Economy Option
HRA $1,500

BCN HMO SM $5000/20%

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.	$5,000 per individual/$10,000 per family per benefit year **HRA to $1,500/$3,000**
Fixed dollar copays **Note:** If you have a deductible, the deductible must be met first for certain services as listed below.	$20 for office visits, $20 for medical online visits, $40 for specialist visits, $50 for urgent care visits, $250 for emergency room visits, $150 for high tech imaging and $5 for allergy injections **$250 after HRA deductible for ER***
Coinsurance	20% and 50% for select services as noted below **HRA to 20%**
Annual Coinsurance maximum	None
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays	$6,350 per member/$12,700 per family per benefit year **HRA TROOP to $5,000/$10,000**

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	Covered – 100%
Maternity Pre-Natal Care	Covered – 100%

Physician Office Services

PCP Office Visits	Covered – $20 copay
Online Visits	Covered – $20 copay
Consulting Specialist Care – when referred for other than preventive services	Covered – $40 copay

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered – $250 copay after deductible **$250 aft HRA ded**
Urgent Care Center	Covered – $50 copay
Ambulance Services – medically necessary	Covered – 80% after deductible **aft HRA ded**

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100%
Diagnostic Tests and X-rays	Covered – 80% after deductible **aft HRA ded**
High Technology Imaging (MRI, CAT, PET)	Covered – $150 copay after deductible **aft HRA ded**
Radiation Therapy	Covered – 80% after deductible **aft HRA ded**

***After the HRA deductible is met, you will owe a $250 copay for the Emergency Room only.**

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 – 80% after deductible; unlimited days **aft HRA ded**
Outpatient Surgery – See member certificate for select surgical coinsurance	Covered – 80% after deductible **aft HRA ded**

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 80% after deductible up to 45 days per benefit year **aft HRA ded**
Hospice Care	Covered – 100% after deductible when authorized
Home Health Care	Covered – $40 copay after deductible **aft HRA ded**

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 80% after deductible **aft HRA ded**
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – 50% after deductible **80% aft HRA ded**
Elective Abortion (One procedure per two-year period of membership)	Covered – 50% after deductible **80% aft HRA ded**
Human Organ Transplants (subject to medical criteria)	Covered – 80% after deductible **aft HRA ded**
Reduction mammoplasty (subject to medical criteria)	Covered – 50% after deductible **80% aft HRA ded**
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible **80% aft HRA ded**
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible **80% aft HRA ded**
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible **80% aft HRA ded**
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 50% after deductible **80% aft HRA ded**

Mental Health Care and Substance Use Disorder Treatment

Inpatient Mental Health Care and Substance Use Disorder	Covered – 80% after deductible **aft HRA ded**
Outpatient Mental Health Care includes online visits **Note:** For diagnostic and therapeutic services, the medical benefit applies.	Covered – $20 copay
Outpatient Substance Use Disorder	Covered – $20 copay

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment through age 18	Covered – $20 copay
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18 Unlimited visits for physical, speech, and occupational therapy with autism spectrum disorder diagnosis	Covered – $40 copay after deductible **aft HRA ded**
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visits and preventive benefit

Other Services

Allergy Testing and serum	Covered – 50% after deductible **HRA to 80% aft ded**
Allergy office visits	Covered – 50% **HRA to 80%**
Allergy Injections	Covered – $5 copay
Chiropractic Spinal Manipulation – when referred	Covered – $40 copay; up to 30 visits per benefit year
Outpatient Physical, Speech and Occupational Therapy – subject to meaningful improvement within 60 days	Covered – $40 copay after deductible; limited to 60 visits per benefit year for any combination of therapies **aft HRA ded**
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible on all associated costs **HRA to 80% aft HRA deductible**
Durable Medical Equipment	Covered – 50% **HRA to 80%**
Prosthetic and Orthotic Appliances	Covered – 50% **HRA to 80%**
Diabetic Supplies	Covered – 80%

Hearing Aid - Binaural hearing aids and exam every 36 months covered 100%

CLSSLG, D5000, CI20%, WDRPOV, 6350PM, CO20, 40RP, ER250, UR50, IMG150, DSR20%, OMRR, VACR50, BENYR

Authorized Group Representative Signature: _____

Print Name/Title: _____ Date: _____