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
00278557 Kent County (Classes 0001, 0002, 0003)

Effective Date: 01/01/2021

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 -(Coinsurance and select fixed dollar copays as defined by your plan documents, apply once the deductible has been met.)	$250 individual/$500 family per calendar year
Fixed Dollar Copays	$5 for allergy injections
	$20 for office visits
	$20 for urgent care visits
	$100 for emergency room visits
	$40 for referral physician visits
Coinsurance	50% for select services as noted below
	10% for select services as noted below
Annual Coinsurance Maximum (ACM)	None
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$3,150 per individual/$6,300 per family (Medical Cost Sharing Only)

Benefits Selected - CLSSLG :
CI10%,D250,DCCRM,DSRCW,IMG150,DME5,ER100,PSTNTW,CO20,OOPMEX,3150PM,P&O5,40RP,100MSR,UR20,WDRPOV

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.	$20 Copay
Medical Online Visits	$20 Copay
Consulting Specialist Care - When referred for other than preventive services. Note: Applicable cost sharing applies when other services are received in the office.	$40 copay

Emergency Medical Care	
Hospital Emergency Room - Copay waived if admitted	$100 Copay after deductible
Urgent Care Center	$20 Copay
Retail Health Clinic	$20 Copay
Ambulance Services	90% after deductible

Diagnostic Services	
Laboratory and Pathology Services	100%
Diagnostic Tests and X-rays	90% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	$150 copay after deductible
Radiation Therapy	90% 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%; Office visit copay applies to non-routine prenatal office visits.
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	90% after deductible
Outpatient Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	90% after deductible

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Alternatives to Hospital Care

Skilled Nursing Care	90% after deductible
	Up to 45 days per member per calendar year
Hospice Care	100% after deductible
Home Health Care	$40 copay after deductible

Surgical Services

Surgery - includes all related surgical services and anesthesia	90% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	100% after deductible
Elective Abortion (One procedure per two year period of membership)	Not Covered
Human Organ Transplants	90% 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	90% after deductible
Inpatient Substance Use Disorder	90% 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.	$20 Copay
Outpatient Substance Use Disorder	$20 Copay

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	$20 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.	$40 copay 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	50% after deductible
Allergy Injections	$5 copay
Chiropractic Spinal Manipulation - when referred	$40 copay
	(up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy	$40 copay after deductible
	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)	100%
Prosthetic and Orthotic Appliances (P&O)	100%
Diabetic Supplies	100%
Hearing Aid	Not Covered

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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.)	Not covered
Mail Order Prescription Drugs	Not covered
Prescription Drug Deductible	None

For Internal Use Only

Medical	0000E679	4708	MED

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