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 Pre65 Retiree
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.	$1,100 per member/$2,200 per family per calendar year	$2,200 per member/$4,400 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	$35 for PCP office visits $55 for Specialist office visits $175 for emergency room visits $60 for urgent care visits $10 copay for online and telemedicine visits $12.50 for Retail Clinic visits $50 for outpatient surgery facility	$175 for emergency room visits $60 urgent care visits
Coinsurance	30% for select services as noted below	50% for select services as noted below. **Note:** Services without a network are covered at the in-network level.
Annual Deductible and Coinsurance Out-of-Pocket Maximum - Applies to deductibles and coinsurance amounts for all covered medical services. Copayments are not included.	$3,675 per member/$7,350 per family per calendar year	$7,350 per member/$14,700 per family per calendar year

Out of Pocket Maximum Details	If you use in-network and out-of-network services, separate maximum amounts apply. The annual deductible and coinsurance out-of-pocket maximum for in-network and out-of-network is not combined.

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	70% after deductible (lab and path services covered 100%)	Not covered with the exception of: lab and pathology services covered 100%
Annual Gynecological Exam	100%	50% after deductible
Pap Smear Screening	100% - through JVHL	100% - through JVHL
Well-Baby and Well-Child Visits	70% after deductible	Not covered
Immunizations - pediatric and adult	70% after deductible	Not covered except for Shingrix and Zostavax starting at age 50; 50% coinsurance after deductible
Prostate Specific Antigen (PSA) Screening	100% - through JVHL	100% - through JVHL
Routine Colon Screenings	70% after deductible	Not covered
Mammography Screening - includes 3D	70% after deductible	50% after deductible

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.	$35 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.	$55 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

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.	$175 copay	$175 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.	$60 copay	$60 copay
Retail Health Clinic visits	$12.50 copay	Not covered
Ambulance Services - medically necessary	70% after deductible	50% after deductible

Diagnostic services

Benefits	In Network	Out of Network
Laboratory and Pathology Tests	100% through JVHL	100% through JVHL
Diagnostic Tests and X-rays	70% after deductible	50% after deductible
Second Surgical Opinion Testing	100%	100%
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	70% after deductible	50% after deductible
Radiation Therapy and Chemotherapy	70% after deductible	50% after deductible

Maternity services provided by a physician

Benefits	In Network	Out of Network
Prenatal Care	70% after deductible	50% after deductible
Postnatal Care	70% after deductible	50% after deductible
Delivery and Nursery Care	70% after deductible	50% after deductible

Hospital care

Benefits	In Network	Out of Network
General Nursing Care, Hospital Services and Supplies - facility and professional	70% after deductible	50% 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 met. The copay does not apply to procedures performed in an office setting.	$50 copay then 30% coinsurance after deductible	$50 copay then 50% coinsurance after deductible

Alternatives to hospital care

Benefits	In Network	Out of Network
Skilled Nursing Care - facility; unlimited days	70% after deductible when authorized	50% after deductible when authorized
Hospice Care Levels 1 - 5	70% after deductible Limited to 365 lifetime days	Not covered
Home Health Care - unlimited days	70% after deductible	50% after deductible
Private Duty Nursing - in a hospital or your home; unlimited	70% after deductible	50% after deductible

Surgical services

Benefits	In Network	Out of Network
Surgery - includes all related surgical services and anesthesia	70% after deductible	50% after deductible
Adult Sterilization - excludes reversal of sterilization	70% after deductible	50% after deductible
Abortion	70% 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.	50% 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	100%	Not covered
Kidney, Cornea, Bone Marrow and Skin transplants	70% after deductible	50% after deductible

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

Benefits	In Network	Out of Network
Inpatient Mental Health Care	70% after deductible	50% after deductible
Residential Substance Use Disorder	70% after deductible	50% after deductible
Outpatient Mental Health Care	$35 copay	Not covered
Outpatient Substance Use Disorder	$35 copay	Not covered

Autism spectrum disorders, diagnoses and treatment

Benefits	In Network	Out of Network
Applied Behavioral Analysis (ABA) treatment	70% after deductible	50% 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.	70% 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	70% after deductible	50% after deductible
Allergy Office Visits	PCP $35 copay Specialist $55 copay after deductible	Not covered
Chiropractic Spinal Manipulation Care	$55 copay	Not covered
Chiropractic Spinal Manipulation Care Limits	Limited to 24 visits per calendar year	Not covered

Outpatient Physical, Speech and Occupational Therapy - PT/OT/ST is unlimited	70% after deductible	Not covered
Cardiac and Pulmonary Rehabilitation - limited to 36 visits which must be completed within 6 months of a qualifying event	70% after deductible	Not covered
Facility Clinic visit - malignant diagnosis only	70% after deductible	50% after deductible
Proctoscopic Exams	70% after deductible	Not covered
Infertility Diagnosis - Artificial insemination is not covered. Infertility treatment is not administered by BCN. Please contact the group vendor.	70% after deductible	50% 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 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	70% after deductible	50% after deductible
Travel Concierge	Coverage is included for a travel concierge for select services.	

For Internal Purposes Only
Benefits Selected - FCA25RF : PDCMXF,PO3SIF,RETDIS,TRVSF,WIG2F