Blue Care Network of Michigan

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

Minimum Value Plan℠ BCN HMO $1500/20%/$5000 OOP

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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.	$1,500 per individual/$3,000 per family per calendar year
Fixed dollar copays	$30 for office visits, $45 for specialist visits, $50 for urgent care visits, $150 for emergency room visits, $150 for high tech imaging and $5 for allergy injections
Coinsurance	20% and 50% for select services as noted below
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays	$5,000 per member/$10,000 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	Covered – $30 copay
Consulting Specialist Care – when referred for other than preventive services	Covered – $45 copay

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered – $150 copay after deductible
Urgent Care Center	Covered – $50 copay
Ambulance Services – medically necessary	Covered – 80% after deductible

Diagnostic Services

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

Maternity Services Provided by a Physician

Post-Natal Care. See Preventive Services section for Pre-Natal Care	Covered – $30 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 – 80% after deductible; unlimited days
Outpatient Surgery – See member certificate for select surgical coinsurance	Covered – 80% after deductible

Alternatives to Hospital Care

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

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 80% 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	Covered – 80% after deductible
Reduction mammoplasty	Covered – 50% after deductible
Male Mastectomy	Covered – 50% after deductible
Temporomandibular Joint Syndrome	Covered – 50% after deductible
Orthognathic Surgery	Covered – 50% after deductible
Weight Reduction Procedures – Limited to one procedure per lifetime	Covered – 50% after deductible

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	Covered – 80% after deductible
Outpatient Mental Health Care	Covered – $30 copay
Outpatient Substance Abuse Care	Covered – $30 copay

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	Covered – $30 copay
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18 Physical, speech and occupational therapy for autism spectrum disorder is unlimited.	Covered – $45 copay after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit

Other Services

Allergy Testing and Therapy	Covered – 50% after deductible
Allergy Injections	Covered – $5 copay
Chiropractic Spinal Manipulation – when referred	Covered – $45 copay; up to 30 visits per calendar year
Outpatient Physical, Speech and Occupational Therapy – subject to meaningful improvement within 60 days	Covered – $45 copay after deductible; limited to a combined benefit maximum of 60 consecutive days per calendar year for a combination of therapies
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 – 80%

CLSSLG, D1500, CI20%, WDRPOV, 5000PM, CO30, 45RP, ER150, UR50, IMG150, DSR20%

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Preventive Prescription Drug Coverage

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Prescription Drugs

Contraceptives **Note:** Your cost sharing may be waived for contraceptive drugs if there are no appropriate generic products or preferred drugs available.	• Tier 1A Generics – Covered in Full • Tier 1B Generics - $40 Copayment • Tier 2 Preferred Brand - $40 Copayment • Tier 3 Non-Preferred Drugs – Not Covered
Other Preventive Medications **Note:** Tier 3 Non-Preferred contraceptives and other Preventive medications are not covered unless a BCN Affiliated Provider certifies to BCN and BCN agrees that the requested medication is medically necessary based on BCN's approved criteria.	• Tier 1A and 1B Generics – Covered in Full • Tier 2 Preferred Brand – Covered in Full • Tier 3 Non-Preferred Drugs – Not Covered
31-90 day supply for Mail-Order Pharmacy	Not Covered
84-90 day supply for Retail Pharmacy	Not Covered
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.

Definitions

Brand Name Drug	Manufactured and marketed under a registered trade name and trademark.
Generic Drugs	Prescription 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.
Preferred Brand Drugs	Prescription drugs that are Single Source Brand drugs that have a proven record for safety and effectiveness.
Non-Preferred Drugs	Prescription drugs that may not have a proven record for safety or their clinical record may not be as high as the BCN preferred alternatives.
Out-of-Pocket Maximum	The highest amount of money you have to pay for covered services during the Calendar Year.