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 Self-funded Large Groups
00278557 KENT COUNTY
Effective Date: 01/01/2024

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 group is self-funded. Blue Care Network provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

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.*

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)	
Deductible	$250 individual/$500 family per calendar year
Fixed Dollar Copays	$5 copay for allergy injections
	$20 copay for office visits
	$20 for urgent care visits
	$100 for emergency room visits
	$40 for referral physician office visits
Coinsurance	50% for select services as noted below
	10% for select services as noted below
Annual Coinsurance Maximum (ACM)	None
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays	$3,150 per individual/$6,300 per family

Benefits Selected - CLSLGF :
ASDF,CI10%F,D250F,DCCRMF,DSRCWF,IM150F,DME5F,ER100F,CO20F,ONVPF,OOPMXF,3150MF,P&O5F,40RPF,EDMP,100MSF,
UR20F,WDRPF

Preventive services

Health Maintenance Exam	Covered 100%
Annual Gynecological Exam	Covered 100%
Pap Smear Screening	Covered 100%
Well-Baby and Child Care	Covered 100%
Immunizations	Covered 100%
Prostate Specific Antigen (PSA) Screening	Covered 100%
Routine Colonoscopy	Covered 100%
Mammography Screening	Covered 100%
Voluntary Female Sterilization	Covered 100%
Breast Pumps (DME guidelines apply.)	Covered 100%
Maternity Pre-Natal care	Covered 100%

Physician office services

Office Visits - Applicable cost sharing applies when other services are received in the office.	$20 copay
Medical Online Visits	Medical online visits including with a BCN designated online vendor (Amwell). Matches your PCP office visit cost share.
Consulting Specialist Care -When referred for other than preventive services. Applicable cost sharing applies when other services are received in the office.	$40 copay

Emergency medical care

Hospital Emergency Room - copay waived if admitted	$100 Copay after deductible
Urgent Care Center	$20 copay
Retail Health Clinic	$20 copay
Ambulance Services	10% coinsurance after deductible

Diagnostic services

Laboratory and Pathology Tests	Covered 100%
Diagnostic Tests and X-rays	10% coinsurance after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	$150 copay after deductible
Radiation Therapy	10% coinsurance after deductible

Maternity services provided by a physician

Post natal care and Non-routine Prenatal care (See Preventive Services section for routine Pre-Natal Care)	$20 copay
Delivery and Nursery Care	Covered 100% for professional services (see Hospital Care for facility charges) after deductible

Hospital care

General Nursing Care, Hospital Services and Supplies	10% coinsurance after deductible
Outpatient Surgery - includes all related surgical services and anesthesia. See member certificate for specific surgical cost sharing.	10% coinsurance after deductible

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Alternatives to hospital care	
Skilled Nursing Care	10% coinsurance after deductible
	Up to 45 days per member per calendar year
Hospice Care	Covered 100% (When authorized) after deductible
Home Health Care	$40 copay after deductible

Surgical services	
Surgery - includes all related surgical services and anesthesia. See member certificate for specific surgical cost sharing.	10% coinsurance after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered 100% after deductible
Elective Abortion (One procedure per two year period of membership	Not covered
Human Organ Transplants	10% coinsurance after deductible
Reduction Mammoplasty	50% coinsurance after deductible
Male Mastectomy	50% coinsurance after deductible
Temporomandibular Joint Syndrome	50% coinsurance after deductible
Orthognathic Surgery	50% coinsurance after deductible
Weight Reduction Procedures (Limited to one procedure per lifetime)	50% coinsurance after deductible

Behavioral health services (mental health and substance use disorder treatment)	
Inpatient Mental Health Care	10% coinsurance after deductible
Residential Substance Use Disorder	10% coinsurance 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.	$20 copay
Outpatient Substance Use Disorder	$20 copay

Autism spectrum disorders, diagnoses and treatment	
Applied behavioral analyses (ABA) treatment	See your PCP office visit cost share. Deductible applies.
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder. Unlimited visits for PT/OT/ST with ASD diagnosis.	See your PCP office visit cost share. Deductible applies.
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit cost sharing. Deductible applies.

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Other services

Allergy Testing and Therapy	50% coinsurance 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- subject to meaningful improvement within 60 days.	$40 copay after deductible
	60 visits per calendar year for any combination of outpatient rehabilitation therapies.
Infertility Counseling and Treatment (Excluding In-vitro fertilization)	50% coinsurance after deductible
Durable Medical Equipment (DME)	Covered 100%
Prosthetic and Orthotic Appliances	Covered 100%
Diabetic Supplies	Covered 100%
	Coverage for Enhanced Condition Management Program(s) can be seen in your online account at https://member.bcbsm.com/mpa/responsive/#/HealthAndWellBeing
Hearing Aid	Not covered

Prescription drugs

Prescription Drugs - Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable pharmacy cost sharing will apply.	Not covered
Mail Order Prescription Drugs	Not covered
Prescription Drug Deductible	None

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