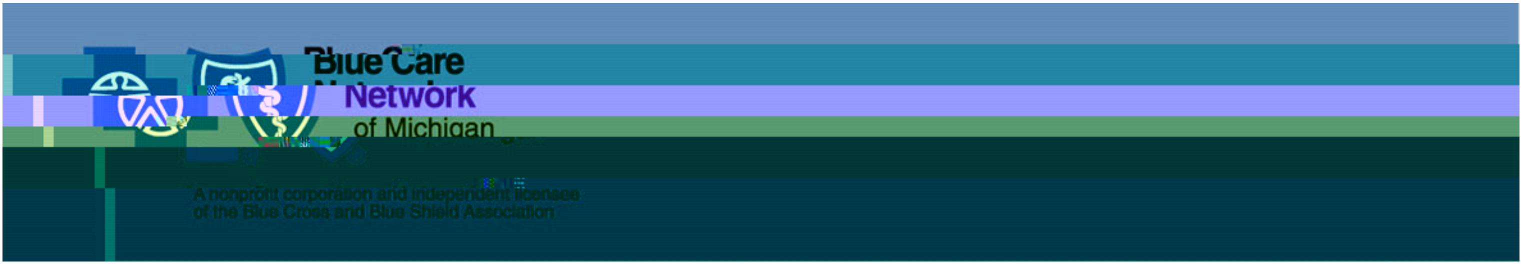

Benefits-at-a-Glance

BCN Classic HMO for Large Groups

00239393-0001-0003 MONTCALM COMMUNITY COLLEGE

Effective Date: 7/1/2023

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 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 for fully insured plans.

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

Preauthorization for Select Services – Services listed in this BAAG 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 bcbsm.com/importantinfo. Select *Approving covered services.*

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)	
Deductible -(Coinsurance and select fixed dollar copays as defined by your plan documents, apply once the deductible has been met.)	$5,000 per individiual/$10,000 per family per benefit year
Fixed Dollar Copays	$5 for allergy injections
	$20 for office visits
	$50 for urgent care visits
	$250 for emergency room visits
	$40 for referral physician visits
Coinsurance	50% for select services as noted below
	20% for select services as noted below
Medical Annual Coinsurance Maximum (ACM)	None
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$8,150 per individual/$16,300 per family (includes pharmacy cost sharing)

Benefits Selected - CLSSLG :
CI20%,D5000,DSR20%,IMG150,ER250,HA1536,CO20,8150PM,8150PM,3068CS,90D3X,PDLR,BENYR,40RP,UR50,WDRPOV

Preventive services

Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening	100%
	100%

Surgical services

Surgery - includes all related surgical services and anesthesia	80% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	50% after deductible
Elective Abortion (One procedure per two year period of membership)	Not Covered
Human Organ Transplants	80% after deductible
Reduction Mammoplasty	50% after deductible
Male Mastectomy	50% after deductible
Temporomandibular Joint Syndrome	50% after deductible
Orthognathic Surgery	50% after deductible
Weight Reduction Procedures (Limited to one procedure per lifetime)	50% after deductible

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

Inpatient Mental Health Care	80% after deductible
Residential Substance Use Disorder	80% 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
Outpatient Substance Use Disorder	$20 Copay

Autism spectrum disorders, diagnoses and treatment

Applied behavioral analyses (ABA) treatment	$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.	$40 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

Allergy Testing and Therapy	50% after deductible
Allergy Injections	$5 copay
Chiropractic Spinal Manipulation - when referred	$40 copay
	(up to 30 visits per benefit year)
Outpatient Physical, Speech and Occupational Therapy	$40 copay after deductible
	60 visits per benefit year for any combination of outpatient rehabilitation therapies.
Infertility Counseling and Treatment (See plan benefit documents for exclusions)	50% after deductible
Durable Medical Equipment (DME)	50%
Prosthetic and Orthotic Appliances (P&O)	50%
Diabetic Supplies	80%
	Monaural hearing aid covered once every 36 months. Monaural benefit maximum - $1,500 every 36 months

Prescription drugs

Prescription Drugs - (Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable pharmacy cost-sharing will apply.)	Tier 1 - $30 copay, Tier 2 - $60 copay, Tier 3 - $80 copay, Tier 4 - 20% coinsurance (max $200), Tier 5 -20% coinsurance (max $300); 30 day supply.

	Applicable tier copay applies to select diabetic supplies. Needles and syringes when dispensed with covered injectable drug or self-administered chemo drug are covered in full.
	Sexual Dysfunction Drugs - 50% coinsurance
	A and B rated drugs defined as preventive medications on the Preferred Drug List are covered in full for generic and select brand name drugs.