Blue Care Network of Michigan

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

BCN HSA℠ HMO $2,000/0% High Deductible Health Plan with Medical and Prescription Drug Coverage

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 all services except preventive services.

Deductible **Note:** deductible is combined for both medical and prescription drug coverage. The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract	$2,000 for a one-person contract, $4,000 for a family contract (2 or more members) each calendar year (No 4th quarter carryover)
Fixed Dollar Copay **Note**: Copay amounts apply once the deductible has been met	None
Coinsurance **Note**: Coinsurance amounts apply once the deductible has been met	0% and 50% for select services as noted below
Out of Pocket Maximum – Total amount paid toward medical and pharmacy services including deductible, copays and coinsurance cost-sharing amounts.	$4,000 for a one-person contract, $8,000 for a family contract (2 or more members) each 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	Covered - 100% after deductible
Medical Online Visits – when performed by a BCN participating provider or BCN designated online vendor	Covered - 100% after deductible
Consulting Specialist Care – when referred	Covered - 100% after deductible

Emergency Medical Care

Hospital Emergency Room	Covered - 100% after deductible
Urgent Care Center	Covered - 100% after deductible
Retail Health Clinic	Covered - 100% after deductible
Ambulance Services – medically necessary	Covered - 100% after deductible

Diagnostic Services

Laboratory and Pathology Tests	Covered - 100% after deductible
Diagnostic Tests and X-rays	Covered - 100% 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

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered - 100% after deductible; unlimited days
Outpatient Surgery – see member certificate for specific 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
Home Health Care	Covered - 100% 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 – Male - 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 Diagnostic Services section above for applicable cost sharing.	Covered - 100% after deductible
Outpatient Substance Use Disorder	Covered - 100% after deductible

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 - 100% after deductible
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 - 100% 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 Therapy	Covered - 100% after deductible
Allergy office visits	Covered - 100% after deductible
Allergy Injections	Covered - 100% after deductible
Chiropractic Spinal Manipulation – when referred	Covered - 100% after deductible; up to 30 visits per calendar year
Outpatient Therapy/Rehabilitation – subject to meaningful improvement within 60 days	Covered - 100% after deductible; limited to 60 visits per calendar year for any combination of therapies
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible
Durable Medical Equipment	Covered – 50% after deductible
Prosthetic and Orthotic Appliances	Covered – 50% after deductible
Diabetic Supplies **Note:** Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable prescription drug cost-sharing will apply.	Covered - 100% after deductible

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High Deductible Health Plan
Custom Drug List℠ $4/$15/$40/$80/20%/20%
Prescription Drug Coverage

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Prescription Drugs

Deductible	The Deductible is combined for both medical and prescription drug coverage. The Deductible amount is listed with your medical benefits.
Preferred Generic Tier	$4 Copayment after Deductible
Non-Preferred Generic Tier	$15 Copayment after Deductible
Preferred Brand Tier	$40 Copayment after Deductible
Non-Preferred Brand Tier	$80 Copayment after Deductible
Preferred Specialty Tier	20% Coinsurance of the BCN Approved Amount after Deductible (Maximum Copayment $200) - Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.
Non-Preferred Specialty Tier	20% Coinsurance of the BCN Approved Amount after Deductible (Maximum Copayment $300) - Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.
Sexual Dysfunction Drugs	50% Coinsurance of the BCN Approved Amount after Deductible
Contraceptives **Note:** Your Preferred Brand and Non-Preferred Brand cost sharing may be waived for female contraceptive drugs if there are no clinically appropriate alternative products covered in full on the Custom Drug List.	• Preferred Generic Tier – Covered in Full; Deductible does not apply • Non-Preferred Generic Tier – $15 Copay after Deductible • Preferred Brand Tier - $40 Copay after Deductible • Non-Preferred Brand Tier - $80 Copay after Deductible • Preferred Specialty Tier – Not applicable • Non-Preferred Specialty Tier – Not applicable
Disposable Syringes and Needles	Applicable Tiered Copayment or Coinsurance will apply after Deductible. Note: Insulin syringes and needles are covered in full after Deductible when dispensed at the same time as insulin
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.
Preventive Medications **Note:** A and B Preventive Medications must be dispensed through a Participating Pharmacy with a prescription.	Covered in Full
31-90 day supply for Mail-Order Pharmacy	Three times applicable copay minus $10 after Deductible **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.
84-90 day supply for Retail Pharmacy	Three times applicable copay minus $10 after Deductible **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	Your medical out-of-pocket maximum is integrated with your BCN covered Prescription Drugs. The out-of-pocket maximum amount is listed with your medical benefits. **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.

Definitions

Brand Name Drug	Generally means a drug that is manufactured and marketed under a registered trade name or trademark.
Generic Drugs	Prescription Drugs that contain the same active ingredients, is identical in strength and dosage form, and are administered in the same way as the Brand Name Drug. Generic Drugs usually cost significantly less that the Brand Name Drug equivalent.
Non-Preferred Generic Tier	Drugs that have been determined by the FDA to be bioequivalent to Brand Name Drugs. and are not manufactured or marketed under a registered trade name or trademark. Some brand name drugs may be included in this tier .These drugs generally have lower Cost Sharing compared to the Preferred Brand Tier.
Non-Preferred Brand Tier	Includes Brand-Name drugs for which there are either generic alternatives or safer, more cost-effective, preferred brand-name drugs available. The higher Cost Sharing applies.
Non-Preferred Specialty Tier	Includes covered Specialty Drugs that may have less favorable adverse effects or their clinical value may not be as high as the Preferred Specialty Drugs. The highest Specialty Drug Cost Sharing applies.
Out-of-Pocket Maximum	The highest amount of money you have to pay for covered services during the Calendar Year.
Preferred Generic Tier	Select Generic and Brand Name Prescription Drugs that have a proven clinical value essential for treatment of chronic conditions such as diabetes and hypertension. These drugs have lower Cost Sharing compared to other Tiers
Preferred Brand Tier	Includes brand drugs that have a proven record for safety and effectiveness. These drugs generally are more expensive than Generic Drugs. Generic Drug alternatives may be available, offering more cost-effective therapies.
Preferred Specialty Tier	Includes generic or Single Source brand specialty drugs that may have safety and efficacy advantages over the Non-Preferred Specialty drugs and offer the best value to our Members. The lowest Specialty Drug Cost Sharing applies.