BEPLG

Michigan Catholic Conference Employee

	BCN NETWORK	OUT OF NETWORK

Note: The **Deductible** will apply to certain services as defined below.

Deductible, Copays and Dollar Maximums

Deductible	$100 per member/$300 per family of 3 or more per calendar year	$500 per member/$1,500 per family of 3 or more per calendar year
	*Note- Members with a family contract of 2 will never each pay more than the individual deductible.	
Fixed Dollar Copays:		
	$20 for PCP office visits	No fixed dollar copay for office visits. See below for applicable coinsurance.
	$35 for urgent care visits	$35 for urgent care visits
	$150 for emergency room visits	$150 for emergency room visits
	$50 for ambulance service	$50 for ambulance service
	$35 for specialist visits	No fixed dollar copay for specialist office visits. See below for applicable coinsurance.
	No fixed dollar copay for high tech imaging	No fixed dollar copay for high tech imaging
Coinsurance	20% and 50% for selected services as noted below	20% and 50% for selected services as noted below
Out-of-Pocket Maximums – applies to deductibles, copays and coinsurance amounts for covered medical and pharmacy services	$1,000 per member/$3,000 per family per calendar year	$3,000 per member/$9,000 per family per calendar year
	*Note- Members with a family contract of 2 will never each pay more than the individual out-of-pocket maximum.	

Preventive Services

Health Maintenance Exam	100%	Not Covered
Annual Gynecological Exam	100%	Not Covered
Pap Smear Screening	100%	Not Covered
Well-Baby and Child Care	100%	Not Covered
Immunizations	100%	Not Covered
Prostate Specific Antigen (PSA) Screening	100%	Not Covered
Routine Colonoscopy	100%	80% of the allowed amount after deductible
Mammography Screening	100%	80% of the allowed amount after deductible
Voluntary Female Sterilization	Not Covered	Not Covered
Breast Pumps (DME guidelines apply.)	100%	Not Covered
Maternity Pre-Natal care	100%	80% of the allowed amount after deductible
Female contraceptive counseling and methods	Not Covered	Not Covered

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Physician Office Services		
PCP Office Visits - Note: Applicable cost sharing applies when other services are received in the office.	$20 Copay	80% of the allowed amount after deductible
Online Visits	$20 Copay	80% of the allowed amount after deductible
Consulting Specialist Care - Note: Applicable cost sharing applies when other services are received in the office.	$35 Copay	80% of the allowed amount after deductible
Emergency Medical Care		
Hospital Emergency Room - Copay waived if admitted	$150 Copay	$150 Copay
Urgent Care Center	$35 Copay	$35 Copay
Retail Health Clinic	$35 Copay	$35 Copay
Ambulance Services	$50 Copay ground and air services	$50 Copay ground and air services
Diagnostic Services		
Laboratory and Pathology Services	100%	100% of the allowed amount
Diagnostic Tests and X-rays	80% after deductible	80% of the allowed amount after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	80% after deductible	80% of the allowed amount after deductible
Radiation Therapy	80% after deductible	80% of the allowed amount 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)	$20 Copay	80% of the allowed amount after deductible
Delivery and Nursery Care	80% after deductible	80% of the allowed amount after deductible
Hospital Care		
General Nursing Care, Hospital Services and Supplies	80% after deductible when authorized, unlimited days	80% of the allowed amount after deductible when authorized, unlimited days
Outpatient Facility Services	80% after deductible when authorized, unlimited days	80% of the allowed amount after deductible

	BCN NETWORK	OUTOFNETWORK
Alternatives to Hospital Care		
Skilled Nursing Care	80% after deductible when authorized	80% of the allowed amount after deductible
	Up to 120 days per calendar year combined for in and out-of-network	
Hospice Care	100% after deductible	80% of the allowed amount after deductible
Home Health Care	100% after deductible	80% of the allowed amount after deductible

Surgical Services		
Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	See Hospital Care for surgical copay	See Hospital Care for surgical copay
Voluntary Male Sterilization - See Preventive Services section for voluntary female sterilization	Not Covered	Not Covered
Elective Abortion (One procedure per two year period of membership)	Not Covered	Not Covered
Human Organ Transplants	80% after deductible	80% of the allowed amount after deductible
Reduction Mammoplasty	50% after deductible	50% of the allowed amount after deductible
Male Mastectomy	50% after deductible	50% of the allowed amount after deductible
Temporomandibular Joint Syndrome	50% after deductible	50% of the allowed amount after deductible
Orthognathic Surgery	50% after deductible	50% of the allowed amount after deductible
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	50% after deductible	Not Covered

Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)		
Inpatient Mental Health Care	80% after deductible when authorized	80% of the allowed amount after deductible
Inpatient Substance Use Disorder	80% after deductible when authorized	80% of the allowed amount 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.	$20 Copay	80% of the allowed amount after deductible
Outpatient Substance Use Disorder	$20 Copay	80% of the allowed amount after deductible

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Autism Spectrum Disorders, Diagnoses and Treatment		
Applied behavioral analyses (ABA) treatment	$20 Copay	80% of the allowed amount 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.	$35 Copay	80% of the allowed amount after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visit and preventive benefit.	See your outpatient mental health, medical office visit and preventive benefit.

Other Services		
Allergy Testing and Therapy	100% including allergy injections; office visit copay may apply	50% of the allowed amount, including allergy injections after deductible
Chiropractic Spinal Manipulation – limited to 24 visits per calendar year	$35 Copay	Not covered
Outpatient Therapy/Rehabilitation - subject to meaningful improvement within 60 days	$35 Copay	80% of the allowed amount after deductible
	Limited to 60 visits per calendar year for any combination of outpatient rehabilitative therapies for in and out-of-network combined	
Infertility Counseling	50% coinsurance after deductible	Not covered
Infertility Treatment	Not covered	Not covered

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Durable Medical Equipment (DME)	100%	Not covered
Prosthetic and Orthotic Appliances (P&O)	100%	Not covered
Diabetic Supplies Note: Certain diabetic supplies are covered through the pharmacy benefit. Applicable pharmacy cost-sharing will apply.	100%	Not covered
Gender Dysphoria Treatment	Not covered	Not covered
Hearing Aid	Binaural hearing aids and exam covered every 36 months – Covered 100%	
	Note: This Group is self-funded. Blue Care Network provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.	

Blue Care Network of Michigan

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	BCN NETWORK	OUT OF NETWORK
Prescription Drugs		
Prescription Drugs	**Preferred Drug List** Tier 1 - $10 copay, Tier 2 - $30 copay, Tier 3 - $50 copay; 30-day supply. Sexual Dysfunction Drugs-applicable tiered copay.	Not covered
	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.	Not covered
	Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs	Not covered
	Women's contraceptives including office administered are not covered.	
	Feminizing or masculinizing hormone therapy when prescribed for treatment of gender transition is not covered.	
Retail Prescription Drugs	Maintenance drugs: Must be filled at a Walgreens pharmacy after the initial two 30-day supply fills at any BCN participating retail pharmacy.	Not covered
	Non-maintenance drugs: 30-day retail supply can be filled at any BCN participating pharmacy. 84 to 90-day retail supply must be filled at a Walgreen pharmacy.	Not covered
Mail Order Prescription Drugs	Tier 1 - $20 copay, Tier 2 - $60 copay, Tier 3 - $100 copay; 90-day supply	Not covered
Prescription Drug Deductible	None	None

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.

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.*

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10305F, PDLR, SMT90W, MOPD2O, BCN2SF
HA2, BCN2SF

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