



**Blue Care  
Network  
of Michigan**

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

## Benefits-at-a-Glance

### High Deductible Health Plan with HSA

00134678 FARMINGTON BOARD OF EDUCATION

0003/0036

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 <b>Note:</b> The Deductible will apply to all services except preventive services	\$1,700 per member/\$3,400 per family per calendar year. Any deductible paid during the current benefit year will not be carried over into the new benefit year.
The deductible is combined for both medical and prescription drug coverage.	The deductible is aggregate. The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract.
Coinsurance <b>Note:</b> Coinsurance applies once the deductible has been met	50% for select services as noted below 10% for select services noted below
Coinsurance Maximum	\$1,000 per member/\$2,000 per family per calendar year Services that DO NOT apply to the ACM: Deductible, 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 - applies to deductibles, copays and coinsurance amounts for all covered services	\$6,350 per member/\$6,350 per family per calendar year The out-of-pocket maximum is aggregate. For a two-person or family contract, one person on the contract can meet the entire family out-of-pocket maximum.

## Preventive services

Benefits	
Health Maintenance Exam	Covered 100%
Annual Gynecological Exam	Covered 100%

## Preventive services (continued)

Benefits	
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	10% coinsurance after deductible
Medical Online Visits - when performed by a BCN participating provider <b>Note:</b> Not all services delivered virtually are considered an online visit but may be considered telemedicine.	10% coinsurance after deductible - Online visits with the BCN designated online vendor are covered.
Telemedicine Services - medical and behavioral health	10% coinsurance after deductible
Consulting Specialist Care - when referred	10% coinsurance after deductible

## Emergency medical care

Benefits	
Hospital Emergency Room	10% coinsurance after deductible
Urgent Care Center	10% coinsurance after deductible
Retail Health Clinic	10% coinsurance after deductible
Ambulance Services - medically necessary	10% coinsurance after deductible

## Diagnostic services

Benefits	
Laboratory and Pathology Tests	10% coinsurance after deductible
Diagnostic Tests and X-rays	10% coinsurance after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	10% coinsurance after deductible
Radiation Therapy	10% coinsurance after deductible

## Maternity services provided by a physician

Benefits	
Routine Prenatal and Postnatal Care Visits	Covered 100%
Delivery and Nursery Care	10% coinsurance after deductible

## Hospital care

### Benefits

General Nursing Care, Hospital Services and Supplies	10% coinsurance after deductible
Outpatient Surgery	10% coinsurance after deductible

## Alternatives to hospital care

### Benefits

Skilled Nursing Care	10% coinsurance after deductible Limited to 730 days per lifetime
Hospice Care	10% coinsurance after deductible
Home Health Care	10% coinsurance after deductible

## Surgical services

### Benefits

Surgery - includes all related surgical services and anesthesia.	10% 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. <b>Note:</b> Abortions are not covered if rendered in a location where abortion is not legal.
Human Organ Transplants (subject to medical criteria)	10% coinsurance after deductible
Reduction Mammoplasty (subject to medical criteria)	10% coinsurance after deductible
Male Mastectomy (subject to medical criteria)	10% coinsurance after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	10% coinsurance after deductible
Orthognathic Surgery (subject to medical criteria)	10% coinsurance after deductible
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	10% coinsurance after deductible

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

### Benefits

Inpatient Mental Health Care	10% coinsurance after deductible
Residential Substance Use Disorder	10% coinsurance after deductible
Outpatient Mental Health Care includes online and telemedicine visits <b>Note:</b> For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	10% coinsurance after deductible
Outpatient Substance Use Disorder	10% coinsurance after deductible

## Autism spectrum disorders, diagnoses and treatment

Benefits	
Applied behavioral analysis (ABA) treatment <b>Note:</b> 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)	10% coinsurance 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.	10% coinsurance after deductible
Other covered services, including mental health services, for autism spectrum disorder	See your outpatient mental health benefit and medical office visit cost sharing

## Other services

Benefits	
Allergy Testing and Therapy	10% coinsurance after deductible
Allergy Injections	10% coinsurance after deductible
Chiropractic Spinal Manipulation - when referred	10% coinsurance after deductible Limited to 30 visits per calendar year
Outpatient Physical, Speech and Occupational Therapy - subject to meaningful improvement within 60 days	10% coinsurance after deductible 60 visits for each therapy per medical episode per calendar year for physical therapy, occupational therapy and speech therapy treatment
Infertility Counseling and Treatment	10% coinsurance after deductible (excludes in-vitro fertilization)
Durable Medical Equipment	Covered 100%
Prosthetic and Orthotic Appliances	Covered 100%
Diabetic Supplies <b>Note:</b> Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable prescription drug cost-sharing will apply.	10% coinsurance after deductible
Hearing Aid	Monaural benefit maximum - \$3,000 every 36 months; Binaural benefit maximum - \$6,000 every 36 months after deductible

## Prescription drugs

Benefits	
Generic Tier	\$10 copay after deductible
Preferred Brand Tier	\$40 copay after deductible
Nonpreferred Brand Tier	\$40 copay after deductible
Contraceptives	Women's Contraceptives: Generic - 100%, Preferred Brand - \$40 copay after deductible, Nonpreferred Brand - \$40 copay after deductible
Drugs for the Treatment of Sexual Dysfunction	50% coinsurance after deductible
GLP-1 Products	GLP-1 products for conditions other than diabetes are not covered.
Mail Order Prescription Drugs	Two times the applicable copay after deductible up to a 90-day supply. Specialty drugs are not covered through mail order pharmacies.

## Prescription drugs (continued)

### Benefits

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 Drug Deductible	The prescription drug deductible is integrated with the medical deductible
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 <a href="https://www.bcbsm.com/druglists">https://www.bcbsm.com/druglists</a>

For Internal Purposes Only

Benefits Selected - HDLGF : 1044DF,10CHDF,17HDF,1CMHDF,63HDMF,ASDHDF,CHD10F,DME5F,GLP1XF,H3K3DF,MOP2OF,MRVRF,ONVPF,P&O5F,SN730F,VAR20F