Blue Care Network of Michigan

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

Group Name / Group ID: MITTEN EDUCATIONAL MANAGEMENT LLC / 00279912
Sub Group Name / Sub Group ID: MITTEN EDUCATIONAL MANAGEMENT LLC / 0001
Class ID: 0005
Plan Description: HDHP High Deductible Health Plan
Effective Date: 2023-09-01

Disclaimer: 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 certificate 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 benefit summary and any applicable plan documents, the plan document will control.

DEDUCTIBLE

$3,000 per individual; $6,000 per family embedded deductible per calendar year. The deductible is embedded. One member of a family contract cannot contribute more than the individual deductible amount towardthe family deductible.

COINSURANCE MAXIMUM

This plan has no coinsurance maximum.

OUT-OF-POCKET MAXIMUM

$5,000 per individual; $10,000 per family embedded out-of-pocket maximum per calendar year. The out-of-pocket maximum is embedded. One member of a family contract cannot contribute more than the individualOOPM amount toward the family OOPM. Once the member meets the individual OOPM, then they don't pay any more cost-sharing for the rest of the year, even if the family OOPM has not been met.

ALLERGY OFFICE VISIT

Allergy office visits are covered in full after deductible

AMBULANCE EMERGENT

Emergency ambulance transport is covered in full after deductible when other transportation would endanger a member's life.

AMBULANCE NON-EMERGENT

Non-emergent ambulance transport is covered in full after deductible. Requires prior authorization by BCN.

DETOX - SUB ABUSE

Detoxification services provided in an inpatient or residential setting are covered in full after deductible. Requires prior authorizationby BCN.

DURABLE MEDICAL EQUIPMENT

50% coinsurance after deductible for durable medical equipment. Mustbe preauthorized and obtained from a BCN supplier. Breast pump to support breast feeding is covered in full.

EMERGENCY ROOM

Emergency room treatment is covered in full after deductible.

HOME CARE VISITS

Home care visits are covered in full after deductible.

INFERTILITY CARE (CRITERIA REQUIRED)

50% coinsurance after deductible for infertility services. Requires prior authorization by BCN. In-vitro fertilization is not covered.

INPATIENT HOSPITAL

Inpatient hospital admission is covered in full after deductible; unlimited days. See certificate for specific surgical coinsurance.

LAB

Lab and pathology services are covered in full after deductible.

MENTAL HEALTH INPATIENT

Inpatient mental health/partial hospitalization is covered in full after deductible. Requires prior authorization by BCN.

MENTAL HEALTH INPATIENT DAYS

Unlimited visits when medically necessary. Requires prior authorization by BCN Behavioral Health management.

MENTAL HEALTH INPATIENT TIME PERIOD

Coordinated by BCN Behavioral Health management

MENTAL HEALTH OUTPATIENT

Outpatient/intensive outpatient mental health is covered in full after deductible. Online mental health visit with a designated online BCNparticipating provider is covered in full after deductible. Prior authorization not required for routine psychotherapy visits.

MENTAL HEALTH OUTPATIENT VISITS

Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.

MENTAL HEALTH OUTPT ADDL VISITS

Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.

ORTHOGNATHIC SURGERY

50% coinsurance after deductible for orthognathic surgery

ORTHOTICS

50% coinsurance after deductible for orthotics. Must be preauthorized and obtained from a BCN supplier.

OUTPATIENT SURGERY FACILITY

Outpatient surgery is covered in full after deductible. Preventive services and screenings as mandated by the Affordable Care Act are covered in full. See certificate for specific surgical coinsurance.

OUTPT FAC VISITS/DIAGNOSTIC SRVCS

Outpatient diagnostic or therapeutic services are covered in full after deductible. Preventive services and screenings as mandated by the Affordable Care Act are covered in full, deductible does not apply.

PCP VISITS

Primary care physician office visits are covered in full after deductible. Preventive services and screenings as mandated by the Affordable Care Act are covered in full. See BCBSM.com for a complete list of preventive services. Medical online visits when performed by a BCN designated online vendor, PCP or participating referral physician are covered in full after deductible.

PHYSICAL THERAPY/REHAB OUTPT

Physical therapy and rehabilitation covered in full after deductible.

PHYSICAL THERAPY/REHAB OUTPT LIMITS

Limited to 60 consecutive days per calendar year for any combination of therapies. Effective 1/1/20 outpatient therapy is limited to 60 visits per calendar year for any combination of therapies.

PRE-EXISTING CONDITION

Not applicable

PRE-EXISTING TIME PERIOD

Not applicable

PROSTHETICS

50% coinsurance after deductible for prosthetics. Must be preauthorized and obtained from a BCN supplier.

SKILLED NURSING FACILITY

Services in a skilled nursing facility is covered in full after deductible.

SKILLED NURSING FACILITY DAYS

Limited to 45 days of skilled nursing care per calendar year in a skilled nursing facility. Requires prior authorization by BCN.

SPECIALIST VISITS

Specialist office visit when referred is covered in full after deductible. Spinal manipulations are limited to 30 combined visits per calendar year when provided by a chiropractor or osteopathic physician. Preventive services and screenings as mandated by the Affordable Care Act are covered in full.

STERILIZATIONS

50% coinsurance after deductible for sterilization of male reproductive organs. Sterilization of female organs is covered in full.

SUB ABUSE INTERMEDIATE

Residential/intermediate/partial hospitalization substance use disorder is covered in full after deductible. Requires prior authorization by BCN Behavioral Health management.

SUB ABUSE INTERMEDIATE TIME PERIOD

Coordinated by BCN Behavioral Health management

SUB ABUSE OUTPATIENT

Outpatient/intensive outpatient substance use disorder is covered in full after deductible. Prior authorization not required for routine psychotherapy visits.

SUB ABUSE OUTPATIENT VISITS

Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.

TEMPOROMANDIBULAR JOINT

50% coinsurance after deductible for TMJ services. Requires prior authorization by BCN.

ELECTIVE ABORTIONS

50% coinsurance after deductible for first trimester elective abortion. Limited to one procedure per 24 month period.

URGENT CARE CENTER

Urgent care visits are covered in full after deductible.

WEIGHT REDUCTION (CRITERIA REQUIRED)

50% coinsurance after deductible for weight reduction procedures. Requires prior authorization by BCN. Limited to one procedure per lifetime.

X-RAY

X-ray and radiology services are covered in full after deductible. Preventive services and screenings as mandated by the Affordable Care Act are covered in full, deductible does not apply.

ANESTHESIA

Anesthesia is covered in full after deductible.

SURGICAL ASSISTANT

Services performed by a surgical assistant are covered in full after deductible.

SECOND SURGICAL OPINION

Second surgical opinion when referred is covered in full after deductible.

HOSPICE

Inpatient and outpatient hospice is covered in full after deductible. Inpatient care requires prior authorization.

NEWBORN CARE

Newborn care in an inpatient setting is covered in full after deductible.

IMMUNIZATIONS

Pediatric and adult immunizations as recommended by the Advisory Committee on Immunization Practices are covered in full.

MATERNITY

Routine prenatal and postnatal visits are covered in full.

DIALYSIS

Dialysis treatment in an inpatient or outpatient facility setting is covered in full after deductible.

CHEMOTHERAPY

Chemotherapy in an inpatient or outpatient facility setting is covered in full after deductible.

RADIATION THERAPY

Radiation therapy in an inpatient or outpatient facility setting is covered in full after deductible.

AUTISM

Applied behavioral analysis is covered in full after deductible. Outpatient rehabilitation benefit applies for autism related speech, physical and occupational therapy with unlimited visits.

DIABETIC SUPPLIES

Diabetic supplies and equipment are covered in full after deductible. Must be preauthorized and obtained from a BCN supplier.

ALLERGY EVAL/SERUM/TESTING

Allergy related services are covered in full after deductible

ALLERGY INJECTIONS

Allergy injections are covered in full after deductible

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Group Name / Group ID: MITTEN EDUCATIONAL MANAGEMENT LLC / 00279912
Sub Group Name / Sub Group ID: MITTEN EDUCATIONAL MANAGEMENT LLC / 0001
Class ID: 0005
Plan Description: Pharmacy BCN
Effective Date: 2023-09-01

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PRESCRIPTION DRUG COVERAGE WITH CONTRACEPTIVES

Preferred Generic Tier - $6 copay after deductible, Non-Preferred Generic Tier - $25 copay after deductible, Preferred Brand Tier - $50 copayment after deductible, Non-Preferred Brand Tier -$80 copayment afterdeductible, Preferred Specialty Tier - 20% coinsurance after deductible (max $200), Non-Preferred Specialty Tier - 20% coinsurance after deductible (max $300). Drugs for the treatment of sexual dysfunction 50% coinsurance after deductible. 30 day supply. Preventive medications and Preferred Generic Tier contraceptives are covered in full. 90 day retail and mail order covered at 3 times the applicable copay minus$10. The deductible is integrated; covered medical and pharmacy benefits are combined to satisfy the overall plan deductible. The deductible is embedded. One member of a family contract cannot contribute more than the individual deductible amount toward the family deductible.