



**Blue Care
Network
of Michigan**

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

Benefits-at-a-Glance

Classic

00134678 FARMINGTON BOARD OF EDUCATION

0003/0004

Effective Date: 01/01/2026

This is intended as an easy-to-read summary. **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. **Services must be provided or arranged by 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 <https://bcbsm.com/priorauth>.

Note: Blue Care Network provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	
Deductible - Coinsurance and select fixed dollar copays apply (as defined by your plan documents), once the deductible has been met. Note: The Deductible will apply to certain services as defined below.	\$1,000 per member/\$2,000 per family per calendar year
Fixed Dollar Copays	\$0 for allergy injections \$20 for PCP office visits \$20 for referral physician visits \$20 for urgent care visits \$150 for emergency room visits
Coinsurance	50% for select services as noted below 20% for select services as noted below
Coinsurance Maximum	1,000 per member /\$2,000 per family per calendar year Services that DO NOT apply to the ACM: Deductible, Flat Dollar Copays, Infertility, Male Mastectomy, Reduction Mammoplasty, Male Sterilization, Elective Abortion, TMJ, Orthognathic Surgery, Weight Reduction, DME, P&O, Diabetic Supplies, Prescription Drugs
Out of Pocket Maximum - Includes deductible, copays, and coinsurance amounts for all covered services.	\$6,350 per member/\$12,700 per family per calendar year

Preventive services

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

Physician office services

Benefits	
PCP Office Visits Note: Applicable cost sharing applies when other services are received in the office	\$20 copay
Medical Online Visits - when performed by a BCN participating provider 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.	\$20 copay - Online visits with the BCN online vendor are covered.
Referral Physician Visits - when referred for other than preventive services Note: Applicable cost sharing applies when other services are received in the office	\$20 copay

Emergency medical care

Benefits	
Hospital Emergency Room - copay waived if admitted as inpatient	\$150 copay
Urgent Care Center	\$20 copay
Retail Health Clinic	\$20 copay
Ambulance Services - medically necessary	20% coinsurance after deductible

Diagnostic services

Benefits	
Laboratory and Pathology Tests	Covered 100%
Diagnostic Tests and X-rays	20% coinsurance after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	20% coinsurance after deductible
Radiation Therapy	20% coinsurance after deductible

Maternity services provided by a physician

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

Hospital care

Benefits	
General Nursing Care, Hospital Services and Supplies	20% coinsurance after deductible
Outpatient Surgery	20% coinsurance after deductible

Alternatives to hospital care

Benefits	
Skilled Nursing Care	20% coinsurance after deductible Limited to 730 days per lifetime
Hospice Care	Covered 100% after deductible
Home Health Care	\$20 copay

Surgical services

Benefits	
Surgery - includes all related surgical services and anesthesia	20% coinsurance after deductible
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	50% coinsurance after deductible
Elective Abortion Services	20% coinsurance 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)	20% coinsurance after deductible
Reduction Mammoplasty (subject to medical criteria)	20% coinsurance after deductible
Male Mastectomy (subject to medical criteria)	20% coinsurance after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	20% coinsurance after deductible
Orthognathic Surgery (subject to medical criteria)	20% coinsurance after deductible
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	20% coinsurance after deductible

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

Benefits	
Inpatient Mental Health Care	20% coinsurance after deductible
Residential Substance Use Disorder	20% coinsurance 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

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)	See your outpatient mental health care cost share
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	\$20 copay
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	Covered 100% after deductible
Allergy Office Visits	\$20 copay
Allergy Injections	Covered 100%
Chiropractic Spinal Manipulation - when referred	\$20 copay Limited to 30 visits per calendar year
Outpatient Physical, Speech and Occupational Therapy - subject to meaningful improvement within 60 days	\$20 copay 60 visits combined for physical therapy, occupational therapy and speech therapy treatment per medical episode per year.
Infertility Counseling and Treatment	20% coinsurance (excludes in-vitro fertilization) after deductible
Durable Medical Equipment	Covered 100%
Diabetic Supplies Note: Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable prescription drug cost-sharing will apply.	Covered 100%
Prosthetic and Orthotic Appliances	Covered 100%
Hearing Aid	Monaural benefit maximum - \$3,000 every 36 months; Binaural benefit maximum - \$6,000 every 36 months

Prescription drugs

Benefits	
Generic Tier	\$5 copay
Preferred Brand Tier	\$20 copay
Nonpreferred Brand Tier	\$30 copay
Contraceptives	Women's Contraceptives: Generic - 100%, Preferred Brand - \$20 copay, Nonpreferred Brand - \$30 copay
Drugs for the Treatment of Sexual Dysfunction	50% coinsurance
GLP-1 Products	GLP-1 products for conditions other than diabetes are not covered.
Mail Order Prescription Drugs	Two times the applicable copay up to a 90 day supply. Specialty drugs are not covered through mail order pharmacies.

Prescription drugs (continued)

Benefits

Specialty Drug Pharmacy	Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs
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.
Prescription Drug Deductible	None
Custom 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 Drug List require prior authorization and/or step therapy by BCN before they are covered. The 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 - CLSLGF :

1KECMF,52030F,6350MF,AS5F,ASDF,CHD20F,C120%F,CO20F,D1000F,DME5F,DSRCWF,ER150F,GLP1XF,H3K36F,MOP20F,MRSRF,ONVPF,P&O5F,SN730F,UR20F,VAR20F,WD
EDF