Blue Care Network of Michigan

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

Benefits-at-a-Glance
Blue Elect Plus HSA℠ POS℠ $2,000/20%
Effective Date: 01/01/2027

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/or 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.

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 https://bcbsm.com/priorauth

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

Benefits	In Network	Out of Network
Deductible **Note:** The Deductible will apply to all services except preventive services	$2,000 per member, $4,000 per family per calendar year (no 4th quarter carry-over)	$4,000 per member, $8,000 per family per calendar year (no 4th quarter carry-over)
The deductible is combined for both medical and prescription drug coverage.	The deductible is aggregate. The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract.	
Coinsurance **Note:** Coinsurance applies once the deductible has been met	50% for select services as noted below 20% for select services as noted below	50% for select services as noted below 40% for select services as noted below
Coinsurance Maximum	None	None
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$4,000 per member, $8,000 per family per calendar year	$8,000 per member, $16,000 per family per calendar year
Out of Pocket Maximum Description	The out-of-pocket maximum is aggregate. For a two-person or family contract, one person on the contract can meet the entire family out-of-pocket maximum.	

Preventive services

Benefits	In Network	Out of Network
Health Maintenance Exam	100%	Not covered
Annual Gynecological Exam	100%	Not covered
Pap Smear Screening - laboratory services only	100%	Not covered

Well-Baby and Well-Child Visits	100%	Not covered
Immunizations	100%	Not covered
Prostate Specific Antigen (PSA) Screening - laboratory services only	100%	Not covered
Routine Colonoscopy	100%	60% after deductible
Mammography Screening	100%	60% after deductible
Voluntary Sterilization of Female Reproductive Organs	100%	Not covered
Breast Pumps (DME guidelines apply.)	100%	Not covered
Routine Maternity Prenatal and Postnatal Care	100%	60% after deductible

Physician office services

Benefits	In Network	Out of Network
PCP Office Visits	80% after deductible Michigan residents must select a BCN PCP	60% after deductible applies to out-of-network physicians
Medical Online Visits – when performed by a BCN participating provider or BCN designated online vendor **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.	80% after deductible	60% after deductible
Consulting Specialist Care	80% after deductible	60% after deductible

Emergency medical care

Benefits	In Network	Out of Network
Hospital Emergency Room	80% after deductible	80% after deductible
Urgent Care Center	80% after deductible	80% after deductible
Retail Health Clinic	80% after deductible	80% after deductible
Ambulance Services - medically necessary	80% after deductible	80% after deductible

Diagnostic services

Benefits	In Network	Out of Network
Laboratory and Pathology Tests	80% after deductible	60% after deductible
Diagnostic Tests and X-rays	80% after deductible	60% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	80% after deductible	60% after deductible
Radiation Therapy	80% after deductible	60% after deductible

Maternity services provided by a physician

Benefits	In Network	Out of Network
Routine Prenatal and Postnatal Care Visits	100%	60% after deductible
Delivery and Nursery Care	80% after deductible	60% after deductible

Hospital care

Benefits	In Network	Out of Network
General Nursing Care, Hospital Services and Supplies	80% after deductible	60% after deductible
Outpatient Surgery	80% after deductible	60% after deductible

Alternatives to hospital care

Benefits	In Network	Out of Network
Skilled Nursing Care	80% after deductible	60% after deductible
	Up to 45 days per calendar year	
Hospice Care	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible

Surgical services

Benefits	In Network	Out of Network
Surgery - included all related surgical services and anesthesia.	80% after deductible	60% after deductible
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	80% after deductible	Not covered
Elective Abortion services	Not Covered	Not Covered
Human Organ Transplants (subject to medical criteria)	80% after deductible	80% 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	Not covered

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

Benefits	In Network	Out of Network
Inpatient Mental Health Care	80% after deductible	60% after deductible
Residential Substance Use Disorder	80% after deductible	60% after deductible
Outpatient Mental Health Care includes online and telemedicine visits **Note:** For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	80% after deductible	60% after deductible
Outpatient Substance Use Disorder	80% after deductible	60% after deductible

Autism spectrum disorders, diagnoses and treatment

Benefits	In Network	Out of Network

Applied behavioral analysis (ABA) treatment **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)	80% after deductible	60% after deductible
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	80% after deductible	60% 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	In Network	Out of Network
Allergy Testing and Therapy	80% after deductible	60% after deductible
Allergy Injections	80% after deductible	60% after deductible
Chiropractic Spinal Manipulation	80% after deductible	Not covered
Chiropractic Spinal Manipulation Limit	Limited to 30 visits per calendar year	N/A
Outpatient Physical, Speech and Occupational Therapy - subject to meaningful improvement within 60 days	80% after deductible	60% after deductible
Outpatient Physical, Speech and Occupational Therapy Limit	60 visits per calendar year for any combination of outpatient rehabilitation therapies	
Infertility Counseling and Treatment	50% after deductible (excludes in-vitro fertilization)	Not covered
Durable Medical Equipment	50% after deductible	Not covered
Prosthetic and Orthotic Appliances	50% after deductible	Not covered
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. - Continuous glucose monitors and related supplies are covered only when obtained from the BCN designated exclusive vendor.	80% after deductible	Not covered
Hearing Aid	Not covered	Not covered

Prescription drugs

Benefits	In Network	Out of Network
Preferred Generic Tier	$4 copay after deductible	Not covered
Nonpreferred Generic Tier	$15 copay after deductible	Not covered
Preferred Brand Tier	$40 copay after deductible	Not covered
Nonpreferred Brand Tier	$80 copay after deductible	Not covered
Preferred Specialty Tier	20% coinsurance (Max $200) after	Not covered

	deductible	
Nonpreferred Specialty Tier	20% coinsurance (Max $300) after deductible	Not covered
Contraceptives	Women's Contraceptives - Preferred Generic - 100%, Non-Preferred Generic - $15 copay after deductible, Preferred Brand - $40 copay after deductible, Non-Preferred Brand - $80 copay after deductible	Not covered
Drugs for the Treatment of Sexual Dysfunction	50% coinsurance	Not covered
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	
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.	Not covered
Continuous Glucose Monitors	Continuous glucose monitors and related supplies are covered only when obtained from the BCN designated exclusive vendor.	Not covered
Specialty Drug Pharmacy	Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs	Not covered
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.	Not covered
Prescription Drug Deductible	Prescription drug deductible integrated with the medical deductible	None
Custom Drug List	The list of prescription drugs that have been approved by the U.S. Food and Drug Administration and approved by the BCBSM/BCN Pharmacy and Therapeutics Committee. The list represents the clinical judgment of Michigan physicians, pharmacists and other experts in the diagnosis and treatment of disease and promotion of health. Medications are selected based on clinical effectiveness, safety and opportunity for cost savings. Some drugs included in the Custom Drug List require prior authorization and/or step therapy by BCN before they are covered. The drug list may be modified by BCN as needed to remove or add a covered drug or to modify the requirements for authorization of a covered drug. The list may be found at https://www.bcbsm.com/druglists	

Benefits Selected - BPHDLG, IN2KHD, ON4KHD, IN20CH, ON40CH, IN4KPM, ON8KPM, P415DL, 90D3X
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