Blue Care Network of Michigan

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

BCN HMO SM $500

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 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 member's primary care physician or health plan.

Member's Responsibility: Deductible, Copays, Coinsurance and Dollar Maximums

Note: The **Deductible** will apply to certain services as defined below.

Deductible **Note:** Coinsurance and select fixed dollar copays apply once the deductible has been met.	$500 per individual/$1,000 per family per calendar year **(or benefit year for HRA)**
Fixed dollar copays	$20 for office visits, $30 for specialist visits, $35 for urgent care visits, $150 for emergency room visits, $150 for high tech imaging and $5 for allergy injections
Coinsurance	0% and 50% for select services as noted below
Annual Coinsurance maximum	None
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays	$1,000 per member/$2,000 per family per calendar year **(or benefit year for HRA)**

Preventive Services – as defined by the Affordable Care Act and included in your Certificate of Coverage

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%
Routine Colonoscopy	Covered – 100%
Mammography Screening	Covered – 100%
Voluntary Female Sterilization	Covered – 100%
Breast Pumps (DME guidelines apply. Limited to no more than one per 24 month period)	Covered – 100%
Maternity Pre-Natal Care	Covered – 100%

Physician Office Services

PCP Office Visits	Covered – $20 copay
Consulting Specialist Care – when referred for other than preventive services	Covered – $30 copay

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered – $150 copay after deductible
Urgent Care Center	Covered – $35 copay
Ambulance Services – medically necessary	Covered – $25 copay

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100%
Diagnostic Tests and X-rays	Covered – 100% after deductible
High Technology Imaging (MRI, CAT, PET)	Covered – $150 copay after deductible
Radiation Therapy	Covered – 100% after deductible

Maternity Services Provided by a Physician

Post-Natal Care. See Preventive Services section for Pre-Natal Care	Covered – $20 copay
Delivery and Nursery Care	Covered – 100% after deductible for professional services; see Hospital Care for facility charges

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 100% after deductible; unlimited days
Outpatient Surgery – See member certificate for select surgical coinsurance	Covered – 100% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100% after deductible up to 45 days per calendar year **(or benefit year for HRA)**
Hospice Care	Covered – 100% after deductible when authorized
Home Health Care	Covered – $30 copay after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 100% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – 50% after deductible
Elective Abortion (One procedure per two year period of membership)	Covered – 50% after deductible
Human Organ Transplants (subject to medical criteria)	Covered – 100% after deductible
Reduction mammoplasty (subject to medical criteria)	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 50% after deductible

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	Covered – 100% after deductible
Outpatient Mental Health Care	Covered – $20 copay
Outpatient Substance Abuse Care	Covered – $20 copay

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	Covered – $20 copay
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18 Physical, speech and occupational therapy for autism spectrum disorder is unlimited.	Covered – $30 copay after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit

Other Services

Allergy Testing and serum	Covered – 50% after deductible
Allergy office visits	Covered – 50% after deductible
Allergy Injections	Covered – $5 copay
Chiropractic Spinal Manipulation – when referred	Covered – $30 copay; up to 30 visits per calendar year **(or benefit year for HRA)**
Outpatient Physical, Speech and Occupational Therapy – subject to meaningful improvement within 60 days	Covered – $30 copay after deductible; limited to a combined benefit maximum of 60 consecutive days per calendar year **(or benefit year for HRA)** for a combination of therapies
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%
Diabetic Supplies	Covered – 100%

CLSSLG, D500, WDRPOV, 1000PM, CO20, 30RP, ER150, UR35, AMB25, IMG150, DSRCW, VACR50

Optional Riders:

- FOCUS – PCP Focus Rider
- BENYR – Benefit Year Rider (HRA groups only)