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Group Name / Group ID: WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE / 00009001
Sub Group Name / Sub Group ID: WAYNE STATE SCHOOL OF MEDICINE / 0001
Class ID: 0001
Plan Description: Medical Regular Member HMO Classic Group
Effective Date: 2023-07-01

Disclaimer: 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 certificate 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 benefit summary and any applicable plan documents, the plan document will control.

DEDUCTIBLE

$500 per individual; $1,000 per family deductible per calendar year

COINSURANCE MAXIMUM

This plan has no coinsurance maximum.

OUT-OF-POCKET MAXIMUM

$2,500 per individual; $5,000 per family out-of-pocket maximum per calendar year

ALLERGY OFFICE VISIT

50% coinsurance for allergy office visits

AMBULANCE EMERGENT

20% coinsurance after deductible for emergency ambulance transport when other transportation would endanger a member's life

AMBULANCE NON-EMERGENT

20% coinsurance after deductible for non-emergent ambulance transport. Requires prior authorization by BCN.

DETOX - SUB ABUSE

20% coinsurance after deductible for inpatient detox services. $30 copay per visit for outpatient detox services. Requires

prior authorization by BCN.

DURABLE MEDICAL EQUIPMENT

50% coinsurance for durable medical equipment. Must be preauthorizedand obtained from a BCN supplier. Breast pump to support breast feeding is covered in full.

EMERGENCY ROOM

$100 copay after deductible for emergency room treatment. ER copay waived if admitted as an inpatient. Your inpatient hospital benefit applies. See Inpatient Hospital.

HOME CARE VISITS

$30 copay after deductible per day for home care visits

INFERTILITY CARE (CRITERIA REQUIRED)

50% coinsurance after deductible for infertility services. Requires prior authorization by BCN. In-vitro fertilization is not covered.

INPATIENT HOSPITAL

20% coinsurance after deductible per inpatient hospital admission; unlimited days. See certificate for specific surgical coinsurance.

LAB

Lab and pathology services are covered in full.

MENTAL HEALTH INPATIENT

20% coinsurance after deductible for inpatient mental health/partial hospitalization per hospital admission. Requires prior authorization by BCN.

MENTAL HEALTH INPATIENT DAYS

Unlimited visits when medically necessary. Requires prior authorization by BCN Behavioral Health management.

MENTAL HEALTH INPATIENT TIME PERIOD

Coordinated by BCN Behavioral Health management

MENTAL HEALTH OUTPATIENT

$30 copay per visit for outpatient/intensive outpatient mental health Prior authorization not required for routine

psychotherapy visits.

MENTAL HEALTH OUTPATIENT VISITS

Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.

MENTAL HEALTH OUTPT ADDL VISITS

Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.

ORTHOGNATHIC SURGERY

50% coinsurance after deductible for orthognathic surgery

ORTHOTICS

50% coinsurance for orthotics. Must be preauthorized and obtained from a BCN supplier.

OUTPATIENT SURGERY FACILITY

20% coinsurance after deductible for outpatient surgery. Preventive services and screenings as mandated by the Affordable Care Act are covered in full. See certificate for specific surgical coinsurance.

OUTPT FAC VISITS/DIAGNOSTIC SRVCS

20% coinsurance after deductible for outpatient diagnostic or therapeutic services. Lab and pathology services, prenatal ultrasound, preventive services and screenings as mandated by the Affordable Care Act are covered in full.

PCP VISITS

$30 copay per primary care physician office visit. Preventive services and screenings as mandated by the Affordable Care Act are covered in full. See BCBSM.com for a complete list of preventive services. $30 copay per visit with a designated online BCN participating provider.

PHYSICAL THERAPY/REHAB OUTPT

$30 copay after deductible per outpatient rehabilitative and habilitative visit

PHYSICAL THERAPY/REHAB OUTPT LIMITS

One period of treatment for a combination of therapies within 90 consecutive days. Outpatient rehabilitation services are limited to 30 combined visits per calendar year for physical and occupational therapy and a separate 30 visit limit per calendar year for speech and cardiactherapy. Outpatient habilitative services are limited to 30 combinedvisits per calendar year for physical and occupational therapy and a separate 30 visit limit per calendar year for speech therapy.

PRE-EXISTING CONDITION

Not applicable

PRE-EXISTING TIME PERIOD

Not applicable

PROSTHETICS

50% coinsurance for prosthetics. Must be preauthorized and obtained from a BCN supplier.

SKILLED NURSING FACILITY

20% coinsurance after deductible for services in a skilled nursing facility

SKILLED NURSING FACILITY DAYS

Limited to 45 days of skilled nursing care per calendar year in a skilled nursing facility. Requires prior authorization by BCN.

SPECIALIST VISITS

$30 copay after deductible per specialist office visit when referred. Spinal manipulations limited to 30 combined visits per calendar yearwhen provided by a chiropractor or osteopathic physician. Preventiveservices and screenings as mandated by the Affordable Care Act are covered in full.

STERILIZATIONS

50% coinsurance after deductible for male sterilization. Female sterilization is covered in full.

SUB ABUSE INTERMEDIATE

20% coinsurance after deductible for inpatient partial hospitalization substance use disorder. Requires prior authorization by BCN Behavioral Health management.

SUB ABUSE INTERMEDIATE TIME PERIOD

Coordinated by BCN Behavioral Health management

SUB ABUSE OUTPATIENT

$30 copay per visit for outpatient/intensive outpatient substance usedisorder. Prior authorization not required for routine psychotherapy visits.

SUB ABUSE OUTPATIENT VISITS

Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.

TEMPOROMANDIBULAR JOINT

50% coinsurance after deductible for TMJ services. Requires prior authorization by BCN.

ELECTIVE ABORTIONS

50% coinsurance after deductible for first trimester elective abortion. Limited to one procedure per 24 month period.

URGENT CARE CENTER

$60 copay per urgent care visit

WEIGHT REDUCTION (CRITERIA REQUIRED)

50% coinsurance after deductible for weight reduction procedures. Requires prior authorization by BCN. Limited to one procedure per lifetime.

X-RAY

20% coinsurance after deductible for x-ray and radiology services. Preventive services are covered in full.

ANESTHESIA

20% coinsurance after deductible for anesthesia

SURGICAL ASSISTANT

Services performed by a surgical assistant are covered in full after deductible.

SECOND SURGICAL OPINION

$30 copay after deductible for second surgical opinion when referred

HOSPICE

Inpatient and outpatient hospice are covered in full after deductible. Inpatient care requires prior authorization.

NEWBORN CARE

20% coinsurance after deductible for newborn care in an inpatient setting

IMMUNIZATIONS

Pediatric and adult immunizations as recommended by the Advisory Committee on Immunization Practices are covered in full.

MATERNITY

$30 copay for postnatal maternity visits. Routine prenatal visits arecovered in full. Effective 1/1/23, routine postnatal visits are covered in full.

DIALYSIS

20% coinsurance after deductible for dialysis treatment in an inpatient or outpatient facility setting

CHEMOTHERAPY

20% coinsurance after deductible for chemotherapy in an inpatient or outpatient facility setting. Chemotherapy drugs are covered in full.

RADIATION THERAPY

20% coinsurance after deductible for radiation therapy in an inpatient or outpatient facility setting

AUTISM

$30 copay after deductible per visit for applied behavioral analysis. Outpatient therapy cost sharing applies for autism related speech, physical and occupational therapy with unlimited visits.

DIABETIC SUPPLIES

50% coinsurance for diabetic supplies and equipment. Must be preauthorized and obtained from a BCN supplier.

ALLERGY EVAL/SERUM/TESTING

50% coinsurance after deductible for allergy related services with the exception of allergy injections

ALLERGY INJECTIONS

$5 copay per visit for allergy injections