Blue Care Network of Michigan

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

# Benefits-at-a-Glance
# Healthy *Blue* Living SM
# 00126477 Western Michigan University
# Effective Date: 01/01/2024

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. **Services must be provided or arranged by 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 **https://bcbsm.com/priorauth**.

**Note:** Blue Care Network provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

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.

## Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

| Benefits | Enhanced | Standard |
|---|---|---|
| Deductible - Coinsurance and select fixed dollar copays apply (as defined by your plan documents), once the deductible has been met.<br>**Note:** The Deductible will apply to certain services as defined below. | $700 per member/$1,400 per family per calendar year | $1,600 per member/$3,200 per family per calendar year |
| Fixed Dollar Copays | $5 for allergy injections<br>$25 copay for office visits<br>$40 for referral physician office visits<br>$40 for urgent care visits<br>$150 for emergency room visits | $5 for allergy injections<br>$35 copay for office visits<br>$65 for referral physician visits<br>$65 for urgent care visits<br>$150 for emergency room visits |
| Coinsurance | 50% for select services as noted below<br>10% for select services as noted below | 50% for select services as noted below<br>30% for select services as noted below |
| Coinsurance Maximum | None | None |
| Out of Pocket Maximum - Includes deductible, copays, and coinsurance amounts for all covered services. | $1,700 per member/$3,400 per family per calendar year | $3,400 per member/$6,800 per family per calendar year |

## Preventive services

| Benefits | Enhanced | Standard |
|---|---|---|
| Health Maintenance Exam | 100% | 100% |
| Annual Gynecological Exam | 100% | 100% |
| Pap Smear Screening - laboratory services only | 100% | 100% |
| Well-Baby and Well-Child Visits | 100% | 100% |
| Immunizations | 100% | 100% |
| Prostate Specific Antigen (PSA) Screening - laboratory services only | 100% | 100% |
| Routine Colonoscopy | 100% | 100% |
| Mammography Screening | 100% | 100% |
| Voluntary Sterilization of Female Reproductive Organs | 100% | 100% |
| Breast Pumps (DME guidelines apply) | 100% | 100% |
| Routine Maternity Prenatal and Postnatal Care | 100% | 100% |

## Physician office services

| Benefits | Enhanced | Standard |
|---|---|---|
| PCP Office Visits<br>**Note:** Applicable cost sharing applies when other services are received in the office | $25 copay | $35 copay |
| Medical Online Visits - when performed by a BCN participating provider<br>**Note:** Not all services delivered virtually are considered an online visit but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided. | $25 copay - Online visits with the BCN online vendor are not covered. | $35 copay - Online visits with the BCN online vendor are not covered. |
| Consulting Specialist Care - when referred for other than preventive services<br>**Note:** Applicable cost sharing applies when other services are received in the office | $40 copay after deductible | $65 copay after deductible |

## Emergency medical care

| Benefits | Enhanced | Standard |
|---|---|---|
| Hospital Emergency Room - copay waived if admitted as inpatient | $150 Copay after deductible | $150 Copay after deductible |
| Urgent Care Center | $40 Copay after deductible | $65 Copay after deductible |
| Retail Health Clinic | $40 Copay after deductible | $65 Copay after deductible |
| Ambulance Services - medically necessary | 90% after deductible | 70% after deductible |

## Diagnostic services

| Benefits | Enhanced | Standard |
|---|---|---|
| Laboratory and Pathology Tests | 100% | 100% |
| Diagnostic Tests and X-rays | 90% after deductible | 70% after deductible |
| High Technology Radiology Imaging (MRI, MRA, CAT, PET) | 90% after deductible | 70% after deductible |
| Radiation Therapy | 90% after deductible | 70% after deductible |

## Maternity services provided by a physician

| Benefits | Enhanced | Standard |
|---|---|---|
| Routine Prenatal and Postnatal Care Visits | 100% | 100% |
| Delivery and Nursery Care - professional services (see "Hospital Care" for facility charges) | 100% after deductible | 100% after deductible |

## Hospital care

| Benefits | Enhanced | Standard |
|---|---|---|
| General Nursing Care, Hospital Services and Supplies | 90% after deductible | 70% after deductible |
| Outpatient Surgery | 90% after deductible | 70% after deductible |

## Alternatives to hospital care

| Benefits | Enhanced | Standard |
|---|---|---|
| Skilled Nursing Care | 90% after deductible<br>Up to 45 days per member per calendar year | 70% after deductible<br>Up to 45 days per member per calendar year |
| Hospice Care | 100% after deductible | 100% after deductible |
| Home Health Care | $40 copay after deductible | $65 copay after deductible |

## Surgical services

| Benefits | Enhanced | Standard |
|---|---|---|
| Surgery - includes all related surgical services and anesthesia | 90% after deductible | 70% after deductible |
| Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs | 50% after deductible | 50% after deductible |
| Elective Abortion (One procedure per two-year period of membership) | Not covered | Not covered |
| Human Organ Transplants (subject to medical criteria) | 90% after deductible | 70% after deductible |
| Reduction Mammoplasty (subject to medical criteria) | 50% after deductible | 50% after deductible |
| Male Mastectomy (subject to medical criteria) | 50% after deductible | 50% after deductible |
| Temporomandibular Joint Syndrome (subject to medical criteria) | 50% after deductible | 50% after deductible |
| Orthognathic Surgery (subject to medical criteria) | 50% after deductible | 50% after deductible |
| Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime | 50% after deductible | 50% after deductible |

## Behavioral health services (mental health and substance use disorder treatment)

| Benefits | Enhanced | Standard |
|---|---|---|
| Inpatient Mental Health Care | 90% after deductible | 70% after deductible |
| Residential Substance Use Disorder | 90% after deductible | 70% after deductible |

## Behavioral health services (mental health and substance use disorder treatment) (continued)

| Benefits | Enhanced | Standard |
|---|---|---|
| Outpatient Mental Health Care includes online and telemedicine visits<br>**Note:** For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing. | $25 Copay | $35 copay |
| Outpatient Substance Use Disorder | $25 Copay | $35 copay |

## Autism spectrum disorders, diagnoses and treatment

| Benefits | Enhanced | Standard |
|---|---|---|
| Applied behavioral analysis (ABA) treatment<br>**Note:** Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC) | $25 copay | $35 copay |
| Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis. | $40 copay after deductible | $65 copay 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

| Benefits | Enhanced | Standard |
|---|---|---|
| Allergy Testing and Therapy | 50% after deductible | 50% after deductible |
| Allergy Office Visits | 50% after deductible | 50% after deductible |
| Allergy Injections | $5 copay | $5 copay |
| Chiropractic Spinal Manipulation - when referred | $40 copay after deductible<br>Limited to 30 visits per calendar year | $65 copay after deductible<br>Limited to 30 visits per calendar year |
| Outpatient Physical, Speech and Occupational Therapy - subject to meaningful improvement within 60 days | $40 copay after deductible<br>One period of treatment for any combination of outpatient rehabilitation therapies within 60 consecutive days per calendar year. | $65 copay after deductible<br>One period of treatment for any combination of outpatient rehabilitation therapies within 60 consecutive days per calendar year. |
| Infertility Counseling and Treatment | 50% (excludes in-vitro fertilization) after deductible | 50% (excludes in-vitro fertilization) after deductible |
| Durable Medical Equipment | 100% | 100% |
| Diabetic Supplies<br>**Note:** Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable prescription drug cost-sharing will apply. | 100% | 70% |
| Enhanced Condition Management | Coverage for Enhanced Condition Management Program(s) can be seen in your online account at: https://member.bcbsm.com/mpa/res | Coverage for Enhanced Condition Management Program(s) can be seen in your online account at: https://member.bcbsm.com/mpa/re |

## Other services (continued)

| Benefits | Enhanced | Standard |
|---|---|---|
| | ponsive/#/HealthAndWellBeing | sponsive/#/HealthAndWellBeing |
| Prosthetic and Orthotic Appliances | 100% | 100% |
| Hearing Aid | Not covered | Not covered |

## Prescription drugs

| Benefits | Enhanced | Standard |
|---|---|---|
| Generic Tier | $10 copay | $20 copay |
| Preferred Brand Tier | $40 copay | $60 copay |
| Nonpreferred Brand Tier | $80 copay | $80 copay |
| Preferred Specialty Tier | 20% coinsurance (max copay $100/prescription). Applies to the Specialty Drug Annual Coinsurance Max of $2,400 per member per calendar year. | 20% coinsurance (max $450) |
| Nonpreferred Specialty Tier | 20% coinsurance (max $200 per prescription). Applies to the Specialty Drug Annual Coinsurance Max of $2,400 per member per calendar year. | 20% coinsurance (max $600) |
| Contraceptives | Women's Contraceptives: Generic - 100%, Preferred Brand - $40 copay, Nonpreferred Brand - $80 copay | Women's Contraceptives: Generic - 100%, Preferred Brand - $60 copay, Nonpreferred Brand - $80 copay |
| Drugs for the Treatment of Sexual Dysfunction | 50% coinsurance | 50% coinsurance |
| Mail Order Prescription Drugs | One time the applicable copay up to a 90-day supply | One time the applicable copay up to a 90-day supply |
| Specialty Drug Pharmacy | Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs | Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs |
| Variable Cost Share Coupon Program | Your plan includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum. | Your plan includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum. |
| 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. | 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. |
| Prescription Drug Deductible | None | None |

For Internal Purposes Only
Enhanced Benefits: CLSLGF : 1040CSF,1700MF,40RPF,ASDF,CI10%F,CO25F,D7URF,DCCRMF,DME5F,DSRCWF,EDMP,ER150F,MOPD1F,OMRCF,P&O5F,RXVAR,UR40F
Standard Benefits: CLSLGF : 2068CSF,3400MF,65RPF,ASDF,CI30%F,CO35F,D16URF,DCCRMF,DME5F,DSR30F,EDMP,ER150F,MOPD1F,OMRCF,P&O5F,RXVAR,UR65F