Blue Care Network of Michigan

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

Location/Subgroup: CHURCH SCHOOL DISTRICT

Group-Subgroup-Class: 00290559-0001-0001

BCN HMO SM Platinum $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
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, $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	$1,500 per member/$3,000 per family per calendar year

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 **Note**: Applicable cost sharing applies when other services are received in the office	Covered – $20 copay
Online Visits	Covered – $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	Covered – $30 copay

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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 after deductible
Diagnostic Services	
Laboratory and Pathology Services	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
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)	Not Covered
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 Use Disorder Treatment	
Inpatient Mental Health Care and Substance Use Disorder	Covered – 100% after deductible
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

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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 diagnosis through age 18 Unlimited visits for physical, speech and occupational therapy for autism spectrum disorder diagnosis	Covered – $30 copay after deductible
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
Allergy office visits	Covered – 50%
Allergy Injections	Covered – $5 copay
Chiropractic Spinal Manipulation – when referred	Covered – $30 copay; up to 30 visits per calendar year
Rehabilitative Services – subject to meaningful improvement within 90 days • Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year • Outpatient Speech Therapy – limited to 30 visits per calendar year	Covered – $30 copay after deductible
Habilitative Services • Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year • Outpatient Speech Therapy – limited to 30 visits per calendar year	Covered – $30 copay after deductible
Outpatient Cardiac and Pulmonary Rehabilitation	Covered – $30 copay after deductible; limited to a benefit maximum of 30 visits per calendar year
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%
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	Covered – • Tier 1A - $4 copay, Tier 1B - $15 copay, Tier 2 - $40 copay, Tier 3 - $80 copay, Tier 4 – 20% coinsurance (Max $200), Tier 5 – 20% coinsurance (Max $300); 30-day supply. • Excludes drugs for the treatment of sexual dysfunction, weight loss, cough & cold • 90-day supply for mail order and retail; Three times applicable copay less $10. • Contraceptives - Tier 1A – 100%, Tier 1B – $15 copay, Tier 2 - $40 copay, Tier 3 - $80 copay • Preventive Drugs covered in full