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): 030, 040
# 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 - OpenRoad, Rx2
# Effective Date: 01/01/2022
# 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.

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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<br>The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract. | $1,500 per member<br>$3,000 per family | $3,000 per member<br>$6,000 per family |
| **Copays**<br>• Fixed Dollar Copays | No Copay | No Copay |
| **Coinsurance**<br>• Percent Coinsurance | 20% | 40%<br>**Note:** Services without a network are covered at the in-network level. |
| **Annual out-of-pocket maximums**<br>The full family out of pocket maximum must be met before it is considered satisfied. | $3,500 per member<br>$6,850 per family<br>Includes Deductible, Coinsurance and Copays | $7,000 per member<br>$14,000 per family<br>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 |
| Pap Smear Screening - one per calendar year | Covered - 100% | Covered - 60% after deductible |
| Mammography Screening - one per calendar year<br>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<br>• 8 visits, birth through 12 months<br>• 6 visits, 13 months through 23 months<br>• 6 visits, 24 months through 35 months<br>• 2 visits, 36 months through 47 months<br><br>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<br>Note: Services are payable when rendered through Blue Cross Online Visits℠ | Covered - 80% after deductible | 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<br>Qualified medical emergency | Covered - 80% after deductible | Covered - 80% after deductible |
| Non-Emergency use of the Emergency Room | Covered - 80% after deductible | 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 |

## Maternity Services Provided by a Physician

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Prenatal Care Visits | Covered - 100% | Covered - 60% after deductible |
| Postnatal Care Visits | Covered - 80% after deductible | Covered - 60% after deductible |
| Delivery and Nursery Care | Covered - 80% after deductible | Covered - 60% after deductible |
| Infertility Services<br>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<br>Limited to a maximum of 120 visits per calendar year | Covered - 80% after deductible | Covered - 60% after deductible |
| Skilled Nursing<br>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<br>excludes reversal sterilization | Covered - 80% after deductible | Covered - 60% after deductible |
| Sterilization - females only<br>excludes reversal sterilization | Covered - 100% | Covered - 60% after deductible |

## Human Organ Transplants

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Specified Organ Transplants<br>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 |

## 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<br>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<br>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<br>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
# Effective Date: 01/01/2022
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## Member's responsibility (deductible, coinsurance and benefit maximum)

| Benefits | Participating Provider | Non-Participating Provider |
|---|---|---|
| Deductible | $1,500 per individual<br>$3,000 per family | $1,500 per individual<br>$3,000 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<br><br>Limited to a maximum of $1,000<br><br>Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid. | Covered - 50% after deductible | Covered - 60% after deductible |
| Hearing Aid Conformity Test | Covered - 100% after deductible | Covered - 60% after deductible |

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# Prescription Drugs
# Effective Date: 01/01/2022
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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 |
|---|---|
| Deductible | $1,500 per individual<br>$3,000 per family |
| Retail - 30 day supply | 20% coinsurance after deductible - Generic and Brand drugs<br><br>Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay. |
| Mail Order - 90 day supply | 20% coinsurance after deductible - Generic and Brand drugs |
| Exclusive Saver90 Program | We pay for maintenance drugs only when obtained from a BCBSM Exclusive Saver90 retail or mail order provider. The member's cost share is 20% coinsurance after the deductible is met.<br><br>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.<br><br>After two fills and/or after the deductible is met, 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. |

| | |
|---|---|
| Specialty Drugs – 30 day supply<br>Retail and Mail Order<br><br>**Exclusive Specialty Network**: We only cover specialty drugs when obtained from our exclusive specialty pharmacy network. Covered drugs will be subject to the member's cost-share requirements. If a member obtains specialty drugs from any other provider, they may be responsible for the total cost. | 20% after deductible<br><br>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. |
| 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**<br>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.<br><br>• Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement.<br>• "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.<br>• 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.<br>**Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum. |

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