



**Blue Care
Network
of Michigan**

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

Benefits-at-a-Glance High Deductible Health Plan Effective Date: 07/01/2024

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 to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. 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 the member's primary care physician or health plan.

Preauthorization for Select Services - Services listed in this summary are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCN except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at <https://bcbsm.com/priorauth>.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	
Deductible Note: The Deductible will apply to all services except preventive services	\$3,200 per member/\$6,400 per family per benefit year (no 4th quarter carry-over)
The deductible is combined for both medical and prescription drug coverage.	The Deductible paid by all Members will be combined to satisfy the family Deductible. However, one individual Member cannot contribute more than the individual Deductible amount toward the family Deductible
Coinsurance Note: Coinsurance applies once the deductible has been met	50% for select services as noted below 20% for select services as noted below
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	\$6,900 per member/\$13,800 per family per benefit year For members with more than one person on the contract, if the one member maximum is met even if the family maximum is not, that member does not pay any more cost-sharing for the rest of the year

Preventive services

Benefits	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening - laboratory services only	100%
Well-Baby and Well-Child Visits	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening - laboratory services only	100%
Routine Colonoscopy	100%
Mammography Screening	100%

Preventive services (continued)

Benefits	
Voluntary Sterilization of Female Reproductive Organs	100%
Breast Pumps (DME guidelines apply.)	100%
Routine Maternity Prenatal and Postnatal Care	100%

Physician office services

Benefits	
PCP Office Visits	80% after deductible
Medical Online Visits - when performed by a BCN participating provider or BCN designated online vendor Note: Not all services delivered virtually are considered an online visit but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	80% after deductible
Consulting Specialist Care	80% after deductible

Emergency medical care

Benefits	
Hospital Emergency Room	80% after deductible
Urgent Care Center	80% after deductible
Retail Health Clinic	80% after deductible
Ambulance Services - medically necessary	80% after deductible

Diagnostic services

Benefits	
Laboratory and Pathology Tests	80% after deductible
Diagnostic Tests and X-rays	80% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	80% after deductible
Radiation Therapy	80% after deductible

Maternity services provided by a physician

Benefits	
Routine Prenatal and Postnatal Care Visits	100%
Delivery and Nursery Care	80% after deductible

Hospital care

Benefits	
General Nursing Care, Hospital Services and Supplies	80% after deductible
Outpatient Surgery	80% after deductible

Alternatives to hospital care

Benefits	
Skilled Nursing Care	80% after deductible Up to 45 days per benefit year
Hospice Care	80% after deductible
Home Health Care	80% after deductible

Surgical services

Benefits	
Surgery - included all related surgical services and anesthesia.	80% after deductible
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	50% after deductible
Elective Abortion (One procedure per two-year period of membership)	Not covered
Human Organ Transplants (subject to medical criteria)	80% after deductible
Reduction Mammoplasty (subject to medical criteria)	50% after deductible
Male Mastectomy (subject to medical criteria)	50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	50% after deductible
Orthognathic Surgery (subject to medical criteria)	50% after deductible
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	50% after deductible

Behavioral health services (mental health and substance use disorder treatment)

Benefits	
Inpatient Mental Health Care	80% after deductible
Residential Substance Use Disorder	80% after deductible
Outpatient Mental Health Care includes online and telemedicine visits Note: For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	80% after deductible
Outpatient Substance Use Disorder	80% after deductible

Autism spectrum disorders, diagnoses and treatment

Benefits	
Applied behavioral analysis (ABA) treatment Note: Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC)	80% after deductible
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	80% after deductible
Other covered services, including mental health services, for autism spectrum disorder	See your outpatient mental health, medical office visit and preventive benefit.

Other services

Benefits	
Allergy Testing and Therapy	80% after deductible
Allergy Injections	80% after deductible
Chiropractic Spinal Manipulation - when referred	80% after deductible Limited to 30 visits per benefit year
Outpatient Physical, Speech and Occupational Therapy - subject to meaningful improvement within 60 days	80% after deductible Limited to 60 visits per benefit year for any combination of outpatient rehabilitation therapies.
Infertility Counseling and Treatment	50% after deductible (excludes in-vitro fertilization)
Durable Medical Equipment	50% after deductible
Prosthetic and Orthotic Appliances	50% after deductible
Diabetic Supplies Note: Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable prescription drug cost-sharing will apply.	80% after deductible
Hearing Aid	Hearing aid evaluation and monaural hearing aid covered every 36 months up to a \$1,500 benefit maximum.

Prescription drugs

Benefits	
Preferred Generic Tier	\$10 copay after deductible
Nonpreferred Generic Tier	\$30 copay after deductible
Preferred Brand Tier	\$60 copay after deductible
Nonpreferred Brand Tier	\$80 copay after deductible
Preferred Specialty Tier	20% coinsurance (max \$200) after deductible
Nonpreferred Specialty Tier	20% coinsurance (max \$300) after deductible
Contraceptives	Women's Contraceptives - Preferred Generic - 100%, Non-Preferred Generic- \$30 copay after deductible, Preferred Brand- \$60 copay after deductible, Non-Preferred Brand - \$80 copay after deductible
Drugs for the Treatment of Sexual Dysfunction	50% coinsurance after deductible
Mail Order Prescription Drugs	30 day supply or less - applicable tiered copay/coinsurance, 31-90 day supply - 3x's the 30 day copay/coinsurance minus \$10 after deductible
Diabetic Supplies	Select diabetic supplies and equipment are covered, applicable cost sharing will apply. Cost sharing may not apply to certain preferred glucometers as defined on the drug list.

Prescription drugs (continued)

Benefits

Prescription Drug Deductible	Prescription drug deductible integrated with the medical deductible
Variable Cost Share Coupon Program	Your plan includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum.
Custom Drug List	The list of prescription drugs that have been approved by the U.S. Food and Drug Administration and approved by the BCBSM/BCN Pharmacy and Therapeutics Committee. The list represents the clinical judgment of Michigan physicians, pharmacists and other experts in the diagnosis and treatment of disease and promotion of health. Medications are selected based on clinical effectiveness, safety and opportunity for cost savings. Some drugs included in the Custom Drug List require prior authorization and/or step therapy by BCN before they are covered. The drug list may be modified by BCN as needed to remove or add a covered drug or to modify the requirements for authorization of a covered drug. The list may be found at https://www.bcbsm.com/druglists

For Internal Purposes Only

Benefits Selected - HDHPLG : 20COHD,3200HD,690MHD,90D3X,BENYR,EDEPM,H1536D,P136HD