Blue Care Network of Michigan

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

Benefits-at-a-Glance for Farmington Board of Education- HDHP
January 1, 2018

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 and shall be construed under the jurisdiction and according to the laws of the State of Michigan. **Services must be provided or arranged by member's primary care physician or health plan.**

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. The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract.	$1,350 per individual / $2,700 per family per calendar year
Fixed Dollar Copays	None
Coinsurance	20% on select services
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays	$6,350 per individual / $6,350 per family per calendar year

Preventive Services – as defined by the Affordable Care Act and included in your Benefit Document

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 - DME guidelines apply	Covered 100%
Maternity Prenatal Care	Covered 100%

Physician Office Services

PCP Office Visits	Covered 100% after deductible. Deductible does not apply to preventive services and routine maternity care.
Online Visits - Medical	Covered 100% after deductible
Consulting Specialist Care – when referred for other than preventive services	Covered 100% after deductible. Deductible does not apply to preventive services and routine maternity care.

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered 100% after deductible
Urgent Care Center	Covered 100% after deductible
Ambulance Services – medically necessary	Covered 100% after deductible

Diagnostic Services

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

Maternity Services Provided by a Physician

Post-Natal and Non-routine Pre-natal Care. See Preventive Services section for Pre-Natal Care	Covered 100% (Deductible applies for non-routine maternity care)
Delivery and Nursery Care	Covered 100% after deductible

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered 100% after deductible
Outpatient Surgery – See member certificate for select surgical coinsurance	Covered 100% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered 100% after deductible; up to 730 lifetime days
Hospice Care	Covered 100% after deductible
Home Health Care	Covered 100% after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered 100% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Male- Covered 80% after deductible. Female – covered in full.
Elective Abortion	Covered 80% after deductible
Human Organ Transplants (subject to medical criteria)	Covered 100% after deductible
Reduction Mammoplasty	Covered 80% after deductible
Male Mastectomy	Covered 80% after deductible
Temporomandibular Joint Syndrome	Covered 80% after deductible
Orthognathic Surgery	Covered 80% after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered 80% after deductible

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care	Covered 100% after deductible
Inpatient Substance Abuse Care	Covered 100% after deductible
Outpatient Mental Health Care	Covered 100% after deductible
Online Visits – Mental Health	Covered 100% after deductible
Outpatient Substance Abuse Care	Covered 100% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	Covered 100% after deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18.	Covered 100% 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 100% after deductible
Allergy Injections	Covered 100% after deductible
Chiropractic Spinal Manipulation – when referred	Covered 100% after deductible (up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy – subject to meaningful improvement within 60 days	Covered 100% after deductible – limited to 60 visits for each therapy per medical episode per calendar year
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered 80% after deductible
Durable Medical Equipment – must be preauthorized and obtained from a BCN supplier	Covered 100% after deductible
Prosthetic and Orthotic Appliances	Covered 100% after deductible
Diabetic Supplies	Covered 100% after deductible
Prescription Drugs	Tier 1 - $10 copay after deductible, Tier 2 - $40 copay after deductible, Tier 3 – $40 copay after deductible; 30-day supply.
	Sexual Dysfunction drugs – 50% coinsurance after deductible
	Tier 1 female contraceptives and other preventive medications are covered in full.
Mail Order Prescription Drugs	Tier 1 - $20 copay after deductible, Tier 2 - $80 copay after deductible, Tier 3 – $80 copay after deductible; up to a 90-day supply.