Blue Care Network of Michigan

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

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.

Preauthorization for Select Services – Services listed in this summary 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.***

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, $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 cost-sharing amounts	$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%
Routine Maternity Prenatal and Postnatal 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 - when performed by a BCN participating provider or BCN designated online vendor	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 – $30 copay

Emergency Medical Care

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

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

Routine Prenatal and Postnatal Care visits	Covered - 100%
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

Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)

Inpatient Mental Health Care and Residential Substance Use Disorder	Covered – 100% after deductible
Outpatient Mental Health Care includes online and telemedicine visits **Note:** For diagnostic and therapeutic services, see the	Covered – $20 copay

Diagnostic Services section above for applicable cost sharing.	
Outpatient Substance Use Disorder	Covered – $20 copay

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCN approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered – $20 copay
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder Unlimited visits for physical, speech and occupational therapy with 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 Note: Certain diabetic supplies are covered through the pharmacy benefit. Applicable pharmacy cost-sharing will apply.	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

Preferred Generic Tier	Covered – $4 copay
Non-Preferred Generic Tier	Covered – $15 copay
Preferred Brand Tier	Covered – $40 copay
Non-Preferred Brand Tier	Covered – $80 copay
Preferred Specialty Tier	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.
Non-Preferred Specialty Tier	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 – Preferred Generic Tier – 100% , Non-Preferred Generic Tier – $15 copay, Preferred Brand Tier - $40 copay, Non-Preferred Brand Tier - $80 copay
Preventive Drugs	Covered – 100%
90 Day Retail: 84-90 day supply	Covered – Three times applicable copay minus $10 **Note:** If you have a Coinsurance, your Coinsurance will be based on the BCN Approved Amount for the quantity dispensed. If your Coinsurance includes a minimum and maximum Copayment, the minimum and maximum Copayment amounts are three times the 30-day supply minus $10.
Out-of-Pocket Maximum	Applies to deductibles, copays and coinsurance amounts for all covered medical and prescription drug services. See medical section above for out-of-pocket maximum limits. **Note:** Your benefit requires you to take advantage of BCN-approved coupon program for select medications. 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.

CLSSSM, D500, WDRPOV, 1500PM, CO20, 30RP, ER150, UR35, AMB25, IMG150, DSRCW, ONVCW, PVSN, P415CS, 90D3X, RXVAR

Optional Rider:

- VACR50 – Elective Abortion 50% Coinsurance Rider

Blue Cross Blue Shield of Michigan

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

Blue Dental℠ PPO Plus 80/50/50 Pediatric SG
Dental Coverage (Pediatric)
Benefits-at-a-glance
Effective for groups on their plan year

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. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Coverage determination: Claims are subject to dental necessity verification and availability of dental benefits when they are processed, as well as the terms and conditions of the applicable BCBSM certificates and riders.

Note: Pediatric members are members who are 18 years of age or younger on the group's renewal date. They will receive pediatric dental benefits up to the group's renewal date after they turn age 19.

Network access information
With Blue Dental PPO Plus, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.

Blue Dental PPO network- Blue Dental members have unmatched access to PPO (in-network) dentists through the Blue Dental PPO network, which offers more than 535,000 dentist locations* nationwide. PPO dentists agree to accept our approved amount as full payment for covered services, and members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152.**

**A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices is two dentist locations.*

Members who go to non-PPO dentists can still save money through our Blue Par Select arrangement.

Blue Par Select℠ arrangement- Most non-PPO (out-of-network) dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services- members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com.**

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge

Member's responsibility (deductible, coinsurance and dollar maximums)

Benefits	Coverage
Deductibles	$25 per member, $50 for two members, $75 per family per calendar year
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services	20%
• Class II services	50%
• Class III services	50%

Benefits	Coverage
• Class IV services	Not covered
Dollar maximums • Annual maximum for Class I, II and III services	None
• Lifetime maximum for Class IV services	Not applicable
Out-of-pocket maximum • The maximum out-of-pocket expense pediatric members will pay in a calendar year for deductible and coinsurance amounts applied to most covered in-network dental services. The out-of-pocket maximum **does not** apply to charges that exceed our approved PPO fee, services provided by non-PPO dentists, or non-covered services.	$375 for one pediatric member or $750 for two or more pediatric members per calendar year. **Note:** This out-of-pocket maximum is separate from the annual out-of-pocket maximum that applies under your hospital and medical coverage (if any).

Plan's responsibility

The plan's responsibility is subject to a review of the reported diagnosis, dental necessity verification and the availability of dental benefits at the time the claim is processed, as well as the conditions, exclusions and limitations, and deductible and coinsurance requirements under the applicable BCBSM certificates and riders.

Class I services

Benefits	Coverage
Most diagnostic and preventive services: • Routine oral examinations/evaluations - twice per calendar year	80% of approved amount
• Prophylaxes (cleanings) - three times per calendar year	80% of approved amount
• Fluoride treatments or topical fluoride varnishes- twice every calendar year for members to the end of the month of their 19th birthday	80% of approved amount
• Sealants - once per first permanent molar every 36 months for members to the end of the month on their ninth birthday; once per second permanent molar every 36 months for members to the end of the month of their 14th birthday	80% of approved amount
Bitewing X-rays-one set (up to four films) per calendar year	80% of approved amount
Oral brush biopsy sample collection -twice per calendar year	80% of approved amount

Class II services

Benefits	Coverage
Other diagnostic and preventive services: • Diagnostic tests and laboratory examinations	50% of approved amount after deductible
• Space maintainers - for missing posterior primary teeth for members to the end of the month of their 15th birthday	50% of approved amount after deductible
Panoramic or full-mouth X-rays -once per 60 months	50% of approved amount after deductible
Emergency palliative treatment	50% of approved amount after deductible
Minor restorative services: • Amalgam and resin-based composite fillings and fillings of similar materials - once per tooth and surface per 48 months for permanent teeth; once per tooth and surface per 24 months for primary teeth	50% of approved amount after deductible
• Recementation or repair of posts, crowns, veneers, inlays and onlays - three times per tooth per calendar year	50% of approved amount after deductible
Simple and surgical extractions of non-impacted teeth	50% of approved amount after deductible
Non-surgical endodontic services: • Root canal treatments - once per tooth per lifetime (replacement of a root canal 12 or more months after the initial root canal treatment is payable once per tooth per lifetime)	50% of approved amount after deductible
• Therapeutic pulpotomies or pulpal debridement	50% of approved amount after deductible
• Vital pulpotomies on primary teeth	50% of approved amount after deductible
• Apexification	50% of approved amount after deductible

Benefits	Coverage
Non-surgical periodontic services: • Periodontal maintenance - three times per calendar year in place of routine dental prophylaxis	50% of approved amount after deductible
• Periodontal scaling and root planing - once per quadrant per 24 months	50% of approved amount after deductible
Adjustments, repairs, relines, rebases and tissue conditioning for removable prosthetic appliances: • Relines or rebases of partial dentures or complete dentures - once per 36 month per arch	50% of approved amount after deductible
• Tissue conditioning - once per 36 months per arch	50% of approved amount after deductible
Adjunctive general services: • General anesthesia or IV sedation	50% of approved amount after deductible
• Office visits after regularly scheduled hours	50% of approved amount after deductible

Class III services

Benefits	Coverage
Major restorative services: • Onlays, crowns and veneers - once per permanent tooth per 84 months **for members age 12 and older only**	50% of approved amount after decutible
• Substructures, including cores and posts	50% of approved amount after decutible
Oral surgery services:	50% of approved amount after decutible
• Surgical exposure and facilitation of eruption of unerupted teeth	50% of approved amount after decutible
• Incision and drainage of cellulitis or fascial space abscesses of intraoral soft tissue	50% of approved amount after decutible
• Removal of exostoses (excess bony growths of the upper and lower jaw)	50% of approved amount after decutible
• Excision of hyperplastic tissue per arch	50% of approved amount after decutible
• Soft tissue biopsies	50% of approved amount after decutible
• Frenulectomies	50% of approved amount after decutible
Surgical endodontic services:	50% of approved amount after decutible
• Apical surgery on permanent teeth	50% of approved amount after decutible
• Hemisections - once per tooth per lifetime	50% of approved amount after decutible
Surgical periodontic services:	50% of approved amount after decutible
• Gingivectomy and gingivoplasty	50% of approved amount after decutible
• Clinical crown lengthening - hard tissue	50% of approved amount after decutible
• Gingival flap procedures	50% of approved amount after decutible
• Soft tissue grafts	50% of approved amount after decutible
Prosthodontic services: • Complete dentures - once per 84 months	50% of approved amount after decutible
• Removable partial dentures and fixed partial dentures (bridges), including abutment crowns and pontics - once per 84 months **for members age 16 and older only**	50% of approved amount after decutible
• Recementation and repairs of bridges	50% of approved amount after decutible
• Stayplates to replace recently extracted permanent anterior (front) teeth	50% of approved amount after decutible

Class IV services

Benefits	Coverage
Orthodontics and related services	Not covered