50% after deductible
Chemotherapy	Covered – 70% after deductible	Covered – 50% after deductible
Outpatient physical therapy – 60 consecutive days per condition	Covered – 70% after deductible up to the state dollar amount, which changes yearly	Covered – 50% after deductible up to the state dollar amount, which changes yearly
Mental Health and Substance Abuse Care in Approved Facilities		
Inpatient facility charges for mental health and substance abuse care — up to 30 days; 60-day renewal	Covered – 70% after deductible	Covered – 50% after deductible
Outpatient and residential substance abuse care	Covered – 70% after deductible up to the annual amount required by the state	Covered – 70% after deductible up to the annual amount required by the state
Emergency Care		
Emergency room – approved criteria	Covered – 70% after deductible	Covered – 70% after deductible
Physician's services – approved diagnosis	Covered – 70% after deductible	Covered – 70% after deductible
Diagnostic Services		
Laboratory and pathology tests	Covered – 70% after deductible	50% after deductible
Diagnostic tests and X-rays	Covered – 70% after deductible	50% after deductible
Radiation therapy	Covered – 70% after deductible	50% after deductible

In-Network

Out-of-Network

Physician's Services		
Inpatient medical care, unlimited general days; 45 days for mental health and substance abuse; 60-day renewal	Covered – 70% after deductible	Covered – 50% after deductible
Consultations – inpatient	Covered – 70% after deductible	Covered – 50% after deductible
Surgery, technical surgical assistance and anesthesia	Covered – 70% after deductible	Covered – 50% after deductible
Voluntary sterilization	Covered – 70% after deductible	Covered – 50% after deductible
Maternity care – delivery and routine newborn exam only	Covered – 70% after deductible	Covered – 50% after deductible

Human Organ Transplants		
Specified organ transplants – liver, heart, heart-lung and pancreas	Covered – 100% up to \$1 million per transplant type in an approved facility	
Bone marrow transplants	Covered – 70% after deductible	Covered – 50% after deductible
Kidney, cornea and skin	Covered – 70% after deductible	Covered – 50% after deductible

Other Services		
Hemodialysis – outpatient and home	Covered – 70% after deductible	Covered – 70% after deductible
Home health care	Covered – 70% after deductible	Covered – 70% after deductible
Hospice care	Covered – 70% up to the dollar maximum required by the state	Covered – 70% up to the dollar maximum required by the state
Prosthetic appliances	Covered – 70% after deductible	Covered – 70% after deductible

Payment of Benefits		
Preferred hospitals (in the Blue Preferred PPO network): 100% of covered benefits, less applicable deductible and/or copays		
Non-network hospitals (participate with BCBS but are not in the Blue preferred PPO network): 80% of the paid amount, less applicable deductible and/or copays		
Non-participating hospitals (have no agreement with BCBSM to accept our approved amount): Inpatient care in acute-care, general hospitals – \$70 a day, less applicable deductible and/or copays; inpatient care in other hospitals – \$15 a day, less applicable deductible and/or copays; outpatient care – \$25 per covered condition, less applicable deductible and/or copays		
Preferred physicians: 100% of the scheduled payment amount, less any applicable deductible and/or copays		
Non-network physicians: 80% of the scheduled payment amount, less any applicable deductible and/or copays. When the physician is not a BCBSM-participating physician and a non-network physician, you may be required to pay the difference between the approved amount and the physician's charge.		

* Amounts applied to the deductible during the last three months of a calendar year will be credited toward the deductible requirements for the following year.

** Copay maximums are restricted to each calendar year (January 1 through December 31). Once the member meets the copay maximum for the year, covered services will be paid at 100% of the BCBSM approved amount for the remainder of the year.

This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificate and riders. Payment amounts are based on Blue Cross Blue Shield of Michigan approved amount, less any applicable deductions and/or copay amounts required by the plan. The 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.

Value BlueSM

Traditional Benefits-at-a-Glance

Value Blue

Deductible*	\$1,000/ \$2,000 family
Copay	30%
Copay dollar maximums**	\$2,500

Preventive Services

Well-baby care	Not covered
Immunizations	Not covered
Mammography	Covered - 70% after deductible

Hospital Care at Participating Hospitals

Covered up to 120 day; 60 days renewal, semiprivate room	Covered - 70% after deductible
Chemotherapy	Covered - 70% after deductible
Outpatient physical therapy - 60 consecutive days per condition	Covered - 70% after deductible

Mental Health and Substance Abuse Care in Approved Facilities

Inpatient facility charges for mental health and substance abuse care – up to 30 days; 60-day renewal	Covered - 70% after deductible
Outpatient and residential substance abuse care	Covered - 70% after deductible

Emergency Care

Emergency room –approved criteria	Covered - 70% after deductible
Physician's services – approved diagnosis	Covered - 70% after deductible

Diagnostic Services

Laboratory and pathology tests	Covered - 70% after deductible
Diagnostic tests and X-rays	Covered - 70% after deductible
Radiation therapy	Covered - 70% after deductible

Physician's Services

Home, outpatient and office visits	Not covered
Inpatient medical care, unlimited general days; 45 days for mental health and substance abuse; 60-day renewal	Covered - 70% after deductible
Consultations - inpatient	Covered - 70% after deductible
Surgery, technical surgical assistance and anesthesia	Covered - 70% after deductible
Voluntary sterilization	Covered - 70% after deductible
Maternity care - delivery and routine newborn exam only	Covered - 70% after deductible

Human Organ Transplants

Specified organ transplants - liver, heart, heart-lung and pancreas	Covered - 100%
	Up to \$1 million lifetime maximum for each specified organ transplant type
Bone marrow transplants	Covered - 70% after deductible
Kidney, cornea and skin	Covered - 70% after deductible

Other Services

Hemodialysis - outpatient and home	Covered - 70% after deductible
Home health care	Covered - 70% after deductible
Hospice care	Covered - 70%
	Up to the dollar maximum required by the state (changes each year)
Prosthetic appliances	Covered - 70% after deductible

Payment of Benefits

Participating hospitals: 100% of covered benefits, less applicable deductible and/or copays

Nonparticipating hospitals: Inpatient care in acute-care, general hospitals - \$70 a day, less applicable deductible and/or copays; inpatient care in other hospitals - \$15 a day, less applicable deductible and/or copays; outpatient care - \$25 per covered condition, less applicable deductible and/or copays

Participating physicians: 100% of the BCBSM-approved amount, less applicable deductible and/or copay

Nonparticipating physicians: The physician has no agreement with BCBSM to accept the approved amount as payment in full. You may be responsible for paying the difference between the physician's charge and the BCBSM approved amount.

* Amounts applied to the deductible during the last three months of a calendar year will be credited toward the deductible requirements for the following year.

** Copay maximums are restricted to each calendar year (January 1 through December 31). Once the member meets the copay maximum for the year, covered services will be paid at 100% of the BCBSM approved amount for the remainder of the year.