Blue Care Network of Michigan

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

Healthy *Blue* Living℠ HMO $500

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 and/or copay amounts required by the plan. 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.

Preauthorization for Select Services - Services listed in this summary 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.***

Healthy Blue Living subscribers must complete program requirements within the first 90 days of enrollment or re-enrollment. To qualify for or maintain enhanced benefits, the subscriber needs to complete a health assessment and qualification form during the first 90 days and follow their primary care physician's recommendations for a healthy lifestyle. If a tobacco user, must enroll in the BCN-sponsored tobacco cessation program within 120 days of the start of the plan year. If BMI is greater than or equal to 30, must select and begin participating in a weight management program within 120 days of the start of the plan year.

	Enhanced Benefits	**Standard Benefits**
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 member/$1,000 per family per calendar year	$1,250 per member/$2,500 per family per calendar year
Fixed dollar copays **Note:** If you have a deductible, the deductible must be met first for certain services as listed below.	$20 for office visits, $20 for medical online visits, $30 for specialist visits, $35 for urgent care visits, $250 for emergency room visits, $150 for high tech imaging, $5 for allergy injections	$30 for office visits, $30 for medical online visits, $40 for specialist visits, $50 for urgent care visits, $250 for emergency room visits, $150 for high tech imaging, $5 for allergy injections
Coinsurance	0% and 50% for select services as noted below	20% and 50% for select services as noted below
Annual Coinsurance Maximum - The following services DO NOT apply to the Annual Coinsurance Maximum if they are included in your coverage: • Deductible amounts • Services with a flat dollar copay • Infertility services • Male Mastectomy • Reduction Mammoplasty • Male Sterilization • Elective Abortion • TMJ • Orthognathic Surgery • Weight Reduction procedures • Durable Medical Equipment • Prosthetics and Orthotics • Diabetic Supplies	None	$2,500 per member/$5,000 per family per calendar year
Annual out-of-pocket maximums - applies to deductibles, copays and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts	$8,150 per member/$16,300 per family	$8,150 per member/$16,300 per family

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	Enhanced Benefits	Standard Benefits
Preventive Services - as defined by the Affordable Care Act and included in your Certificate of Coverage		
Health Maintenance Exam	Covered - 100%	Covered - 100%
Annual Gynecological Exam	Covered - 100%	Covered - 100%
Pap Smear Screening - laboratory services only	Covered - 100%	Covered - 100%
Well-Baby and Child Care	Covered - 100%	Covered - 100%
Immunizations - pediatric and adult	Covered - 100%	Covered - 100%
Prostate Specific Antigen (PSA) Screening - laboratory services only	Covered - 100%	Covered - 100%
Routine Colonoscopy	Covered - 100%	Covered - 100%
Mammography Screening	Covered - 100%	Covered - 100%
Voluntary Female Sterilization	Covered - 100%	Covered - 100%
Breast Pumps	Covered - 100%	Covered - 100%
Maternity Pre-Natal Care	Covered - 100%	Covered - 100%
Physician Office Services		
PCP Office Visits **Note:** Applicable cost sharing applies when other services are received in the office	Covered - $20 copay	Covered - $30 copay
Medical Online Visits	Covered - $20 copay	Covered - $30 copay
Consulting Specialist Care - when referred for other than preventive services **Note:** Applicable cost sharing applies when other services are received in the office	Covered - $30 copay	Covered - $40 copay
Emergency Medical Care		
Hospital Emergency Room - copay waived if admitted	Covered - $250 copay after deductible	Covered - $250 copay after deductible
Urgent Care Center	Covered - $35 copay	Covered - $50 copay
Retail Health Clinic	Covered - $35 copay	Covered - $50 copay
Ambulance Services - medically necessary	Covered - 100% after deductible	Covered - 80% after deductible
Diagnostic Services		
Laboratory and Pathology Tests	Covered - 100%	Covered - 100%
Diagnostic Tests and X-rays	Covered - 100% after deductible	Covered - 80% after deductible
High Technology Imaging (MRI, CAT, PET)	Covered - $150 copay after deductible	Covered - $150 copay after deductible
Radiation Therapy	Covered - 100% after deductible	Covered - 80% after deductible

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	Enhanced Benefits	Standard Benefits
Maternity Services Provided by a Physician		
Post-Natal Care. See Preventive Services section for Pre-Natal Care	Covered - $20 copay	Covered - $30 copay
Delivery and Nursery Care	Covered - 100% after deductible for professional services; see Hospital Care for facility charges	Covered - 100% after deductible for professional services; see Hospital Care for facility charges
Hospital Care		
General Nursing Care, Hospital Services and Supplies	Covered - 100% after deductible; unlimited days	Covered - 80% after deductible; unlimited days
Outpatient Surgery - See member certificate for select surgical coinsurance	Covered - 100% after deductible	Covered - 80% after deductible
Alternatives to Hospital Care		
Skilled Nursing Care	Covered - 100% after deductible up to 45 days per calendar year	Covered - 80% after deductible up to 45 days per calendar year
Hospice Care	Covered - 100% after deductible when authorized	Covered - 100% after deductible when authorized
Home Health Care	Covered - $30 copay after deductible	Covered - $40 copay after deductible
Surgical Services		
Surgery - includes all related surgical services and anesthesia.	Covered - 100% after deductible	Covered - 80% after deductible
Voluntary Male Sterilization - See Preventive Services section for voluntary female sterilization	Covered - 50% after deductible	Covered - 50% after deductible
Elective Abortion (One procedure per two year period of membership)	Covered - 50% after deductible	Covered - 50% after deductible
Human Organ Transplants (subject to medical criteria)	Covered - 100% after deductible	Covered - 80% after deductible
Reduction mammoplasty (subject to medical criteria)	Covered - 50% after deductible	Covered - 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered - 50% after deductible	Covered - 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered - 50% after deductible	Covered - 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered - 50% after deductible	Covered - 50% after deductible
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	Covered - 50% after deductible	Covered - 50% after deductible
Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)		
Inpatient Mental Health Care	Covered - 100% after deductible	Covered - 80% after deductible
Residential Substance Use Disorder	Covered - 100% after deductible	Covered - 80% after deductible
Outpatient Mental Health Care **Note:** For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing. Includes onlines visits.	Covered - $20 copay	Covered - $30 copay
Outpatient Substance Use Disorder	Covered - $20 copay	Covered - $30 copay

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	Enhanced Benefits	Standard Benefits
Autism Spectrum Disorders, Diagnoses and Treatment		
Applied behavioral analyses (ABA) treatment through age 18 **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCN approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - $20 copay	Covered - $30 copay
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18 Unlimited visits for physical, speech and occupational therapy with autism spectrum disorder diagnosis	Covered - $30 copay after deductible	Covered - $40 copay after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visits and preventive benefit	See your outpatient mental health, medical office visits and preventive benefit
Other Services		
Allergy Testing and serum	Covered - 50% after deductible	Covered - 50% after deductible
Allergy office visits	Covered - 50%	Covered - 50%
Allergy Injections	Covered - $5 copay	Covered - $5 copay
Chiropractic Spinal Manipulation - when referred	Covered - $30 copay; up to 30 visits per calendar year	Covered - $40 copay; up to 30 visits per calendar year
Outpatient Therapy/Rehabilitation - subject to meaningful improvement within 60 days	Covered - $30 copay after deductible after deductible; limited to 60 visits per calendar year for any combination of therapies	Covered - $30 copay after deductible after deductible; limited to 60 visits per calendar year for any combination of therapies
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered - 50% after deductible on all associated costs	Covered - 50% after deductible on all associated costs
Durable Medical Equipment	Covered - 50%	Covered - 50%
Prosthetic and Orthotic Appliances	Covered - 50%	Covered - 50%
Diabetic Supplies **Note:** Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable prescription drug cost-sharing will apply.	Covered - 100% after deductible	Covered - 80% after deductible
	CLSSLG, D500, WDRPOV, 8150PM, CO20, 30RP, ER250, UR35, AMB25, IMG150, DSRCW, VACR50, FOCUS	CLSSLG, D1250, WDRPOV, CI20%, 25ECM, 8150PM, CO30, 40RP, ER250, UR50, IMG150, DSR20%, VACR50, FOCUS

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Benefits-at-a-Glance for Healthy Blue Living℠
Prescription Drug Coverage

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Prescription Drugs	Enhanced	Standard
Tier 1A – Value Generics	$4 Copayment	$6 Copayment
Tier 1B - Generics	$15 Copayment	$25 Copayment
Tier 2 – Preferred Brand Drugs	$40 Copayment	$50 Copayment
Tier 3 – Non-Preferred Drugs	$80 Copayment	$80 Copayment
Tier 4 – Preferred Specialty	20% Coinsurance of the BCN Approved Amount (Maximum Copayment $200) - Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.	
Tier 5 Non-Preferred Specialty	20% Coinsurance of the BCN Approved Amount (Maximum Copayment $300) - Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.	
Sexual Dysfunction Drugs	50% Coinsurance of the BCN Approved Amount	
Contraceptives **Note:** Your cost sharing may be waived for Tier 1B, Tier 2 or Tier 3 contraceptive drugs if there are no appropriate generic products or preferred drugs available.	• Tier 1A – Covered in Full • Tier 1B – $15 Copay • Tier 2 - $40 Copay • Tier 3 - $80 Copay	• Tier 1A – Covered in Full • Tier 1B - $25 Copay • Tier 2 - $50 Copay • Tier 3 - $80 Copay
Preventive Medications	Covered in Full	Covered in Full
Diabetic Supplies	Select diabetic supplies and equipment are covered – applicable cost sharing will apply. Cost-sharing may not apply to certain preferred glucometers as defined on the drug list.	
31-90 day supply for Mail-Order Pharmacy	Three times applicable copay minus $10	
84-90 day supply for Retail Pharmacy	Three times applicable copay minus $10	
Out-of-Pocket Maximum	Your medical out-of-pocket maximum is integrated with your BCN covered Prescription Drugs. The out-of-pocket maximum amount is listed with your medical benefits. **Note:** When a manufacturer coupon is used through the BCN high cost drug discount program, the amount paid after the discount applies toward the out- of-pocket maximum.	

Definitions

Brand Name Drug	Manufactured and marketed under a registered trade name and trademark. • Multi-source Brand Name Drug: a drug that is available from a brand name manufacturer and also has a generic version. • Single Source Brand Name Drug: the drug can only be produced by the company holding the patent; no generics are available.
Generic Drugs	Prescription drugs that have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark.
Non-Preferred Drugs	Prescription drugs that may not have a proven record for safety or their clinical record may not be as high as the BCN preferred alternatives.
Non-Preferred Specialty Drugs	Specialty drugs that may not have a proven record for safety or their clinical value may not be as high as the Specialty Drugs.
Out-of-Pocket Maximum	The highest amount of money you have to pay for covered services during the Calendar Year.
Preferred Brand Drugs	Prescription drugs that are Single Source Brand drugs that have a proven record for safety and effectiveness.
Preferred Specialty Drugs	Generic or Single Source Brand Specialty drugs that have a proven record for safety and effectiveness and offer the best value to our members.
Value Generic Drugs	Prescription drugs that have a proven clinical value essential for treatment of chronic conditions.

Enhanced: P415CL, 90D3X; Standard: P625CL, 90D3X