Blue Care Network of Michigan

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

GlidePath℠

Comparison Benefit Chart – Menu B HMO Plans with Rx B

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. Payment amounts are based on BCN's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCN certificates and riders. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Benefits	BCN HMO – Plan 250 Medical Coverage℠	BCN HMO – Plan 500 Medical Coverage℠	BCN HMO – Plan 1000 Medical Coverage℠	BCN HMO HSA – Plan 1300/20% Medical Coverage℠	BCN HMO HSA – Plan 2000/0% Medical Coverage℠
Member's Responsibility (deductibles, copays, coinsurance, coinsurance maximum and out-of-pocket maximum) Note: The Deductible will apply to certain services as defined below					
Deductibles **Note:** Coinsurance and select fixed dollar copays apply once the deductible has been met.	$250 per member, $500 per family per calendar year	$500 per member, $1,000 per family per calendar year	$1,000 per member, $2,000 per family per calendar year	$1,300 per member, $2,600 per contract per calendar year	$2,000 per member, $4,000 per contract per calendar year
Flat-dollar copays	$20 for office visits $40 for specialist visits $40 for urgent care visits $150 for emergency room visits $150 for high tech imaging $5 for allergy injections	$20 for office visits $40 for specialist visits $40 for urgent care visits $150 for emergency room visits $150 for high tech imaging $5 for allergy injections	$30 for office visits $50 for specialist visits $50 for urgent care visits $150 for emergency room visits $150 for high tech imaging $5 for allergy injections	None	None
Coinsurance amounts **Note:** Coinsurance amounts apply once the deductible has been met.	20% and 50% for select services noted below	20% and 50% for select services noted below	20% and 50% for select services noted below	20% and 50% for select services noted below	50% for select services noted below
***Annual Coinsurance Maximums**	$1,500 per member, $3,000 per family per calendar year	$1,500 per member, $3,000 per family per calendar year	$2,500 per member, $5,000 per family per calendar year	None	None
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services including prescription drug copays	$6,350 per member, $12,700 per family per calendar year	$6,350 per member, $12,700 per family each calendar year	$6,350 per member, $12,700 per family per calendar year	$2,300 per member,$4,600 per family per calendar year	$3,000 per member, $6,000 per family per calendar year

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Preventive Care Services					
Health maintenance exam	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Gynecological exam	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Pap smear screening – laboratory and pathology services	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Voluntary sterilizations for females	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Well-baby and child care	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Prostate specific antigen (PSA) screening – laboratory services only	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Mammography Screening	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Breast Pumps	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Maternity Pre-natal Care	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Routine Colonoscopy	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%
Physician Office Services					
PCP Office Visits	Covered – $20 copay	Covered – $20 copay	Covered – $30 copay	Covered – 80% after deductible	Covered – 100% after deductible
Consulting Specialist Care – when referred for other than preventive services	Covered – $40 copay	Covered – $40 copay	Covered – $50 copay	Covered – 80% after deductible	Covered – 100% after deductible

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Emergency Medical Care					
Hospital emergency room – copay waived if admitted	Covered – $150 copay after deductible	Covered – $150 copay after deductible	Covered – $150 copay after deductible	Covered – 80% after deductible	Covered – 100% after deductible
Urgent Care Center	Covered – $40 copay	Covered – $40 copay	Covered – $50 copay	Covered – 80% after deductible	Covered – 100% after deductible
Ambulance services – must be medically necessary	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 100% after deductible
Diagnostic Services					
Laboratory and pathology tests	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 80% after deductible	Covered – 100% after deductible
Diagnostic tests and x-rays	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 100% after deductible
High Technology Imaging (MRI, CAT, PET)	Covered – $150 copay after deductible	Covered – $150 copay after deductible	Covered – $150 copay after deductible	Covered – 80% after deductible	Covered – 100% after deductible
Radiation Therapy	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 100% after deductible
Maternity Services Provided by a Physician					
Postnatal care. See Preventive Services for Pre-Natal Care	Covered – $20 copay	Covered – $20 copay	Covered – $30 copay	Covered – 80%	Covered – 100%
Delivery and nursery care	Covered – 100% after deductible for professional services; see Hospital Care for facility charges	Covered – 100% after deductible for professional services; see Hospital Care for facility charges	Covered – 100% after deductible for professional services; see Hospital Care for facility charges	Covered – 80% after deductible	Covered – 100% after deductible
Hospital Care					
General Nursing Care, Hospital Services and Supplies	Covered – 80% after deductible; unlimited days	Covered – 80% after deductible; unlimited days	Covered – 80% after deductible; unlimited days	Covered – 80% after deductible; unlimited days	Covered – 100% after deductible; unlimited days
Outpatient surgery	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 100% after deductible

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Alternatives to Hospital Care					
Skilled nursing care	Covered – 80% after deductible up to 45 days per calendar year	Covered – 80% after deductible up to 45 days per calendar year	Covered – 80% after deductible up to 45 days per calendar year	Covered – 80% after deductible up to 45 days per calendar year	Covered – 100% after deductible up to 45 days per calendar year
Hospice care	Covered – 100% after deductible	Covered – 100% after deductible	Covered – 100% after deductible	Covered – 80% after deductible	Covered – 100% after deductible
Home health care	Covered – $40 copay after deductible	Covered – $40 copay after deductible	Covered – $50 copay after deductible	Covered – 80% after deductible	Covered – 100% after deductible
Surgical Services					
Surgery – includes related surgical services and anesthesia	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 100% after deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see "**Preventive services.**"	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible
Human Organ Transplants (subject to medical criteria)	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 100% after deductible
Reduction Mammoplasty (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible

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Mental Health Care and Substance Abuse Treatment					
Inpatient mental health care and **inpatient** substance abuse care	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 80% after deductible	Covered – 100% after deductible
Outpatient mental health care	Covered – $20 copay	Covered – $20 copay	Covered – $30 copay	Covered – 80% after deductible	Covered – 100% after deductible
Outpatient substance abuse care	Covered – $20 copay	Covered – $20 copay	Covered – $30 copay	Covered – 80% after deductible	Covered – 100% after deductible
Autism Spectrum Disorders, Diagnoses and Treatment					
Applied behavioral analyses (ABA) treatment Limited to 25 hours per week for line therapy for children through age 18	Covered – $20 copay	Covered – $20 copay	Covered – $30 copay	Covered – 80% after deductible	Covered – 100% after deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18 Physical, speech and occupational therapy for autism spectrum disorder is unlimited.	Covered – $40 copay after deductible	Covered – $40 copay after deductible	Covered – $50 copay after deductible	Covered – 80% after deductible	Covered – 100% after deductible
Other covered services, including mental health services, for autism spectrum disorder	See your outpatient mental health benefit and medical office visit benefit	See your outpatient mental health benefit and medical office visit benefit	See your outpatient mental health benefit and medical office visit benefit	See your outpatient mental health benefit and medical office visit benefit	See your outpatient mental health benefit and medical office visit benefit

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Other Services					
Allergy testing and therapy	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 80% after deductible	Covered – 100% after deductible
Allergy Office Visits	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 50% after deductible	Covered – 80% after deductible	Covered – 100% after deductible
Allergy Injections	Covered -- $5 copay	Covered -- $5 copay	Covered -- $5 copay	Covered – 80% after deductible	Covered – 100% after deductible
Chiropractic spinal manipulation – when referred	Covered – $40 copay; up to 30 visits per calendar year	Covered – $40 copay; up to 30 visits per calendar year	Covered – $50 copay; up to 30 visits per calendar year	Covered – 80% after deductible; up to 30 visits per calendar year	Covered – 100% after deductible; up to 30 visits per calendar year
Outpatient Physical, Speech, and Occupational Therapy – subject to meaningful improvement within 60 days	Covered – $40 after deductible; limited to 60 visits per calendar year for any combination of therapies	Covered – $40 after deductible; limited to 60 visits per calendar year for any combination of therapies	Covered – $50 after deductible; limited to 60 visits per calendar year for any combination of therapies	Covered – 80% after deductible; limited to 60 visits per calendar year for any combination of therapies	Covered – 100% after deductible; limited to 60 visits per calendar year for any combination of therapies
Infertility Counseling and Treatment (excluding in-vitro fertilization)	Covered – 50% after deductible on all associated costs	Covered – 50% after deductible on all associated costs	Covered – 50% after deductible on all associated costs	Covered – 50% after deductible on all associated costs	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%	Covered – 50%	Covered – 50%	Covered – 50% after deductible	Covered – 50% after deductible
Prosthetic and Orthotic Appliances	Covered – 50%	Covered – 50%	Covered – 50%	Covered – 50%after deductible	Covered – 50% after deductible
Diabetic Supplies	Covered – 50%	Covered – 50%	Covered – 50%	Covered – 80% after deductible	Covered – 100% after deductible

***Annual Coinsurance Maximum –** The following services DO NOT apply to the Annual Coinsurance Maximum if they are included in your coverage:

- Deductible amounts
- Services with a flat dollar copay
- Infertility Services
- Male Mastectomy
- Reduction Mammoplasty
- Male Sterilization
- Elective Abortion
- TMJ
- Orthognathic Surgery
- Weight Reduction Procedures
- Durable Medical Equipment
- Prescription Drugs
- Prosthetics and Orthotics
- Diabetic Supplies

Comparison Benefit Chart – Menu B
$10/$40/$80 Prescription Drug Coverage

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Benefits	BCN HMO Rx Prescription Drug Coverage	BCN HMO HSA Prescription Drug Coverage
		The deductible is combined for both medical and prescription drug coverage. The deductible amount is listed with your medical benefits.
Tier 1 – Formulary Preferred	$10 copayment	$10 copayment after deductible
Tier 2 – Formulary Options	$40 copayment	$40 copayment after deductible
Tier 3 – Nonformulary	$80 copayment	$80 copayment after deductible
Sexual Dysfunction Drugs	50% coinsurance of the BCN Approved Amount	50% coinsurance of the BCN Approved Amount after the deductible
Contraceptives Note: Your cost sharing may be waived for Tier 2 or Tier 3 contraceptive drugs if there are no appropriate generic products or preferred drugs available	Tier 1 – Covered in full Tier 2 – $40 copay Tier 3 – $80 copay	Tier 1 – Covered in full Tier 2 – $40 copay after deductible Tier 3 – $80 copay after deductible
Preventive Medications	Tier 1 – Covered in full Tier 2 – Covered in full Tier 3 – Covered in full	Tier 1 – Covered in full Tier 2 – Covered in full Tier 3 – Covered in full
31-90 day supply for Mail-Order Pharmacy	Two times applicable copay	Two times applicable copay
84-90 day supply for Retail Pharmacy	Two times applicable copay	Two times applicable copay
Out-of-Pocket Maximum	Your medical out-of-pocket maximum is integrated with your BCN covered Prescription Drugs. The out-of-pocket maximum amount is listed with your medical benefits.	Your medical out-of-pocket maximum is integrated with your BCN covered Prescription Drugs. The out-of-pocket maximum amount is listed with your medical benefits.

Definitions

Brand Name Drug	Manufactured and marketed under a registered trade name and trademark. • Multi-source Brand Name Drug: a drug that is available from a brand name manufacturer and also has a generic version. • Single Source Brand Name Drug: the drug can only be produced by the company holding the patent; no generics are available.
Generic Drugs	Prescription drugs that have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark.
Non-preferred Drugs	Prescription drugs that may not have a proven record for safety or their clinical record may not be as high as the BCN preferred alternatives.
Non-preferred Specialty Drugs	Specialty drugs that may not have a proven record for safety or their clinical value may not be as high as the Specialty Drugs.
Out-of-pocket Maximum	The highest amount of money you have to pay for covered services during the Calendar Year.
Preferred Brand Drugs	Prescription drugs that are Single Source Brand drugs that have a proven record for safety and effectiveness.
Preferred Specialty Drugs	Generic or Single Source Brand Specialty drugs that have a proven record for safety and effectiveness and offer the best value to our members.
Value Generic Drugs	Prescription drugs that have a proven clinical value essential for treatment of chronic conditions.