Blue Care Network of Michigan

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

Benefits-at-a-Glance
2026 BCN Silver Option 2 W/Elective Abortion
ONE STOP PROPERTY MAINTENANCE
Effective Date: 01/01/2026

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. Services must be provided or arranged by the member's primary care physician or health plan.

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	
Deductible (Coinsurance and select fixed dollar copays as defined by your plan documents, apply once the deductible has been met.) **Note:** The Deductible will apply to certain services as defined below.	$5,000 per member/$10,000 per family per calendar year
Fixed Dollar Copays **Note:** If you have a deductible, the deductible must be met first for certain services as listed below.	$5 for allergy injections $40 for office visits $60 for urgent care visits $350 for emergency room visits $60 for referral physician visits
Coinsurance	50% for select services as noted below 30% for select services as noted below
Coinsurance Maximum	None
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$10,150 per member/$20,300 per family per calendar year

Preventive services

Benefits	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening - laboratory services only	100%
Well-Baby and Well-Child Visits	100%
Immunizations	100%

Preventive services (continued)

Benefits	
Prostate Specific Antigen (PSA) Screening - laboratory services only	100%
Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Sterilization of Female Reproductive Organs	100%
Breast Pumps (DME guidelines apply.)	100%
Routine Maternity Prenatal and Postnatal Care	100%

Physician office services

Benefits	
PCP Office Visits **Note:** Applicable cost sharing applies when other services are received in the office	$40 Copay
Medical Online Visits - when performed by a BCN participating provider or BCN designated online vendor **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.	100%
Referral Physician Visits - when referred for other than preventive services **Note:** Applicable cost sharing applies when other services are received in the office	$60 Copay

Emergency medical care

Benefits	
Hospital Emergency Room - copay waived if admitted as inpatient	$350 Copay after deductible
Urgent Care Center	$60 Copay
Retail Health Clinic	$60 Copay
Ambulance Services - medically necessary	70% after deductible

Diagnostic services

Benefits	
Laboratory and Pathology Tests	100%
Diagnostic Tests and X-rays	70% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	$150 Copay after deductible
Radiation Therapy	70% after deductible

Maternity services provided by a physician

Benefits	
Routine Prenatal and Postnatal Care Visits	100%
Delivery and Nursery Care - professional services (see "Hospital Care" for facility charges)	100% after deductible

Hospital care

Benefits	
General Nursing Care, Hospital Services and Supplies	70% after deductible
Outpatient Surgery	70% after deductible

Alternatives to hospital care

Benefits	
Skilled Nursing Care	70% after deductible
Skilled Nursing Care Limit	Up to 45 days per member per calendar year
Hospice Care	100% after deductible
Home Health Care	$60 Copay after deductible

Surgical services

Benefits	
Surgery - includes all related surgical services and anesthesia.	70% after deductible
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	50% after deductible
Elective Abortion Services	50% 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)	70% after deductible
Reduction Mammoplasty (subject to medical criteria)	50% after deductible
Male Mastectomy (subject to medical criteria)	50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	50% after deductible
Orthognathic Surgery (subject to medical criteria)	50% after deductible
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	50% after deductible

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

Benefits	
Inpatient Mental Health Care	70% after deductible
Residential Substance Use Disorder	70% 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	$40 Copay
Outpatient Substance Use Disorder	$40 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)	$40 Copay
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	$60 Copay 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	50% after deductible
Allergy Office Visits	50%
Allergy Injections	$5 copay
Chiropractic Spinal Manipulation - when referred	$60 Copay Limited to 30 visits per calendar year
Rehabilitative Services -subject to meaningful improvement within 90 days	$60 Copay after deductible Rehabilitative outpatient physical and occupational therapy - limited to a combined benefit maximum of 30 visits per calendar year. Rehabilitative outpatient speech therapy - limited to 30 visits per calendar year.
Habilitative Services	$60 Copay after deductible Habilitative outpatient physical and occupational therapy - limited to a combined benefit maximum of 30 visits per calendar year Habilitative outpatient speech therapy - limited to 30 visits per calendar year
Outpatient Cardiac and Pulmonary Rehabilitation	$60 Copay after deductible Cardiac and pulmonary rehab limited to 30 visits combined per calendar year
Infertility Counseling and Treatment	50% (excludes in-vitro fertilization) after deductible
Durable Medical Equipment	50%
Prosthetic and Orthotic Appliances	50%
Diabetic Supplies **Note:** Certain diabetic supplies are covered through the pharmacy benefit. Applicable pharmacy cost-sharing will apply.	70%
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.	100%
Hearing Aid	Not covered

Prescription drugs

Benefits	
Preferred Generic Tier	$15 copay
Nonpreferred Generic Tier	$40 copay
Preferred Brand Tier	$80 copay
Nonpreferred Brand Tier	$150 copay
Preferred Specialty Tier	20% coinsurance (max $300)
Nonpreferred Specialty Tier	20% coinsurance (max $500)
Contraceptives	Women's Contraceptives - Preferred Generic - Covered 100%, Non-Preferred Generic, $40 copay, Preferred Brand - $80 copay, Non-Preferred Brand - $150 copay
Drugs for the Treatment of Sexual Dysfunction, Weight Loss, Cough & Cold	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. 90-day retail 84-90 day supply, 3X's the 30-day copay/coinsurance minus $10.
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 Select 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 Select Drug List require prior authorization and/or step therapy by BCN before they are covered. The Custom Select 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 - CLSSSM : 10150M,150CS,60RP,90D3X,CI30%,CO40,D5000,DSR30%,ER350,IMG150,ONVCW,PVSN,RXVAR,UR60,VACR50,WDRPOV