Blue Care Network of Michigan

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

Benefits-at-a-Glance
2025 BCN Fixed Cost Gold Option 1 W/Expanded Abortion
CMU RESEARCH CORPORATION
Effective Date: 12/01/2025

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.)	None
Fixed Dollar Copays - the cost share will be the defined copayment or the approved amount, whichever is less	$5 for allergy injections $20 for PCP office visits $50 for specialist, outpatient therapy, home visits, urgent care and retail health visits $50 for allergy evaluation and serum, and skilled nursing facility per day $50 for DME and P&O purchase $20 copay for DME rental $100 for ambulance services and standard x-rays $150 for injectable drugs $200 for high tech imaging $200 for infertility drugs $250 for emergency room visits $500 for surgery in an ambulatory surgical center $1000 per day up to $3000 per inpatient facility admission and per outpatient facility visit $1000 per visit for outpatient facility
Annual Out of Pocket Maximum - applies to all covered services with a copay including prescription drug copays	$9,200 per member/$18,400 per family per calendar year

Preventive services

Benefits	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%

Preventive services (continued)

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

Physician office services

Benefits	
PCP Office Visits **Note:** copay includes other services received in the office by the same visit and practitioner with the exception of injectable drugs	$20 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%
Consulting Specialist Care - when referred for other than preventive services **Note:** copay includes other services received in the office by the same visit and practitioner with the exception of injectable drugs	$50 copay

Emergency medical care

Benefits	
Hospital Emergency Room - copay waived if admitted as inpatient	$250 copay
Urgent Care Center	$50 copay
Retail Health Clinic	$50 copay
Ambulance Services - medically necessary	$100 copay

Diagnostic services

Benefits	
Laboratory and Pathology Tests	100%
Diagnostic Tests	100% when performed in a physician's office 100% for professional fees When performed inpatient or in an outpatient facility setting, inpatient and outpatient facility copays apply.

Diagnostic services (continued)

Benefits	
Standard X-Rays	100% when performed in a physician's office 100% for professional fees $100 copay when performed in a free-standing imaging center or outpatient facility. If performed in an outpatient facility in coordination with other services, you are only responsible for the maximum outpatient facility copay per visit Copay waived when the service is performed in an inpatient setting or emergency room. Inpatient and ER copays will apply.
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	100% when performed in a physician's office 100% for professional fees $200 copay when performed in a free-standing imaging center or outpatient facility. If performed in an outpatient facility in coordination with other services, you are only responsible for the maximum outpatient facility copay Copay waived when the service is performed in an inpatient setting or emergency room. Inpatient and ER copays will apply.
Radiation Therapy	100% when performed in a physician's office 100% for professional fees When performed inpatient or in an outpatient facility setting, inpatient and outpatient facility copays apply.

Maternity services provided by a physician

Benefits	
Routine Prenatal and Postnatal Care Visits	100%
Delivery and Nursery Care	$1,000 copay per day, up to $3,000 per admission for facility charges 100% for professional services

Hospital care

Benefits	
Inpatient Hospital Services including Rehabilitation Care Facility	$1000 copay per day, up to $3000 per admission for facility charges 100% for professional services.
Outpatient Surgery- facility and professional services	$1000 copay per visit for facility charges 100% for professional services
Ambulatory Surgery	$500 copay per visit for facility charges 100% for professional services

Alternatives to hospital care

Benefits	
Skilled Nursing Care	$50 copay per day; Includes facility and professional Limited to 45 days per calendar year
Hospice Care	100%
Home Health Care	$50 copay per day
Home Infusion	100%

Surgical services

Benefits	
Surgery - includes all related surgical services and anesthesia.	100% when performed in a physician's office When performed inpatient, outpatient, or in an ambulatory surgical center, the applicable facility copays apply
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	100% when performed in a physician's office When performed inpatient, outpatient, or in an ambulatory surgical center, the applicable facility copays apply
Elective Abortion Services	Cost dependent on the location you receive the service, such as office visit, Outpatient facility or Inpatient facility.
Human Organ Transplants (subject to medical criteria)	100% when performed in a physician's office When performed inpatient, outpatient, or in an ambulatory surgical center, the applicable facility copays apply
Reduction Mammoplasty (subject to medical criteria)	100% when performed in a physician's office When performed inpatient, outpatient, or in an ambulatory surgical center, the applicable facility copays apply
Male Mastectomy (subject to medical criteria)	100% when performed in a physician's office When performed inpatient, outpatient, or in an ambulatory surgical center, the applicable facility copays apply
Temporomandibular Joint Syndrome (subject to medical criteria)	100% when performed in a physician's office When performed inpatient, outpatient, or in an ambulatory surgical center, the applicable facility copays apply
Orthognathic Surgery (subject to medical criteria)	100% when performed in a physician's office When performed inpatient, outpatient, or in an ambulatory surgical center, the applicable facility copays apply
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	100% when performed in a physician's office When performed inpatient, outpatient, or in an ambulatory surgical center, the applicable facility copays apply

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

Benefits	
Inpatient Mental Health Care and Residential Substance Use Disorder	$1000 copay per day up to $3000 per admission for facility charges 100% for professional services.
Residential Substance Use Disorder	$1000 copay per day up to $3000 per admission for facility charges 100% for professional services.
Outpatient Mental Health Care includes online and telemedicine visits **Note:** For diagnostic and therapeutic services, the medical benefit applies.	$20 copay
Outpatient Substance Use Disorder	$20 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)	$20 copay
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	$50 copay
Other covered services, including mental health services, for autism spectrum disorder	See your outpatient mental health, medical office visits and preventive benefit

Other services

Benefits	
Allergy Testing and Therapy	$50 copay; if billed with office visit, one copay applies per provider, per visit. The highest copay will apply.
Allergy Office Visits	$20 copay if performed by PCP; $50 copay if performed by specialist
Allergy Injections	$5 copay
Chiropractic Spinal Manipulation - when referred	$50 copay; up to 30 visits per calendar year
Rehabilitative Services -subject to meaningful improvement within 90 days	$50 copay Outpatient Physical and Occupational Therapy - limited to a combined benefit maximum of 30 visits per calendar year. Outpatient Speech Therapy - limited to 30 visits per calendar year
Habilitative Services	$50 copay Outpatient Physical and Occupational Therapy limited to a combined benefit maximum of 30 visits per calendar year Outpatient Speech Therapy limited to 30 visits per calendar year
Outpatient Cardiac and Pulmonary Rehabilitation	$50 copay Limited to 30 combined visits per calendar year
Infertility Counseling and Treatment	Copay based on site of care $200 copay for infertility drugs

Other services (continued)

Benefits	
Durable Medical Equipment	$50 copay for purchase $20 copay per item, per month for rental 100% for medical supplies
Prosthetic and Orthotic Appliances	$50 copay for each item
Diabetic Supplies **Note:** Certain diabetic supplies are covered through the pharmacy benefit. Applicable pharmacy cost-sharing will apply.	100%
Injectable Drugs	$150 copay per injection when administered in an office setting, home, or outpatient facility
Cancer Therapy Drugs	100% Outpatient facility copay applies to the administration
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% Eye Exam, Frames and Lenses - Limited to once per calendar year through the last day of the year in which an individual turns age 19.

Prescription drugs

Benefits	
Preferred Generic Tier	$15 copay
Nonpreferred Generic Tier	$40 copay
Preferred Brand Tier	$80 copay
Nonpreferred Brand Tier	$100 copay
Preferred Specialty Tier	$200 copay
Nonpreferred Specialty Tier	$300 copay
Contraceptives	Women's Contraceptives - Preferred Generic - 100%, Non-Preferred Generic - Copayment above applies, Preferred Brand - Copayment above applies, Non-Preferred Brand - Copayment above applies
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

Prescription drugs (continued)

Benefits	
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 - FCSM : 1481CS,90D3X,9200PM,FCBRE,ONVCW,PVSN,RXVAR,VAFCR