



**Blue Care
Network
of Michigan**

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

Benefits-at-a-Glance

BCN1LG

00100181 FCA Bargaining Unit

Effective Date: 01/01/2026

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.

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

Benefits	
Deductible (Coinsurance and select fixed dollar copays as defined by your plan documents, apply once the deductible has been met.)	\$150 per member/\$300 per family per calendar year Any deductible paid during the current benefit year will not be carried over into the new benefit year.
Fixed Dollar Copays	\$25 for office visits \$25 for referral physician office visits \$10 copay for medical online visits \$50 for urgent care visits \$15 for retail health clinic visits \$100 for emergency room visits
Coinsurance Maximum	None
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	\$10,600 per member/\$21,200 per family per calendar year

Preventive services

Benefits	
Health Maintenance Exam	Covered 100%
Annual Gynecological Exam	Covered 100%
Pap Smear Screening - laboratory services only	Covered 100%
Well-Baby and Well Child-Care Visits	Covered 100%
Immunizations - pediatric and adult	Covered 100%
Prostate Specific Antigen (PSA) Screening - laboratory services only	Covered 100%

Routine Colonoscopy	Covered 100%
Mammography Screening	Covered 100%
Voluntary Sterilization of Female Reproductive Organs	Covered 100%
Breast Pumps (DME guidelines apply.)	Covered 100%
Routine Maternity Prenatal and Postnatal Care	Covered 100%

Physician office services

Benefits	
PCP Office Visits - Applicable cost sharing applies when other services are received in the office	\$25 copay
Medical Online Visits - when performed by a BCN participating provider 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.	\$10 copay - Online visits with the BCN online vendor are covered
Referral Physician Visits - when referred for other than preventive services Note: Applicable cost sharing applies when other services are received in the office	\$25 copay after deductible

Emergency medical care

Benefits	
Hospital Emergency Room - copay waived if admitted as inpatient	\$100 copay after deductible Emergency room copay waived if admitted for observation or as an inpatient.
Urgent Care Center	\$50 Copay
Retail Health Clinic	\$15 copay
Ambulance Services - medically necessary	Covered 100% after deductible

Diagnostic services

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

Maternity services provided by a physician

Benefits	
Routine Prenatal and Postnatal Care Visits	Covered 100%
Delivery and Nursery Care	Covered 100% for professional services. (See Hospital Care for facility charges) after deductible

Hospital care

Benefits	
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General Nursing Care, Hospital Services and Supplies	100% after deductible
Outpatient Surgery - see member certificate for select surgical coinsurance	Covered 100% after deductible

Alternatives to hospital care

Benefits	
Skilled Nursing Care	Covered 100% after deductible
Skilled Nursing Care Limit	Unlimited days
Hospice Care	Covered 100% after deductible
Home Health Care	Covered 100% after deductible

Surgical services

Benefits	
Surgery - includes all related surgical services and anesthesia.	Covered 100% after deductible
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services section for voluntary sterilization of female organs	Covered 100% after deductible
Elective Abortion Services	Covered 100% after deductible
Elective Abortion Coverage Limit	Limited to one procedure per two-year period of membership. Note: Abortions are not covered if rendered in a location where abortion is not legal.
Human Organ Transplants (subject to medical criteria)	Covered 100% after deductible
Reduction Mammoplasty (subject to medical criteria)	Covered 100% after deductible
Male Mastectomy (subject to medical criteria)	Covered 100% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered 100% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered 100% after deductible
Weight Reduction Procedures (subject to medical criteria)	Covered 100% after deductible

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

Benefits	
Inpatient Mental Health Care	Covered 100% after deductible
Residential Substance Use Disorder	Covered 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.	\$25 copay
Outpatient Substance Use Disorder	\$25 copay

Autism spectrum disorders, diagnoses and treatment

Benefits	
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)	See your outpatient mental health care cost share

Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	Covered 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

Benefits

Allergy Testing and Therapy	Covered 100% after deductible
Allergy Injections	Covered 100%
Chiropractic Spinal Manipulation - when referred	\$25 copay after deductible
Outpatient Physical, Speech and Occupational Therapy	Covered 100% after deductible Limited to 60 visits per medical episode per plan year
Infertility Counseling and Treatment	Covered 100% (excludes in-vitro fertilization) after deductible
Durable Medical Equipment	Covered 100%
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%
Prosthetic and Orthotic Appliances	Covered 100% Prosthetic, orthotic and corrective appliances for unattached shoe inserts is covered 100% when medically necessary
Hearing Aid	One hearing aid and exam every 36 months. Binaural hearing aids and exam every 36 months for children under age 19 covered 100%
Travel Concierge	Coverage is included for a travel concierge for select services.

Prescription drugs

Benefits

Generic Tier	\$6 copay
Preferred Brand Tier	\$12 copay
Nonpreferred Brand Tier	Not covered
Contraceptives	Women's Contraceptives: Generic - 100%, Preferred Brand - \$12 copay, Nonpreferred Brand - Not covered
Drugs for the Treatment of Sexual Dysfunction	\$17 copay
Weight Loss Drugs	GLP-1 products for conditions other than diabetes are not covered.
Mail Order Prescription Drugs	Mail order 83-90 day supply Tier 1 - \$12 copay, Tier 2 - \$17 copay, Tier 3 - Not Covered, Sexual Dysfunction Drugs - \$21 copay Mail-Order required for maintenance drugs after the second filled prescription.
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.
Specialty Drug Pharmacy	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.
Prescription Drug 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

For Internal Purposes Only

Benefits Selected - BC1LGF :

1060MF,627MF,ASDF,D150F,D4QCXF,DCCRMF,ER100F,EROCWF,GLP1XF,GM25F,HA1F,MOPDMF,ONV10F,PDCMXF,PO1SIF,RHC15F,RXVAR,SNUF,TRVSF,UR50F,VACRF