

Location/Subgroup:

Group-Subgroup-Class:

VERONA TOWNSHIP DISTRICT 1 00283881-0001-0001

BCN HMO SM Gold \$1000/20%

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.	\$1,000 per individual/\$2,000 per family per calendar year
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, \$40 for specialist visits, \$50 for urgent care visits, \$250 for emergency room visits, \$150 for high tech imaging and \$5 for allergy injections
Coinsurance	20% and 50% for select services as noted below
Annual Coinsurance Maximum – The following services DO NOT apply to the Annual Coinsurance Maximum if they are included in your coverage: • Deductible amounts • Services with a flat dollar copay • Infertility services • Male Mastectomy • Reduction Mammoplasty • Male Sterilization • Elective Abortion • TMJ • Orthognathic Surgery • Weight Reduction procedures • Durable Medical Equipment • Prescription Drugs • Prosthetics and Orthotics • Diabetic Supplies	\$3,500 per member/\$7,000 per family per calendar year
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services –	\$8,150 per member/\$16,300 per family per calendar year

including prescription drug cost-sharing amounts

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%



Location/Subgroup: Group-Subgroup-Class: VERONA TOWNSHIP DISTRICT 1 00283881-0001-0001

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

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Breast Pumps	Covered – 100%	
Maternity Pre-Natal Care	Covered – 100%	
Physician Office Services		
PCP Office Visits Note: Applicable cost sharing applies when other services are received in the office	Covered – \$20 copay	
Medical Online Visits	Covered - 100%	
Consulting Specialist Care – when referred for other than preventive services Note: Applicable cost sharing applies when other services are received in the office	Covered – \$40 copay	
Emergency Medical Care		
Hospital Emergency Room – copay waived if admitted	Covered – \$250 copay after deductible	
Urgent Care Center	Covered – \$50 copay	
Retail Health Clinic	Covered – \$50 copay	
Ambulance Services – medically necessary	Covered – 80% after deductible	
Diagnostic Services		
Laboratory and Pathology Services	Covered - 100%	
Diagnostic Tests and X-rays	Covered – 80% after deductible	
High Technology Imaging (MRI, CAT, PET)	Covered – \$150 copay after deductible	
Radiation Therapy	Covered – 80% 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 – 80% after deductible; unlimited days	
Outpatient Surgery – See member certificate for select surgical coinsurance	Covered – 80% after deductible	
Alternatives to Hospital Care		
Skilled Nursing Care	Covered – 80% after deductible up to 45 days per calendar year	
Hospice Care	Covered – 100% after deductible when authorized	
Home Health Care	Covered – \$40 copay after deductible	
Surgical Services		
Surgery – includes all related surgical services and anesthesia.	Covered – 80% 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)	Not Covered	



Surgical Services Human Organ Transplants (subject to medical criteria) Covered – 50% after deductible Reduction mannoplasty (subject to medical criteria) Covered – 50% after deductible Male Mastectomy (subject to medical criteria) Covered – 50% after deductible Temporomandibutar Joint Syndrome (subject to medical criteria) Covered – 50% after deductible Orthognathic Surgery (subject to medical criteria) Covered – 50% after deductible Behavioral Health Services (Mental Health and Substance Use Disorder Treatment) Covered – 50% after deductible Outpatient Mental Health Care and Substance Use Disorder Covered – 520 copay Outpatient Substance Use Disorder Covered – 520 copay Attism Spectrum Disorders, Diagnoss and reations were for applicate cost sharing, and a treatment. Covered – 520 copay Applied behavioral analyses (ABA) treatment through age 18 Covered – 520 copay Atter Services section disorder and a treatment from ada treatment agerowice dation evolution procedures and a treatment. Covered – 520 copay Outpatient physical thrapy, speach thrapy and occupational theaptore and a treatment. Covered – 520 copay Applied behavioral analyses speach through age 18 Covered – 540 copay after deductible Outpatient physical through age 18 Covered – 540 copay after deduct		Location/Subgroup: VERONA TOWNSHIP DISTRICT Group-Subgroup-Class: 00283881-0001-0001
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Durable Medical Equipment Covered – 50%		
Prosthetic and Orthotic Appliances Covered – 50%	,	Covered – 50%
	Prosthetic and Orthotic Appliances	Covered – 50%
Diabetic Supplies Covered – 80%	Diabetic Supplies	Covered – 80%



Location/Subgroup:

Group-Subgroup-Class:

VERONA TOWNSHIP DISTRICT 1 00283881-0001-0001

Other Services	
 Pediatric Vision Eye Exam – Limited to once per calendar year through the last day of the year in which an individual turns age 19 Prescription Glasses – Frames (chosen from a select collection) and lenses are covered once in a calendar year through the last day of the year in which an individual turns age 19 	Covered – 100%
Prescription Drugs Note: When a manufacturer coupon is used through the BCN high cost drug discount program, the amount paid after the discount applies toward the out- of-pocket maximum.	Tier 1A – Value Generics Covered – \$15 copay Tier 1B – Generics Covered – \$40 copay Tier 2 Preferred Brand Covered – \$80 copay Tier 3 Non-Preferred Brand Covered – \$100 copay Tier 4 Preferred Specialty Covered – 20% Coinsurance of the BCN Approved Amount (Maximum Copayment \$200) - Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network. Tier 5 Non-Preferred Specialty Covered – 20% Coinsurance of the BCN Approved Amount (Maximum Copayment \$300) – Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network. Drugs for sexual dysfunction, weight loss, cough & cold Not Covered 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. Contraceptives Covered – 100% , Tier 1B – \$40 copay, Tier 2 - \$80 copay, Tier 3 - \$100 copay Preventive Drugs Covered – 100% 90 Day Retail: 84-90 day supply Covered – Three times applicable copay minus \$10