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
00165637 GRAND TRAVERSE PAVILIONS
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.)	$1,500 individual/$3,000 family per calendar year
Fixed Dollar Copays	$5 for allergy injections
	$20 for office visits
	$50 for urgent care visits
	$150 for emergency room visits
	$40 for referral physician visits
Coinsurance	50% for select services as noted below
	20% 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	$6,350 per individual/$12,700 per family

Benefits Selected - CLSSLG :
CI20%,D1500,DSR20%,IMG150,VACR50,ER150,CO20,6350PM,6350PM,P103CL,90D3X,40RP,UR50,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	$150 Copay after deductible
Urgent Care Center	$50 Copay
Retail Health Clinic	$50 Copay
Ambulance Services	80% after deductible

Diagnostic Services

Laboratory and Pathology Services	100%
Diagnostic Tests and X-rays	80% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	$150 copay after deductible
Radiation Therapy	80% 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)	$20 Copay
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	80% after deductible
Outpatient Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	80% after deductible

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Alternatives to Hospital Care

Skilled Nursing Care	80% 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	80% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	50% after deductible
Elective Abortion (One procedure per two year period of membership)	50% after deductible
Human Organ Transplants	80% 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	80% after deductible
Inpatient Substance Use Disorder	80% 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)	50%
Prosthetic and Orthotic Appliances (P&O)	50%
Diabetic Supplies	80%
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.)	Tier 1A - $10, Tier 1B - $30, T2- $60, T3- $80, T4- 20% coinsurance (max $200), T5- 20% coinsurance (max $300) 30 day supply

	Sexual Dysfunction Drugs - 50% coinsurance
	Contraceptives – T1A- 100%, Tier 1B - $30, T2 - $60, T3-$80; 30 day supply
Mail Order Prescription Drugs	30 day supply or less - applicable tiered copay / coinsurance; 31-90 day supply - 3x's the 30 day copay/coinsurance minus $10
Prescription Drug Deductible	None
	Effective 1/1/20 -Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs

For Internal Use Only

Pharmacy	0000C107	0158	

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