Blue Care Network of Michigan

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

Healthy *Blue* Living SM HMO 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 certificates 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.***

Healthy Blue Living subscribers must complete program requirements within the first 90 days of enrollment or re-enrollment. To qualify for or maintain enhanced benefits, the subscriber needs to complete a health assessment and qualification form during the first 90 days and follow their primary care physician's recommendations for a healthy lifestyle. If a tobacco user, must enroll in the BCN-sponsored tobacco cessation program within 120 days of the start of the plan year. If BMI is greater than or equal to 30, must select and begin participating in a weight management program within 120 days of the start of the plan year.

	Enhanced Benefits	**Standard Benefits**
	CLSSSM, D500, 2000PM, CO20, 30RP, UR35, ER150, AMB25, DSRCW, IMG150, WDRPOV, ONVCW, PVSN, VACR50, P415CS, 90D3X, RXVAR	**CLSSSM, D1250, CI20%, 4000PM, CO30, 40RP, UR50, ER150, DSR20%, IMG150, WDRPOV, ONVCW, PVSN, VACR50, P625CS, 90D3X, RXVAR**

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	$1,250 per individual/$2,500 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	$30 for office visits, $40 for specialist visits, $50 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	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	None	None
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug cost-sharing amounts	$2,000 per member/$4,000 per family per calendar year	$4,000 per member/$8,000 per family per calendar year

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Preventive Services – as defined by the Affordable Care Act and included in your Certificate of Coverage		
Health Maintenance Exam	Covered – 100%	Covered – 100%
Annual Gynecological Exam	Covered – 100%	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%	Covered – 100%
Well-Baby and Child Care	Covered – 100%	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%	Covered – 100%
Routine Colonoscopy	Covered – 100%	Covered – 100%
Mammography Screening	Covered – 100%	Covered – 100%
Voluntary Female Sterilization	Covered – 100%	Covered – 100%
Breast Pumps	Covered – 100%	Covered – 100%
Routine Maternity Prenatal and Postnatal Care	Covered – 100%	Covered – 100%
Physician Office Services		
PCP Office Visits **Note:** Applicable cost sharing applies when other services are received in the office	Covered – $20 copay	Covered – $30 copay
Medical Online Visits - when performed by a BCN participating provider or BCN designated online vendor	Covered – 100%	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	Covered – $40 copay
Emergency Medical Care		
Hospital Emergency Room – copay waived if admitted	Covered – $150 copay after deductible	Covered – $150 copay after deductible
Urgent Care Center	Covered – $35 copay	Covered – $50 copay
Retail Health Clinic	Covered – $35 copay	Covered – $50 copay
Ambulance Services – medically necessary	Covered – $25 copay after deductible	Covered – 80% after deductible

Diagnostic Services

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

Maternity Services Provided by a Physician

Routine Prenatal and Postnatal Care visits	Covered - 100%	Covered - 100%
Delivery and Nursery Care	Covered – 100% after deductible for professional services; see Hospital Care for facility charges	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	Covered – 80% after deductible; unlimited days
Outpatient Surgery – See member certificate for select surgical coinsurance	Covered – 100% after deductible	Covered – 80% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100% after deductible up to 45 days per calendar year	Covered – 80% after deductible up to 45 days per calendar year
Hospice Care	Covered – 100% after deductible when authorized	Covered – 100% after deductible when authorized
Home Health Care	Covered – $30 copay after deductible	Covered – $40 copay after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 100% after deductible	Covered – 80% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – 50% after deductible	Covered – 50% after deductible
Elective Abortion (One procedure per two year period of membership)	Covered – 50% after deductible	Covered – 50% after deductible
Human Organ Transplants (subject to medical criteria)	Covered – 100% after deductible	Covered – 80% after deductible
Reduction mammoplasty (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 50% after deductible	Covered – 50% after deductible

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Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)		
Inpatient Mental Health Care and Residential Substance Use Disorder	Covered – 100% after deductible	Covered – 80% after deductible
Outpatient Mental Health Care includes online and telemedicine visits **Note:** For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	Covered – $20 copay	Covered – $30 copay
Outpatient Substance Use Disorder	Covered – $20 copay	Covered – $30 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	Covered – $30 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	Covered – $40 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	See your outpatient mental health, medical office visits and preventive benefit

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Other Services		
Allergy Testing and serum	Covered – 50% after deductible	Covered – 50% after deductible
Allergy office visits	Covered – 50%	Covered – 50%
Allergy Injections	Covered – $5 copay	Covered – $5 copay
Chiropractic Spinal Manipulation – when referred	Covered – $30 copay; up to 30 visits per calendar year	Covered – $40 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	Covered – $40 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	Covered – $40 copay after deductible
Outpatient Cardiac and Pulmonary Rehabilitation	Covered – $30 copay after deductible; limited to a benefit maximum of 30 visits per calendar year	Covered – $40 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	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%	Covered – 50%
Diabetic Supplies Note: Certain diabetic supplies are covered through the pharmacy benefit. Applicable pharmacy cost-sharing will apply.	Covered – 100%	Covered – 80%
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%	Covered – 100%

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Prescription Drugs	Covered – • Preferred Generic Tier - $4 copay, Non-Preferred Generic Tier - $15 copay, Preferred Brand Tier - $40 copay, Non-Preferred Brand Tier - $80 copay, Preferred Specialty Tier – 20% coinsurance (Max $200), Non-Preferred Specialty Tier – 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 – Preferred Generic Tier – 100%, Non-Preferred Generic Tier – $15 copay, Preferred Brand Tier - $40 copay, Non-Preferred Brand Tier - $80 copay • Preventive Drugs covered in full • Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network. • 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.	Covered – • Preferred Generic Tier - $6 copay, Non-Preferred Generic Tier - $25 copay, Preferred Brand Tier - $50 copay, Non-Preferred Brand Tier - $80 copay, Preferred Specialty Tier – 20% coinsurance (Max $200), Non-Preferred Specialty Tier – 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 – Preferred Generic Tier – 100%, Non-Preferred Generic Tier – $25 copay, Preferred Brand Tier - $50 copay, Non-Preferred Brand Tier - $80 copay • Preventive Drugs covered in full • Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network. • 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.
Out-of-Pocket Maximum	Applies to deductibles, copays and coinsurance amounts for all covered medical and prescription drug services. See Annual Out-of-pocket Maximum section for out-of-pocket maximum limits. **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.	Applies to deductibles, copays and coinsurance amounts for all covered medical and prescription drug services. See Annual Out-of-pocket Maximum section for out-of-pocket maximum limits. **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.