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- $500 Deductible 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.	$500 per individual / $1,000 per family per calendar year
Fixed Dollar Copays	$20 for PCP office visits
	$20 for Referral Physician visits
	$50 for Emergency Room visits
	$20 for Urgent Care visits
	$20 for Online visits
Coinsurance	20% for select services as noted below
Annual Coinsurance Maximum	$1,000 per individual / $2,000 per family per calendar year
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays	$6,350 per individual / $12,700 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 Pre-Natal Care	Covered – 100%

Physician Office Services

PCP Office Visits	Covered – $20 copay
Online Visits - Medical	Covered – $20 copay
Consulting Specialist Care – when referred for other than preventive services	Covered – $20 copay after deductible

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered – $50 copay after deductible
Urgent Care Center	Covered – $20 copay
Ambulance Services – medically necessary	Covered – 80% after deductible for ground and air services

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100%
Diagnostic Tests and X-rays	Covered – 80% after deductible
High Technology Imaging (MRI, CAT, PET)	Covered – 80% after deductible
Radiation Therapy	Covered – 80% 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 – $20 copay
Delivery and Nursery Care	Covered – 100% after deductible for professional services; see Hospital Care for facility charges

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 80% after deductible
Outpatient Surgery – See member certificate for select surgical coinsurance	Covered – 80% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 80% after deductible; up to 730 days per lifetime
Hospice Care	Covered – 100% after deductible; when authorized
Home Health Care	Covered – $20 copay after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 80% 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)	Covered – 80% after deductible
Human Organ Transplants (subject to medical criteria)	Covered – 80% after deductible
Reduction Mammoplasty (subject to medical criteria)	Covered – 80% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 80% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 80% after deductible
Orthognathic Surgery (subject to medical criteria)	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 – 80% after deductible
Inpatient Substance Abuse Care	Covered – 80% after deductible
Outpatient Mental Health Care	Covered – $20 copay after deductible
Online Visits – Mental Health	Covered – $20 copay after deductible
Outpatient Substance Abuse Care	Covered – $20 copay after deductible

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	Covered – $20 copay after deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18.	Covered – $20 copay 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%
Chiropractic Spinal Manipulation – when referred	Covered – $20 copay after deductible; up to 30 visits per calendar year
Outpatient Physical, Speech and Occupational Therapy – subject to meaningful improvement within 60 days	Covered – $20 copay after deductible; limited to 60 visits for any combination of therapies per medical episode
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%
Prosthetic and Orthotic Appliances	Covered – 100%
Diabetic Supplies	Covered – 100%
Prescription Drugs	Tier 1 - $5 copay, Tier 2 - $20 copay, Tier 3 – $30 copay; 30-day supply.
	Sexual Dysfunction drugs – 50% coinsurance
	Tier 1A female contraceptives and other preventive medications are covered in full.
Mail Order Prescription Drugs	Tier 1 - $10 copay, Tier 2 - $40 copay, Tier 3 – $60 copay; up to a 90-day supply.