PPO –Traditional PPO Plan Final
Benefits-at-a-Glance
Valassis
Group Number: 72519
Package Code(s):001
Section Code(s):1000, 1100, 1200

Deductible, Copays/Coinsurance and Dollar Maximums

	In-Network	Out-of-Network
Deductible - per calendar year	$600 per member $1,200 two person $1,200 per family	$1,200 per member $2,400 two person $2,400 per family
Copays/Coinsurance • Fixed Dollar Copays	$25 pcp copay for: • Office Visits • Initial visit to determine pregnancy $35 copay for: • Urgent Care Services • Chiropractic Spinal Manipulations • Outpatient mental health and substance abuse • Outpatient physical, speech and occupational therapy $35 specialist copay for: • Office Visits $100 copay for: • Emergency Room	$100 copay for: • Emergency Room
• Percent Coinsurance	20%	40% **Note**: Services without a network are covered at the in-network level.
Out-of-Pocket Maximum • Percent Coinsurance *Includes deductible*	$2,100 per member $4,200 two person $4,200 per family	$3,200 per member $6,400 two person $6,400 per family
Lifetime Maximum	Unlimited	

Preventive Services

	In-Network	Out-of-Network
Health Maintenance Exam - 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 - one 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,no age restrictions	Covered - 100%	Covered - 60% after deductible
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

	In-Network	Out-of-Network
Well Child Care – 6 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 & Adult	Covered - 100%	Covered - 60%after deductible

Physician Office Services

Office Visits	Covered - 100% after $25 pcp copay; $35 specialist copay	Covered - 60% after deductible

Emergency Medical Care

Hospital Emergency Room Qualified medical emergency	Covered - 100% after $100 copay; copay waived if admitted	Covered - 100% after $100 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Urgent Care Services	Covered - 100% after $35 copay	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

Diagnostic and Therapeutic Services

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 - 100% after deductible	Covered - 60% after deductible

Maternity Services Provided by a Physician

Prenatal and Postnatal Care	Covered - 80% after deductible	Covered - 60% after deductible
Delivery and Nursery Care	Covered - 80% after deductible	Covered - 60% after deductible

Hospital Care

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

Hospice Care	Covered - 80% after deductible	Covered - 60% after deductible
Home Health Care Limited to 120 visits per calendar year	Covered - 80%	Covered - 60% after deductible
Skilled Nursing Limited to 120 days per calendar year	Covered - 100%	Covered - 60% after deductible

Surgical Services

Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible

Human Organ Transplants

Specified Organ Transplants in designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 60% after deductible

Mental Health and Substance Abuse Services

Inpatient Mental Health and Substance Abuse Care	Covered - 80% after deductible	Covered - 60% after deductible
Outpatient Mental Health and Substance Abuse Care	Covered - 100% after $35 copay	Covered – 60% after deductible

Other Services

Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible

	In-Network	Out-of-Network
Chiropractic Services 20 visit maximum per calendar year	Covered – 100% after $35 copay	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	Covered - 80% after deductible	Covered - 60% after deductible
Allergy Therapy and Testing	Covered - 80% after deductible	Covered - 60% after deductible

Therapy Services

Physical, Occupational and Speech Therapy Limited to 60 visits combined	Covered - 100%after $35 copay	Covered - 60% after deductible

Hearing

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

Benefit Maximum	$1500
Audiometric Exam	Covered -100% after $35copay
Hearing Aid Evaluation	Covered -100%
Hearing Aid	Covered -100%
Hearing Aid Conformity Test	Covered -100%

The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This document is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

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. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-At-A-Glance and any applicable plan document, the plan document will control.