



Benefits at a glance

January 1 through December 31, 2024

Out-of-pocket costs	
Out-of-pocket maximums	\$2,000 per individual/\$4,000 per family
Deductibles	\$125 <i>per member</i> /\$250 <i>per family</i>
Coinsurance	None
Copays	\$20 for office visits \$20 for urgent care visits \$20 for referral physician visits \$200 for emergency room (waived if admitted as inpatient)
The out-of-pocket maximums apply to in-network deductibles, fixed dollar and prescription drug copays. The deductible amounts renew annually with the start of the new plan year.	
Preventive services	
Health maintenance exam	Covered 100%
Annual gynecological exam	Covered 100%
Pap smear screening – laboratory services only ¹	Covered 100%
Well-baby and child care	Covered 100%
Immunizations, annual flu shot & Hepatitis C screening for those at risk	Covered 100%
Childhood Immunizations	Covered 100%
Fecal occult blood screening ¹	Covered 100%
Flexible sigmoidoscopy ¹	Covered 100%
Prostate specific antigen screening ¹	Covered 100%
Mammography, annual standard film or digital mammography screening ¹	Covered 100%
Colonoscopy ¹	Covered 100%
Physician office services	
Office visits, consultations and urgent care visits	Covered, \$20 copay
Outpatient and home visits	
Online visits (Blue Cross online tool - medical)	Covered, \$10 copay
Online visits (Blue Cross online tool - behavioral health/substance use)	Covered 100%
Online visits (Provider tool - medical)	Covered, \$20 copay
Online visits (Provider tool - behavioral health/substance use)	Covered 100%
Emergency medical care	
Hospital emergency room for medical emergency or accidental injury	Covered, \$200 copay (waived if admitted as inpatient)
Ambulance services – medically necessary	Covered 100% after deductible

¹Patient Protection and Affordable Care Act (PPACA) guidelines apply.

Diagnostic services	
Laboratory and pathology tests	Covered 100%
Diagnostic tests and x-rays	Covered 100% after deductible
Radiation therapy	
Maternity services provided by a physician	
Prenatal care	Covered 100%
Delivery and nursery care	Covered 100% after deductible
Postnatal care	Covered 100%
Hospital care	
Semi-private room, intensive care, inpatient physician care, general nursing care, hospital services and supplies. <i>Including plastic, cosmetic and reconstructive surgery to restore bodily function or to correct a deformity from disease, trauma, birth or growth defects, or prior therapeutic processes.</i>	Covered 100% after deductible (unlimited days)
Inpatient consultations	Covered 100% after deductible
Chemotherapy	
Alternatives to hospital care	
Home health care	Covered 100% after deductible, \$20 copay
Hospice care	Covered 100% after deductible (when authorized)
Private duty nursing	
Skilled nursing care	Covered 100% after deductible. (Up to 120 days per confinement. The confinement period renews after 90 consecutive days without skilled nursing facility care).
Surgical services	
Surgery – includes related surgical services	Covered 100% after deductible
Voluntary male sterilization	
Voluntary female sterilization	Covered 100%
Human Organ Transplants	
Liver, heart, lung, pancreas, and other specified organ transplants	Covered 100% after deductible (in designated facilities)
Bone marrow (specific criteria apply)	
Kidney, cornea, and skin	Covered 100% after deductible (Subject to medical criteria)
Autism spectrum disorders, diagnoses and treatment	
Applied Behavioral Analysis (ABA) treatment	Covered 100% after deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for Autism Spectrum Disorder	Covered, \$20 copay
Other covered services, including mental health services for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit.



Other services

Allergy testing and therapy (non-injection)	Covered 100% after deductible
Allergy injections	Covered 100%
Cardiac and Pulmonary Rehabilitation	\$20 copay (limited to 36 visits per plan year)
Chiropractic/spinal manipulation (when referred)	Covered 100% after deductible; \$20 copay
Durable medical equipment	Covered 100%
Hearing aids (limited to one every 36 months)	Covered for conventional standard hearing aids (Limited to one monaural with a max benefit of \$654, or one binaural with a max benefit of \$1,177)
Hearing care exam	Covered 100% (performed in physician's office, \$20 copay may apply)
Online tobacco cessation counseling	Covered 100%
Outpatient Physical, Speech and Occupational Therapy (90 visits per calendar year for any combination of mechanical traction and PT/OT/ST.	\$20 copay
Private duty nursing	Covered 100% after deductible (when authorized)
Prosthetic and orthotic appliances	Covered 100% (for prosthetic, orthotic and corrective appliances for unattached shoe inserts when medically necessary)
Rabies treatment after initial emergency room visit	Office visit: \$20 copay; Injections: Covered 100%
Wig, wig stand, adhesives	Covered 100% (for hair prosthesis (wig or hair piece) for hair loss due to a medical condition or the treatment of a medical condition. One per calendar year; max benefit \$225 per year)

Behavioral health services (Mental health and substance use disorder)

Inpatient mental health	Covered 100% after deductible (when authorized by BCN)
Inpatient substance use disorder	
Outpatient mental health	Covered 100% (when authorized by BCN)
Outpatient substance use disorder	

Prescription drugs

Prescription drug deductible	None	
Retail (30-day supply)	Tier 1: Generic	\$10 copay
	Tier 2: Preferred brand	\$30 copay
	Tier 3: Non-preferred brand	\$60 copay
Mail order (90-day supply)	Tier 1: Generic	\$20 copay
	Tier 2: Preferred brand	\$60 copay
	Tier 3: Non-preferred brand	\$120 copay

Questions?

Contact BCN's Customer Service Center toll-free at 1-800-662-6667



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