Blue Care Network of Michigan

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

Benefits-at-a-Glance
Healthy Blue Choices POS
00100181 FCA NBU Salaried Actives
Effective Date: 01/01/2025

This is intended as an easy-to-read summary. **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. **Services must be provided or arranged by 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 **https://bcbsm.com/priorauth**.

Note: Blue Care Network provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In Network	Out of Network
Deductible - The deductible will apply to certain services as defined below.	$700 per member, $1,400 per family per calendar year	$1,300 per member, $2,600 per family per calendar year
Deductible Details	If you use in-network and out-of-network services, separate deductible amounts apply. The deductible for in-network and out-of-network is not combined to satisfy the deductible limit. Any deductible paid during the last three months of the calendar year will not be carried over into the new calendar year.	
Fixed Dollar Copays	$25 for PCP office visits $35 for Specialist office visits $150 for emergency room visits $50 for urgent care visits $12.50 for retail clinic visits $10 for online and telemedicine visits $50 for outpatient surgery facility	$150 for emergency room visits $50 for urgent care visits $50 for outpatient surgery facility
Coinsurance	20% for select services as noted below	40% for select services as noted below **Note**: Services without a network are covered at the in-network level
Annual Coinsurance Maximum (ACM) Does not include any deductible, copayments or prescription drug cost sharing.	$1,600 per member/$3,200 per family per calendar year	$3,200 per member/$4,400 per family per calendar year

Annual Out of Pocket Maximum (OOPM) Applies to deductibles, copays and coinsurance amounts for all covered services including prescription drugs	$9,200 per member/$18,400 per family per calendar year **Note:** The prescription drug coverage is administered through a separate Pharmacy Benefit Manager (PBM). The PBM is not affiliated with Blue Care Network. However, covered prescription drugs processed by this PBM will apply to the BCN Out-of-Pocket Maximum.	None **Note:** The prescription drug coverage is administered through a separate Pharmacy Benefit Manager (PBM). The PBM is not affiliated with Blue Care Network. However, covered prescription drugs processed by this PBM will apply to the BCN Out-of-Pocket Maximum.

Preventive services

Benefits	In Network	Out of Network
Health Maintenance Exam	100%	Not covered
Routine Physical Related Test X-rays and lab procedures performed as part of the health maintenance exam	80% after deductible (lab and path services covered 100%)	60% after deductible (lab and path services covered 100%)
Annual Gynecological Exam	100%	60% after deductible
Pap Smear Screening	100%	100% - through JVHL
Well-Baby and Well-Child Visits	100%	Not covered
Immunizations - pediatric and adult	100%	Not covered except for Shingrix and Zostavax starting at age 50; 60% after deductible
Prostate Specific Antigen (PSA) Screening	100%	100%
Routine Colon Screenings	100%	60% after deductible
Mammography Screening	100%	60% after deductible
Voluntary Sterilization of Female Reproductive Organs	100%	60% after deductible
Breast Pumps (DME guidelines apply)	100%	Not covered

Physician office services

Benefits	In Network	Out of Network
PCP Office Visits **Note**: Applicable cost sharing applies when other services are received in the office. For surgical procedures performed in the office, the $50 surgical copay does not apply however, deductible and coinsurance do apply.	$25 copay	Not covered
Specialist visit **Note**: Applicable cost sharing applies when other services are received in the office. For surgical procedures performed in the office, the $50 surgical copay does not apply however, deductible and coinsurance do apply.	$35 copay	Not covered
Telemedicine visits	$0 copay for visits 1-5; combined with medical and mental health online visits $10 copay per each additional visit	Not covered

Medical Online Visits - payable when rendered through the BCN Participating Providers or the BCN designated online vendor	$0 copay for visits 1-5; combined with telemedicine visits $10 copay per each additional visit	Not covered
Second Surgical Opinion Office visit	100%	Not covered
Work Clinic visits	Services received at the FCA Family Health and Wellness Detroit are covered in full, including online visits. Referrals, preauthorizations, and visit limits are waived when seen at the clinic.	

Emergency medical care

Benefits	In Network	Out of Network
Hospital Emergency Room - For qualified medical emergency. Copay waived if admitted as an inpatient or to observation care.	$150 copay	$150 copay
Non-Emergency Use of Emergency Room (non-qualified medical emergency)	Not covered	Not covered
Urgent Care Center - Copay waived if sent the same day to the emergency room from the urgent care center. Call customer service to initiate a claim adjustment.	$50 copay	$50 copay
Retail Health Clinic visits	$12.50 copay	Not covered
Ambulance Services - medically necessary	80% after deductible	60% after deductible

Diagnostic services

Benefits	In Network	Out of Network
Laboratory and Pathology Tests	100%	100% through JVHL
Diagnostic Tests and X-rays	80% after deductible	60% after deductible
Second Surgical Opinion Testing	100%	100%
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	80% after deductible	60% after deductible
Radiation Therapy and Chemotherapy	80% after deductible	60% after deductible

Maternity services provided by a physician

Benefits	In Network	Out of Network
Prenatal Care	100%	Not covered
Postnatal Care	100%	60% after deductible
Delivery and Nursery Care	80% after deductible	60% after deductible

Hospital care

Benefits	In Network	Out of Network
General Nursing Care, Hospital Services and Supplies - facility and professional	80% after deductible	60% after deductible
Outpatient Facility Visits Note: A $50 copay applies to outpatient facility. The $50 copay will continue to apply to facility services after deductible and coinsurance are	$50 copay then 20% coinsurance after deductible	$50 copay then 40% coinsurance after deductible

met. The copay does not apply to procedures performed in an office setting.

Alternatives to hospital care

Benefits	In Network	Out of Network
Skilled Nursing Care - facility; unlimited days	80% after deductible when authorized	60% after deductible when authorized
Hospice Care Levels 1 - 5	80% after deductible; Limited to 365 lifetime days	Not covered
Home Health Care - unlimited	80% after deductible	60% after deductible
Private Duty Nursing - in a hospital or your home; unlimited	80% after deductible	60% after deductible

Surgical services

Benefits	In Network	Out of Network
Surgery - includes all related surgical services and anesthesia	80% after deductible	60% after deductible
Outpatient Surgery Facility	**Note**: A $50 copay applies to outpatient facility. The $50 copay will continue to apply to facility services after deductible and coinsurance are met. The copay does not apply to procedures performed in an office setting.	
Voluntary Sterilization of Male Reproductive Organs - Excludes reversal of sterilization; See Preventive Services section for Voluntary Sterilization of Female Reproductive Organs	80% after deductible	60% after deductible
Abortion	80% after deductible - Limited to one procedure per two-year period of membership. **Note:** Abortions are not covered if rendered in a location where abortion is not legal.	60% after deductible - Limited to one procedure per two-year period of membership. **Note:** Abortions are not covered if rendered in a location where abortion is not legal.
Specified Organ Transplants - in designated facilities only	80% after deductible	Not covered
Kidney, Cornea, Bone Marrow and Skin transplants	80% after deductible	60% after deductible

Behavioral health services (mental health and substance use disorder treatment)

Benefits	In Network	Out of Network
Inpatient Mental Health Care	80% after deductible	60% after deductible
Residential Substance Use Disorder	80% after deductible	60% after deductible
Outpatient Mental Health Care	$25 copay	Not covered
Outpatient Substance Use Disorder	$25 copay	Not covered

Autism spectrum disorders, diagnoses and treatment

Benefits	In Network	Out of Network
Applied Behavioral Analysis (ABA) treatment	80% after deductible	60% after deductible

Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	80% after deductible	Not covered
Outpatient Physical, Speech and Occupational Therapy Limits	Unlimited visits	Not covered
Other covered services, including mental health services, for autism spectrum disorder	See your outpatient mental health office visit and preventive benefit.	Not covered

Other services

Benefits	In Network	Out of Network
Allergy Testing, Therapy, and Injections	80% after deductible	60% after deductible
Allergy Office Visits	PCP - $25 copay Specialist - $35 copay after deductible	Not covered
Chiropractic Spinal Manipulation Care	$35 copay	Not covered
Chiropractic Spinal Manipulation Care Limits	Limited to 24 visits per year	Not covered
Outpatient Physical, Speech and Occupational Therapy PT/OT/ST is unlimited	80% after deductible	Not covered
Cardiac and Pulmonary Rehabilitation - limited to 36 visits which must be completed within 6 months of a qualifying event	80% after deductible	Not covered
Facility Clinic visit - malignant diagnosis only	80% after deductible	60% after deductible
Proctoscopic Exams	100%	60% after deductible
Infertility Diagnosis - Artificial insemination is not covered. Infertility treatment is not administered by BCN. Please contact the group vendor.	80% after deductible	60% after deductible
Durable Medical Equipment (DME)	100%	Not covered
Diabetic Supplies	100%	Not covered
Prosthetic and Orthotic Appliances (P&O)	100% - includes coverage for prosthetic, orthotic and corrective appliances for unattached shoe inserts; 2 inserts every 36 months	Not covered
Wigs and Related Supplies	100% coverage for a hair prosthesis (wig or hair piece) for hair loss due to a medical condition or the treatment of a medical condition. Limited to a benefit max of $200 for the first 12-month period. Thereafter, limited to $125 every 12 months. Must be provided by BCN DME vendor.	Not covered
Gender Affirmation Services	80% after deductible	60% after deductible
Travel Concierge	Coverage is included for a travel concierge for select services.	

For Internal Purposes Only
Benefits Selected - FCA25AF : PBMF,PDCMXF,PO3SIF,TRVSF,WCFCAF,WIG2F