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℠ POS
00625536 University of Detroit Mercy
Effective Date: 08/19/2023

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 (Coinsurance applies once the deductible has been met.) **Note:** The Deductible will apply to certain services as defined below.	$350 per member/$700 per family per benefit year	$8,150 per member/$16,300 per family per benefit year
Fixed Dollar Copays	$20 for office visits $35 for urgent care visits $100 for emergency room visits $50 for ambulance service $40 for specialist visits $150 for high tech imaging	$35 for urgent care visits $100 for emergency room visits $50 for ambulance service
Coinsurance **Note:** Coinsurance applies once the deductible has been met	50% for selected services as noted below 25% for select services as noted below	50% for selected services as noted below
Coinsurance Maximum	None	None
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$6,350 per member/$12,700 per family per benefit year	$12,700 per member/$25,400 per family per benefit year

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

Preventive services (continued)

Benefits	In Network	Out of Network
Prostate Specific Antigen (PSA) Screening - laboratory services only	100%	Not Covered
Routine Colonoscopy	100%	50% after deductible
Mammography Screening	100%	50% 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%	50% after deductible

Physician office services

Benefits	In Network	Out of Network
PCP Office Visits **Note:** Applicable cost sharing applies when other services are received in the office	$20 Copay	Not Applicable - must select a BCN PCP; 50% after deductible applies to out-of-network physicians
Medical Online Visits - when received by professional provider or an online vendor	$20 Copay	50% after deductible
Consulting Specialist Care **Note:** Applicable cost sharing applies when other services are received in the office	$40 Copay	50% after deductible

Emergency medical care

Benefits	In Network	Out of Network
Hospital Emergency Room - copay waived if admitted, inpatient hospital benefit will then apply	$100 Copay	$100 Copay
Urgent Care Center	$35 Copay	$35 Copay
Retail Health Clinic	$35 Copay	$35 Copay
Ambulance Services - medically necessary	$50 copay	$50 copay

Diagnostic services

Benefits	In Network	Out of Network
Laboratory and Pathology Tests	100%	100%
Diagnostic Tests and X-rays	75% after deductible	50% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	$150 Copay	50% after deductible
Radiation Therapy	75% after deductible	50% after deductible

Maternity services provided by a physician

Benefits	In Network	Out of Network
Routine Prenatal and Postnatal Care Visits	100%	50% after deductible
Delivery and Nursery Care	75% after deductible	50% after deductible

Hospital care

Benefits	In Network	Out of Network
General Nursing Care, Hospital Services and Supplies	75% after deductible, unlimited days	50% after deductible; unlimited days

Alternatives to hospital care

Benefits	In Network	Out of Network
Skilled Nursing Care	75% after deductible	50% after deductible
Skilled Nursing Care Limit	Up to 45 days per benefit year	
Hospice Care	100% after deductible	50% after deductible
Home Health Care	100% after deductible	50% after deductible

Surgical services

Benefits	In Network	Out of Network
Surgery - included all related surgical services and anesthesia.	See Hospital Care for surgical copay	See Hospital Care for surgical copay
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	Not Covered	Not Covered
Elective Abortion (One procedure per two-year period of membership)	Not Covered	
Human Organ Transplants (subject to medical criteria)	75% after deductible	75% 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	75% after deductible	50% after deductible
Residential Substance Use Disorder	75% after deductible	50% 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.	$20 Copay	50% after deductible
Outpatient Substance Use Disorder	$20 Copay	50% 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)	$20 Copay	50% 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.	$40 Copay	50% 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	100% including allergy injections; office visit copay may apply	50% including allergy injections after deductible
Chiropractic Spinal Manipulation	$40 Copay	Not covered
Chiropractic Spinal Manipulation Limits	Limited to 30 visits per member per benefit year	
Outpatient Physical, Speech and Occupational Therapy - subject to meaningful improvement within 90 days	$40 Copay	50% after deductible
Outpatient Physical, Speech and Occupational Therapy Limit	Rehabilitative outpatient physical and occupational therapy - limited to a combined benefit maximum of 30 visits per benefit year. Rehabilitative outpatient speech therapy - limited to 30 visits per benefit year.	
Habilitative Services	$40 Copay	50% after deductible
Habilitative Services Limit	Habilitative outpatient physical and occupational therapy - limited to a combined benefit maximum of 30 visits per benefit year Habilitative outpatient speech therapy - limited to 30 visits per benefit year	
Outpatient Cardiac and Pulmonary Rehabilitation	$40 Copay	50% after deductible
Outpatient Cardiac and Pulmonary Rehabilitation Limit	Cardiac and pulmonary rehab limited to 30 visits combined per calendar year	
Infertility Counseling and Treatment	50% after deductible (excludes in-vitro fertilization)	Not covered
Durable Medical Equipment	75%	Not covered
Prosthetic and Orthotic Appliances	75%	Not covered
Diabetic Supplies **Note:** Certain diabetic supplies are covered through the pharmacy benefit. Applicable pharmacy cost-sharing will apply.	75%	Not covered

Other services (continued)

Benefits	In Network	Out of Network
Pediatric Vision - Eye exam and prescription glasses (chosen from a select collection) limited to once per calendar year through the last day of the year in which an individual turns 19	Covered 100%	Covered 100% of the approved amount
Hearing Aid	Not Covered	Not Covered

Prescription drugs

Benefits	In Network	Out of Network
Preferred Generic Tier	$6 copay	Not covered
Nonpreferred Generic Tier	$40 copay	Not covered
Preferred Brand Tier	$60 copay	Not covered
Nonpreferred Brand Tier	$80 copay	Not covered
Preferred Specialty Tier	20% coinsurance (max $200)	Not covered
Nonpreferred Specialty Tier	20% coinsurance (max $300)	Not covered
Contraceptives	Women's Contraceptives: Preferred Generic - 100%, Nonpreferred Generic - $40 copay, Preferred Brand - $60 copay, Nonpreferred Brand - $80 copay	Not covered
Drugs for the Treatment of Sexual Dysfunction	Not covered	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	Not covered
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
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	None	None

Benefits Selected - BEPSTU : 90D3XS,BENYR,ER100,IN20CO,IN25%C,IN25DM,IN25DS,IN25PO,IN350D,IN40RP,IN63PM,ON127M,ON815D,OON50%,PS6468,PVSNI,UR35,WMS