Blue Care Network of Michigan

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

Benefits-at-a-Glance
HSA-Qualified Health Plan with Full HMO Network
00111299 WAYNE COUNTY
BCN HDHP HMO
Effective Date: 01/01/2026

This is intended as an easy-to-read summary. **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. **Services must be provided or arranged by 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 **https://bcbsm.com/priorauth**.

Note: Blue Care Network provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

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

Benefits	
Deductible **Note:** The Deductible will apply to all services except preventive services and is combined for both medical and prescription drug coverage.	$1,700 per member/$3,400 per family per calendar year. Any deductible paid during the last three months of the benefit year will not be carried over into the new benefit year.
Coinsurance **Note:** Coinsurance applies once the deductible has been met	50% for select services as noted below 20% 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	$2,300 per member/$4,600 per family per calendar year

Preventive services

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

Preventive services (continued)

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

Physician office services

Benefits	
PCP Office Visits	80% after deductible
Medical Online Visits - when performed by a BCN participating provider **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 - Online visits with the BCN designated online vendor are covered.
Consulting Specialist Care - when referred	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	Covered 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 Limited to 730 days per lifetime
Hospice Care	80% after deductible
Home Health Care	80% after deductible

Surgical services

Benefits	
Surgery - includes 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
Expanded Abortion Services	80% after deductible after deductible
Human Organ Transplants (subject to medical criteria)	80% after deductible
Reduction Mammoplasty (subject to medical criteria)	80% after deductible
Male Mastectomy (subject to medical criteria)	80% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	80% after deductible
Orthognathic Surgery (subject to medical criteria)	80% after deductible
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	80% 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 benefit and medical office visit cost sharing

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 calendar year
Outpatient Physical, Speech and Occupational Therapy - subject to meaningful improvement within 60 days	80% after deductible Limited to 60 visits per member per calendar year for any combination of outpatient rehabilitation therapies.
Infertility Counseling and Treatment	80% after deductible
Durable Medical Equipment	20% coinsurance
Prosthetic and Orthotic Appliances	20% coinsurance
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	Not covered

Prescription drugs

Benefits	
Generic Tier	$10 copay after deductible
Preferred Brand Tier	$35 copay after deductible
Nonpreferred Brand Tier	$50 copay after deductible
Contraceptives	Women's Contraceptives: Generic - 100%, Preferred Brand - $35 copay after deductible, Nonpreferred Brand - $50 copay after deductible
Drugs for the Treatment of Sexual Dysfunction	Health Habit Prescription Drugs (Including sexual dysfunction and weight loss prescription drugs) are not covered
Mail Order Prescription Drugs	Two times the applicable copay after deductible up to a 90-day supply. Specialty drugs are not covered through mail order pharmacies.
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.
Specialty Drug Pharmacy	Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs
Prescription Drug Deductible	The prescription drug deductible is integrated with the medical deductible
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 - HDLGF : 10355DF,165HDF,20CHDF,23MHDF,ASDHDF,CHD20F,DME20F,EDMP,MOP2OF,ONVPF,PO20%F,SN730F,XHHRXF