Blue Care Network

Benefits at a glance

Non-Medicare Retirees

January 1 through December 31, 2025

The deductible amounts renew annually with the start of the new plan year in January. The in-network out-of-pocket maximums apply to in-network deductibles, fixed dollar and prescription drug copays.

Out-of-pocket costs	
Deductible	$125 per individual/$250 per family
Copays	$20 for office visits $20 for urgent care visits $20 for referral physician visits $200 for emergency room (waived if admitted as inpatient)
Coinsurance	None
Annual coinsurance maximum	None
Out-of-pocket maximum – applies to deductibles, copays and coinsurance amounts for all covered services (medical and behavioral health/substance use disorder services)	$2,000 per individual/$4,000 per family
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	
Telemedicine visits (Blue Cross online tool – medical)	Covered, $10 copay
Telemedicine visits (Blue Cross online tool – behavioral health/substance use disorder)	Covered 100%
Online visits (provider tool – medical)	Covered, $20 copay
Online visits (provider tool – behavioral health/ substance use disorder)	Covered 100%

[1] *American Cancer Society guidelines apply.*

Emergency medical care	
Hospital emergency room for medical emergency or accidental injury	$200 copay (waived if admitted as inpatient)
Ambulance services – medically necessary	Covered 100% after deductible
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, $20 copay
Hospital care	
Semi-private room, intensive care, inpatient physician care, general nursing care, hospital services and supplies. *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.*	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	Up to 120 days per confinement. Confinement period renews after 90 consecutive days without skilled nursing facility care.
Surgical services	
Surgery – includes related surgical services	Covered 100% after deductible
Male Voluntary sterilization	
Female Voluntary 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%

Autism spectrum disorders, diagnoses and treatment continued		
Autism Spectrum Disorder	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%	
Chiropractic/spinal manipulation (when referred)	Covered 100% after deductible; $20 copay	
Durable medical equipment	Covered 100%	
Hearing aids (limited to one every 36 months, including binaural)		
Hearing care exam		
Online tobacco cessation counseling		
Outpatient Physical, Speech and Occupational Therapy (90 visits per calendar year for any combination of mechanical traction and PT/OT/ST. 36 visits per calendar year for cardiac and pulmonary rehab.)	$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	100% coverage 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	
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

Blue Cross
Blue Shield
Blue Care Network
of Michigan

Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

Learn more.

Website: **bcbsm.com/som**

Phone: BCN's Customer Service Center (toll-free): 1-800-662-6667

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