Blue Care Network of Michigan

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

Benefits-at-a-Glance
BCN High Deductible Health Plan for Large Groups
00189001 CITY OF TRAVERSE CITY
Effective Date: 07/01/2021

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 - Combined for both medical and drug coverage.	$1,400 for a one-person contract/$2,800 for a family contract (2 or more members) each benefit year (no 4th quarter carry-over)

	Deductible - The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract
Fixed Dollar Copays	None
Coinsurance	50% for select services as noted below
Out of Pocket Maximum	$2,250 for a one-person contract. $4,500 for a family contract (2 or more members) each benefit year
	Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays.

Benefits Selected - HDHPLG :
DCCRM,1400HD,2250OM,1400HD,2250OM,P1024D,MOPD1X,EPPHDC,BENYR,EPMHDC,100MSR,WRCWR

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	100% after deductible. Deductible does not apply to preventive services and routine maternity care
Medical Online Visits	100% after deductible. Deductible does not apply to preventive services and routine maternity care
Consulting Specialist Care	100% after deductible. Deductible does not apply to preventive services and routine maternity care

Emergency Medical Care	
Hospital Emergency Room	100% after deductible
Urgent Care Center	100% after deductible
Retail Health Clinic	100% after deductible
Ambulance Services	100% after deductible

Diagnostic Services	
Laboratory and Pathology Services	100% after deductible
Diagnostic Tests and X-rays	100% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	100% after deductible
Radiation Therapy	100% 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)	100% (Deductible applies for non-routine maternity care)
Delivery and Nursery Care	100% after deductible

Hospital Care	
General Nursing Care, Hospital Services and Supplies	100% after deductible
Outpatient Surgery	100% after deductible

Alternatives to Hospital Care	
Skilled Nursing Care	100% after deductible
	Up to 45 days per benefit year
Hospice Care	100% after deductible
Home Health Care	100% after deductible

Benefits Selected - HDHPLG :
DCCRM,1400HD,2250OM,1400HD,2250OM,P1024D,MOPD1X,EPPHDC,BENYR,EPMHDC,100MSR,WRCWR

Surgical Services

Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	100% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	100%
Elective Abortion (One procedure per two year period of membership)	Not Covered
Human Organ Transplants	100% 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	100%

Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)

Inpatient Mental Health Care	100% after deductible
Residential Substance Use Disorder	100% 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.	100% after deductible
Outpatient Substance Use Disorder	100% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment

Applied Behavioral analysys (ABA) treatment	100% after deductible
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.	100% 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	100% after deductible
Allergy Injections	100% after deductible
Chiropractic Spinal Manipulation - when referred	100% after deductible
	(up to 30 visits per benefit year)
Outpatient Physical, Speech and Occupational Therapy	100% after deductible
	60 visits per benefit year for any combination of outpatient rehabilitation therapies.
Infertility Counseling and Treatment	50% after deductible (Excludes In-vitro fertilization)
Durable Medical Equipment	50% after deductible
Prosthetic and Orthotic Appliances	50% after deductible
Diabetic Supplies	100% after deductible
Hearing Aid	Not covered

Benefits Selected - HDHPLG :
DCCRM,1400HD,2250OM,1400HD,2250OM,P1024D,MOPD1X,EPPHDC,BENYR,EPMHDC,100MSR,WRCWR

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 1 - $10 after deductible, T2- $20 after deductible, T3- $40 after deductible; 30 day supply
	Sexual Dysfunction Drugs - 50% after deductible
	Contraceptives – T1- 100% (deductible does not apply), T2 - $20 after deductible, T3-$40 after deductible; 30 day supply
	The deductible is waived for IRS expanded preventive prescription drugs and medical services (in addition to those defined by the Affordable Care Act) . The applicable copay or coinsurance will continue to apply.
Mail Order Prescription Drugs	One time the applicable copay after deductible up to a 90 day supply
Prescription Drug Deductible	Prescription drug deductible integrated with the medical deductible
	Effective 1/1/20 -Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs

Benefits Selected - HDHPLG :
DCCRM,1400HD,2250OM,1400HD,2250OM,P1024D,MOPD1X,EPPHDC,BENYR,EPMHDC,100MSR,WRCWR