



**Blue Cross
Blue Shield
of Michigan**

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

DENSO International America, Inc.

Group Number: 71490 Package Code(s): 010

Section Code(s): 1000, 1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1014, 1015, 1016, 1017, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2014, 2015, 2016, 2017

PPO, Hearing - MainStreet, Rx1

Effective Date: 01/01/2022

Benefits-at-a-glance

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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
Deductibles - per calendar year	\$750 per member \$1,500 per family	\$1,500 per member \$3,000 per family
Copays • Fixed Dollar Copays	\$400 copay for : • Facility medical emergency	\$400 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	20%	40% Note: Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	\$6,250 per member \$12,500 per family Includes Deductible, Coinsurance and Copays	\$12,500 per member \$25,000 per family Includes Deductible and Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Covered - 60% after deductible
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Covered - 60% after deductible
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Covered - 60% after deductible

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Pap Smear Screening - one per calendar year	Covered - 100%	Covered - 60% after deductible
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 60% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Covered - 60% after deductible
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 60% after deductible
Well Child Care • 8 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	Covered - 100%	Covered - 60% after deductible
Immunizations - pediatric and adult	Covered - 100%	Covered - 100%

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 80% after deductible	Covered - 60% after deductible
Telemedicine Visits	Covered - 80% after deductible	Covered - 60% after deductible
Blue Cross Online Visits Note: Services are payable when rendered through Blue Cross Online Visits SM	Covered - 100% after \$15 copay	Not Covered
Office Consultations	Covered - 80% after deductible	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 80% after deductible	Covered - 60% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after \$400 copay; copay waived if admitted	Covered - 100% after \$400 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Covered - 100% after \$400 copay	Covered - 60% after deductible
Facility Urgent Care Services	Covered - 80% after deductible	Covered - 60% after deductible
Physician Urgent Care Services	Covered - 80% after deductible	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 60% after deductible

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Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 60% after deductible
Delivery and Nursery Care	Covered - 80% after deductible	Covered - 60% after deductible
Infertility Services Limited to a lifetime maximum of \$25,000	Covered - 80% after deductible	Covered - 60% after deductible

Hospital Care * You have Blue Distinction Specialty Care Benefits (BDSC), please refer to the BDSC page for specific cost share information

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible	Covered - 60% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 60% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 80% after deductible	Covered - 60% after deductible
Home Health Care Limited to a maximum of 120 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible
Skilled Nursing Limited to a maximum of 120 days per calendar year	Covered - 80% after deductible	Covered - 60% after deductible

Surgical Services * You have Blue Distinction Specialty Care Benefits (BDSC), please refer to the BDSC page for specific cost share information

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 60% 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 - 100% after deductible	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 60% after deductible

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Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Use Disorder Treatment	Not Covered	Not Covered
Outpatient Mental Health Care and Substance Use Disorder Treatment	Not Covered	Not Covered

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 30 visits combined with acupuncture per calendar year	Covered - 80% after deductible	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 60% after deductible
Private Duty Nursing Care Limited to 120 days per calendar year	Covered - 80% after deductible	Covered - 60% after deductible
Allergy Testing and Therapy	Covered - 80% after deductible	Covered - 60% after deductible
Facility Clinic Visit	Covered - 80% after deductible	Covered - 60% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a separate maximum of 60 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible

Blue Distinction Specialty Care

Blue Distinction Centers identifies facilities that demonstrate proven expertise in delivering safe, effective, high-quality care for select specialty procedures.

Blue Distinction Centers+ are Blue Distinction Centers that are also recognized for their expertise and cost-efficiency in delivering safe, effective, high-quality specialty care.

Specialty	BDC Plus Center	BDC Center	In-Network	Out-of-Network
Bariatric Surgery	Covered - 80% after deductible	Covered - 80% after deductible	Covered - 60% after deductible	Covered - 60% after deductible

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Hearing Care Coverage

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Member's responsibility (deductible, coinsurance and benefit maximum)

Benefits	Participating Provider	Non-Participating Provider
Deductible	\$750 per individual \$1,500 per family	\$750 per individual \$1,500 per family
Coinsurance	No Coinsurance	40%
Benefit Maximum	\$1,000	

Covered services

To be payable, hearing care benefits may be received from a participating or non-participating provider and in the order listed.

Benefits	Participating Provider	Non-Participating Provider
Frequency Limitation	Once every 12 months	
Audiometric Exam	Covered - 100% after deductible	Covered - 60% after deductible
Hearing Aid Evaluation	Covered - 100% after deductible	Covered - 60% after deductible
Hearing Aid	Covered - 50% after deductible	Covered - 60% after deductible
Limited to a maximum of \$1,000		
Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.		
Hearing Aid Conformity Test	Covered - 100% after deductible	Covered - 60% after deductible

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Prescription Drugs

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Retail - 30 day supply	<p>\$10 copay - Generic drugs \$50 copay - Preferred brand drugs \$90 copay - Non-Preferred brand drugs</p> <p>Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.</p>
Mail Order - 90 day supply	<p>\$25 copay - Generic drugs \$125 copay - Preferred brand drugs \$225 copay - Non-Preferred brand drugs</p>
Exclusive Saver90 Program	<p>We pay for maintenance drugs only when obtained from a BCBSM Exclusive Saver90 retail or mail order provider. The member's cost share is two times amount of their 30 day-supply cost share.</p> <p>We make an exception for the first two prescription fills for each maintenance drug. We cover these prescriptions when obtained from any in-network retail or mail order provider. The third fill and all subsequent fills of maintenance drugs prescriptions must be a 90-day supply and payable only when obtained from the BCBSM Exclusive Saver90 retail or mail order provider.</p> <p>After two fills the member will be responsible for the full approved amount of the maintenance drug if the drug is not received from an Exclusive Saver90 retail or mail order provider.</p>

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Specialty Drugs – 30 day supply Retail and Mail Order	\$200 copay Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.
High-Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum. Note - Adjustments may be required to accurately reflect your annual out-of-pocket maximum with your true out-of-pocket costs.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance
Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered - Limited to a lifetime maximum of \$25,000
Diabetic Supplies	Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs. <ul style="list-style-type: none"> • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement. • “Preferred” devices will be covered at 100% of our approved amount. “Nonpreferred” devices will be subject to your nonpreferred brand-name drugs cost-share requirement. • If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies.

Features of your prescription drug plan

Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. Step Therapy , an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at bcbsm.com/pharmacy .
Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the difference in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug plus your applicable copay regardless of whether you or your physician requests the brand name drug. Exception: If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. Note: This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.