Blue Care Network of Michigan

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

# Benefits-at-a-Glance

## HDHPLG

## 00239393 MONTCALM COMMUNITY COLLEGE

## Effective Date: 07/01/2020

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, 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 for fully insured plans.

**Services must be provided or arranged by the 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 bcbsm.com/importantinfo. Select** *Approving covered services.*

## Deductible, Copays and Dollar Maximums

| | |
|---|---|
| Deductible - Combined for both medical and drug coverage. | $1,400 for a one-person contract/$2,800 for a family contract (2 or more members) each benefit year (no 4th quarter carry-over) |

| | |
|---|---|
| | Deductible - The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract |
| Fixed Dollar Copays | None |
| Coinsurance | 50% for select services as noted below |
| Out of Pocket Maximum | $2,350 for a one-person contract. $4,700 for a family contract (2 or more members) each benefit year |
| | Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays |

Benefits Selected - HDHPLG : 1400HD,H1536D,1400HD,2350OM,2350OM,1400HD,2350OM,P136HD,90D3X,BENYR

| Preventive Services | |
|---|---|
| Health Maintenance Exam | 100% |
| Annual Gynecological Exam | 100% |
| Pap Smear Screening | 100% |
| Well-Baby and Child Care | 100% |
| Immunizations | 100% |
| Prostate Specific Antigen (PSA) Screening | 100% |
| Routine Colonoscopy | 100% |
| Mammography Screening | 100% |
| Voluntary Female Sterilization | 100% |
| Breast Pumps (DME guidelines apply.) | 100% |
| Maternity Pre-Natal care | 100% |

| Physician Office Services | |
|---|---|
| PCP Office Visits | 100% after deductible. Deductible does not apply to preventive services and routine maternity care |
| Medical Online Visits | 100% after deductible. Deductible does not apply to preventive services and routine maternity care |
| Consulting Specialist Care | 100% after deductible. Deductible does not apply to preventive services and routine maternity care |

| Emergency Medical Care | |
|---|---|
| Hospital Emergency Room | 100% after deductible |
| Urgent Care Center | 100% after deductible |
| Retail Health Clinic | 100% after deductible |
| Ambulance Services | 100% after deductible |

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

| Maternity Services Provided by a Physician | |
|---|---|
| Post-Natal and Non-routine Pre-Natal Care (See Preventive Services section for routine Pre-Natal Care) | 100% (Deductible applies for non-routine maternity care) |
| Delivery and Nursery Care | 100% after deductible |

| Hospital Care | |
|---|---|
| General Nursing Care, Hospital Services and Supplies | 100% after deductible |
| Outpatient Surgery | 100% after deductible |

| Alternatives to Hospital Care | |
|---|---|
| Skilled Nursing Care | 100% after deductible |
| | Up to 45 days per benefit year |
| Hospice Care | 100% after deductible |
| Home Health Care | 100% after deductible |

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| Surgical Services | |
|---|---|
| Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays. | 100% after deductible |
| Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization | Male - 50% after deductible |
| Elective Abortion (One procedure per two year period of membership) | Not Covered |
| Human Organ Transplants | 100% after deductible |
| Reduction Mammoplasty | 50% after deductible |
| Male Mastectomy | 50% after deductible |
| Temporomandibular Joint Syndrome | 50% after deductible |
| Orthognathic Surgery | 50% after deductible |
| Weight Reduction Procedures | 50% after deductible |

| Behavioral Health Services (Mental Health and Substance Use Disorder Treatment) | |
|---|---|
| Inpatient Mental Health Care | 100% after deductible |
| Inpatient Substance Use Disorder | 100% after deductible |
| Outpatient Mental Health Care includes online visits Note: For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing. | 100% after deductible |
| Outpatient Substance Use Disorder | 100% after deductible |

| Autism Spectrum Disorders, Diagnoses and Treatment | |
|---|---|
| Applied Behavioral analysys (ABA) treatment | 100% after deductible |
| Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis. | 100% after deductible |
| Other covered services, including mental health services, for Autism Spectrum Disorder | See your outpatient mental health, medical office visit and preventive benefit. |

| Other Services | |
|---|---|
| Allergy Testing and Therapy | 100% after deductible |
| Allergy Injections | 100% after deductible |
| Chiropractic Spinal Manipulation - when referred | 100% after deductible |
| | (up to 30 visits per benefit year) |
| Outpatient Physical, Speech and Occupational Therapy | 100% after deductible |
| | One period of treatment for any combination of therapies within 60 consecutive days per benefit year. NOTE: Effective 1/1/20 - the limit will be updated to 60 visits per benefit year for any combination of outpatient rehabilitation therapies. |
| Infertility Counseling and Treatment (Excludes In-vitro fertilization) | 50% after deductible |
| Durable Medical Equipment | 50% after deductible |
| Prosthetic and Orthotic Appliances | 50% after deductible |
| Diabetic Supplies | 100% after deductible |
| Hearing Aid | Hearing aid evaluation and monaural hearing aid covered every 36 months up to a $1,500 benefit maximum. |

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## Prescription Drugs

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|---|---|
| Prescription Drugs | Tier 1A - $10 after ded, Tier 1B - $30 copay after ded, Tier 2 - $60 copay after ded, Tier 3 - $80 copay after ded, Tier 4 - 20% coinsurance after ded (Max $200), Tier 5 - 20% coinsurance after ded (Max $300) |
| | Sexual Dysfunction drugs - 50% coinsurance after deductible |
| | Contraceptives – T1A- 100% (deductible does not apply), Tier 1B - $30 after deductible, T2 - $60 after deductible, T3-$80 after deductible; 30 day supply |
| Mail Order Prescription Drugs | 30 day supply or less - applicable tiered copay/coinsurance, 31-90 day supply - 3x's the 30 day copay/coinsurance minus $10 after deductible |
| Prescription Drug Deductible | Prescription drug deductible integrated with the medical deductible |
| | Effective 1/1/20 -Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs |

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| | | | |
|---|---|---|---|
| Medical | 0000G334 | 4ZG5 | MED |
| Pharmacy | 0000G354 | 4ZX3 | |
| Hearing | 0000G387 | 0068 | MED |

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