Blue Care Network of Michigan

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

Benefits-at-a-Glance
BCN High Deductible Health Plan for Large Groups
00279912-0001-0005 MITTEN EDUCATIONAL MANAGEMENT
Effective Date: 09/01/2020

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 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 for fully insured plans.

Services must be provided or arranged by the member's primary care physician or health plan.

Preauthorization for Select Services – Services listed in this BAAG 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 bcbsm.com/importantinfo. Select *Approving covered services.*

Deductible, Copays and Dollar Maximums	
Deductible - Combined for both medical and drug coverage.	$2,800 for a one-person contract/$5,600 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)
	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.
Fixed Dollar Copays	None
Coinsurance	50% for select services as noted below
Out of Pocket Maximum	$5,000 for a one-person contract. $10,000 for a family contract (2 or more members) each calendar year
	Out of Pocket Maximum – An individual member can't contribute in excess of the individual OOPM amount. The remaining members in the family contract must combine to meet the Family OOPM.

Benefits Selected - HDHPLG : VACR50,EDEPM,2800HD,5KOMHD,2800HD,5KOMHD,P625DL,90D3X

Preventive Services	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening	100%
Well-Baby and Child Care	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening	100%
Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Female Sterilization	100%
Breast Pumps (DME guidelines apply.)	100%
Maternity Pre-Natal care	100%

Physician Office Services	
PCP Office Visits	100% after deductible. Deductible does not apply to preventive services and routine maternity care
Medical Online Visits	100% after deductible. Deductible does not apply to preventive services and routine maternity care
Consulting Specialist Care	100% after deductible. Deductible does not apply to preventive services and routine maternity care

Emergency Medical Care	
Hospital Emergency Room	100% after deductible
Urgent Care Center	100% after deductible
Retail Health Clinic	100% after deductible
Ambulance Services	100% after deductible

Diagnostic Services	
Laboratory and Pathology Services	100% after deductible
Diagnostic Tests and X-rays	100% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	100% after deductible
Radiation Therapy	100% after deductible

Maternity Services Provided by a Physician	
Post-Natal and Non-routine Pre-Natal Care (See Preventive Services section for routine Pre-Natal Care)	100% (Deductible applies for non-routine maternity care)
Delivery and Nursery Care	100% after deductible

Hospital Care	
General Nursing Care, Hospital Services and Supplies	100% after deductible
Outpatient Surgery	100% after deductible

Alternatives to Hospital Care	
Skilled Nursing Care	100% after deductible
	Up to 45 days per calendar year
Hospice Care	100% after deductible
Home Health Care	100% after deductible

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Surgical Services	
Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	100% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Male - 50% after deductible
Elective Abortion (One procedure per two year period of membership)	50% after deductible
Human Organ Transplants	100% after deductible
Reduction Mammoplasty	50% after deductible
Male Mastectomy	50% after deductible
Temporomandibular Joint Syndrome	50% after deductible
Orthognathic Surgery	50% after deductible
Weight Reduction Procedures	50% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)	
Inpatient Mental Health Care	100% after deductible
Inpatient Substance Use Disorder	100% after deductible
Outpatient Mental Health Care includes online visits Note: For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	100% after deductible
Outpatient Substance Use Disorder	100% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment	
Applied Behavioral analysys (ABA) treatment	100% after deductible
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	100% 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	
Allergy Testing and Therapy	100% after deductible
Allergy Injections	100% after deductible
Chiropractic Spinal Manipulation - when referred	100% after deductible
	(up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy	100% after deductible
	One period of treatment for any combination of therapies within 60 consecutive days per calendar year. NOTE: Effective 1/1/20 - the limit will be updated to 60 visits per calendar year for any combination of outpatient rehabilitation therapies.
Infertility Counseling and Treatment (Excludes In-vitro fertilization)	50% after deductible
Durable Medical Equipment	50% after deductible
Prosthetic and Orthotic Appliances	50% after deductible
Diabetic Supplies	100% after deductible
Hearing Aid	Not covered

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Prescription Drugs

Prescription Drugs	Tier 1A - $6 after ded, Tier 1B - $25 copay after ded, Tier 2 - $50 copay after ded, Tier 3 - $80 copay after ded, Tier 4 - 20% coinsurance after ded (Max $200), Tier 5 - 20% coinsurance after ded (Max $300)
	Sexual Dysfunction drugs - 50% coinsurance after ded
	Female Contraceptives - Tier 1A - Covered in full, Tier 1B - $25 copay after ded, Tier 2 - $50 copay after ded, Tier 3 - $80 copay after ded
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
Prescription Drug Deductible	Prescription drug deductible integrated with the medical deductible
	Effective 1/1/20 -Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs

Medical	0000H085	4ZG3	MED

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