



**Blue Care  
Network  
of Michigan**

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

## Benefits-at-a-Glance

### BCN Classic HMO for Large Groups

00111299 Wayne County \$500 Deductible Plan

**Effective Date:** 1/1/2022

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](http://bcbsm.com/importantinfo). Select Approving covered services.

### Deductible, Copays and Dollar Maximums

Deductible -(Coinsurance and select fixed dollar copays as defined by your plan documents, apply once the deductible has been met.)	\$500 individual/\$1,000 family per calendar year
Fixed Dollar Copays	\$5 for allergy injections \$30 for office visits \$30 for urgent care visits \$100 for emergency room visits \$30 for referral physician visits
Coinsurance	50% for select services as noted below
Medical Annual Coinsurance Maximum (ACM)	None
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	\$6,600 per individual/\$13,200 per family

Benefits Selected - CLSSLG : D500,VACR50,ER100,CO30,6600PM,10355C,MOPD20,EDMP,BCNSF,BCN2SF,UR30,WDEDFC

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## 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 - Note: Applicable cost sharing applies when other services are received in the office.	\$30 Copay
Medical Online Visits	\$30 Copay
Consulting Specialist Care - When referred for other than preventive services. Note: Applicable cost sharing applies when other services are received in the office.	\$30 Copay

## Emergency Medical Care

Hospital Emergency Room - Copay waived if admitted	\$100 Copay
Urgent Care Center	\$30 Copay
Retail Health Clinic	\$30 Copay
Ambulance Services	100% after deductible

## Diagnostic Services

Laboratory and Pathology Services	100%
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)	\$30 Copay
Delivery and Nursery Care	100% For professional services. (See Hospital Care for facility charges) after deductible

## Hospital Care

General Nursing Care, Hospital Services and Supplies	100% after deductible
Outpatient Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	100% after deductible

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## Alternatives to Hospital Care

Skilled Nursing Care	100% after deductible
	Up to 45 days per member per calendar year
Hospice Care	100% after deductible
Home Health Care	\$30 Copay

## Surgical Services

Surgery - includes all related surgical services and anesthesia	100% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	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 (Limited to one procedure per lifetime)	50% after deductible

## Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)

Inpatient Mental Health Care	100% after deductible
Residential 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.	\$30 Copay
Outpatient Substance Use Disorder	\$30 Copay

## Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	\$30 Copay
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.	\$30 Copay
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	50% after deductible
Allergy Injections	\$5 copay
Chiropractic Spinal Manipulation - when referred	\$30 Copay
	(up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy	\$30 Copay
	60 visits per calendar year for any combination of outpatient rehabilitation therapies.
Infertility Counseling and Treatment	50% (Excludes In-vitro fertilization) after deductible
Durable Medical Equipment (DME)	50%
Prosthetic and Orthotic Appliances (P&O)	50%
Diabetic Supplies	50%
Hearing Aid	Not Covered
	Note: This Group is self-funded. Blue Care Network provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims

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## Prescription Drugs

Prescription Drugs - (Eff. 1/1/21 Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable pharmacy cost-sharing will apply.)	Tier 1 - \$10 copay, Tier 2 - \$35 copay, Tier 3 - \$50 copay
	Sexual Dysfunction Drugs - 50% coinsurance
	Women's Contraceptives - Tier 1 - 100%, Tier 2 - Tier 2 Copayment/Coinsurance above applies, Tier 3 - Tier 3 Copayment/Coinsurance above applies
Mail Order Prescription Drugs	Two times the applicable copay up to a 90 day supply
Prescription Drug Deductible	None
	Effective 1/1/20 -Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs

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