



**Blue Care
Network
of Michigan**

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

Benefits-at-a-Glance

Healthy *Blue Living* SM

00630555 ACCIDENT FUND HOLDINGS INC

0001/0001

Effective Date: 01/01/2027

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 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>.

Healthy Blue Living subscribers must complete program requirements within the first 90 days of enrollment or re-enrollment. To qualify for or maintain enhanced benefits, the subscriber needs to complete a health assessment and qualification form during the first 90 days and follow their primary care physician's recommendations for a healthy lifestyle. If a tobacco user, must Enroll in the BCN-sponsored tobacco cessation program within 120 days of the start of the plan year. If BMI is greater than or equal to 30, must select and begin participating in a weight management program within 120 days of the start of the plan year.

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

Benefits	Enhanced	Standard
Deductible (Coinsurance and select fixed dollar copays as defined by your plan documents, apply once the deductible has been met.)	None	\$250 per member/\$500 per family per calendar year
Fixed Dollar Copays	\$10 for office visits \$10 for urgent care visits \$50 for emergency room visits \$10 for referral physician visits	\$20 for office visits \$20 for urgent care visits \$100 for emergency room visits \$20 for referral physician visits
Coinsurance	50% for select services as noted below	50% for select services as noted below 10% for select services as noted below
Coinsurance Maximum	None	None
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	\$1,250 per member/\$2,500 per family per calendar year	\$1,250 per member/\$2,500 per family per calendar year

Preventive services

Benefits	Enhanced	Standard
Health Maintenance Exam	100%	100%
Annual Gynecological Exam	100%	100%

Preventive services (continued)

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

Physician office services

Benefits	Enhanced	Standard
PCP Office Visits Note: Applicable cost sharing applies when other services are received in the office	\$10 copay	\$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.	\$10 copay	\$20 Copay
Referral Physician Visits - when referred for other than preventive services Note: Applicable cost sharing applies when other services are received in the office	\$10 copay	\$20 Copay after deductible

Emergency medical care

Benefits	Enhanced	Standard
Hospital Emergency Room - copay waived if admitted as inpatient	\$50 Copay	\$100 Copay after deductible
Urgent Care Center	\$10 Copay	\$20 Copay
Retail Health Clinic	\$10 Copay	\$20 Copay
Ambulance Services - medically necessary	100%	90% after deductible

Diagnostic services

Benefits	Enhanced	Standard
Laboratory and Pathology Tests	100%	100%
Diagnostic Tests and X-rays	100%	90% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	100%	90% after deductible
Radiation Therapy	100%	90% after deductible

Maternity services provided by a physician

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

Hospital care

Benefits	Enhanced	Standard
General Nursing Care, Hospital Services and Supplies	100%	90% after deductible
Outpatient Surgery	100%	90% after deductible

Alternatives to hospital care

Benefits	Enhanced	Standard
Skilled Nursing Care	100% Up to 730 days per lifetime	90% after deductible Up to 730 days per lifetime
Hospice Care	100%	100% after deductible
Home Healthcare	\$10 copay	\$20 Copay after deductible

Surgical services

Benefits	Enhanced	Standard
Surgery - includes all related surgical services and anesthesia.	100%	90% after deductible
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	100%	100% after deductible
Elective Abortion Services	50%	50% 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.	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)	100%	90% after deductible
Reduction Mammoplasty (subject to medical criteria)	50%	50% after deductible
Male Mastectomy (subject to medical criteria)	50%	50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	50%	50% after deductible
Orthognathic Surgery (subject to medical criteria)	50%	50% after deductible
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	100%	100% after deductible

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

Benefits	Enhanced	Standard
Inpatient Mental Healthcare	100%	90% after deductible
Residential Substance Use Disorder	100%	90% after deductible

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

Benefits	Enhanced	Standard
Outpatient Mental Healthcare includes online and telemedicine visits Note: For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	\$10 copay	\$20 Copay
Outpatient Substance Use Disorder	\$10 copay	\$20 Copay

Autism spectrum disorders, diagnoses and treatment

Benefits	Enhanced	Standard
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)	\$10 copay	\$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.	\$10 copay	\$20 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.	See your outpatient mental health, medical office visit and preventive benefit.

Other services

Benefits	Enhanced	Standard
Allergy Testing and Therapy	100%	100% after deductible
Allergy Office Visits	\$10 copay	\$20 Copay after deductible
Allergy Injections	100%	100%
Chiropractic Spinal Manipulation - when referred	\$10 copay Limited to 30 visits per calendar year	\$20 Copay after deductible Limited to 30 visits per calendar year
Outpatient Physical, Speech and Occupational Therapy - Subject to meaningful improvement within 60 days	\$10 copay Limited to 60 visits per calendar year for any combination of outpatient rehabilitation therapies	\$20 Copay after deductible Limited to 60 visits per calendar year for any combination of outpatient rehabilitation therapies
Infertility Counseling and Treatment	50% (excludes in-vitro fertilization)	50% (excludes in-vitro fertilization) after deductible
Durable Medical Equipment	100%	100%
Prosthetic and Orthotic Appliances	100% 100% coverage for prosthetic, orthotic and corrective appliances for unattached shoe inserts, when medically necessary. 100% coverage for a hair prosthesis (wig or hair piece) for hair loss due to a medical condition or the treatment of a medical condition. One per calendar year; max benefit \$225 per year.	100% 100% coverage for prosthetic, orthotic and corrective appliances for unattached shoe inserts, when medically necessary. 100% coverage for a hair prosthesis (wig or hair piece) for hair loss due to a medical condition or the treatment of a medical condition. One per calendar year; max benefit \$225 per year.

Other services (continued)

Benefits	Enhanced	Standard
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. - Continuous glucose monitors and related supplies are covered only when obtained from the BCN designated exclusive vendor.	100%	100%
Hearing Aid	Monaural benefit maximum - \$1,507; Binaural benefit maximum - \$2,707	Monaural benefit maximum - \$1,507; Binaural benefit maximum - \$2,707

Prescription drugs

Benefits	Enhanced	Standard
Generic Tier	\$5 copay up to a 34 day supply	\$15 copay up to a 34 day supply
Preferred Brand Tier	\$20 copay up to 34 day supply	\$50 copay up to 34 day supply
Nonpreferred Brand Tier	Not covered	Not covered
Contraceptives	Women's Contraceptives - Generic - 100%, Preferred Brand - Copayment/Coinsurance above applies, Non-Preferred Brand - Copayment/Coinsurance above applies	Women's Contraceptives - Generic - 100%, Preferred Brand - Copayment/Coinsurance above applies, Non-Preferred Brand - Copayment/Coinsurance above applies
Drugs for the Treatment of Sexual Dysfunction	Covered at the applicable generic or brand cost share	Covered at the applicable generic or brand cost share
Mail Order Prescription Drugs	Two times the applicable copay up to a 90 day supply. Specialty drugs are not covered through mail order pharmacies.	Two times the applicable copay up to a 90 day supply. Specialty drugs are not covered through mail order pharmacies.
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.	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	Note: Specialty Drugs may be obtained from any BCN participating specialty pharmacy	Note: Specialty Drugs may be obtained from any BCN participating specialty pharmacy
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.	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 drugs (continued)

Benefits	Enhanced	Standard
Prescription Drug Deductible	None	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	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

Enhanced Benefits: CLSSLG :

100MSR,10OVCR,1250PM,AS5,BCNWIG,DME5,DSRCW,ER50,HA2707,HHRX,MOPD2C,P&O5,PD34DS,PD520C,PNSD,PO1SI,SN730,UR10,VACR50,WRCWR

Standard Benefits: CLSSLG :

100MSR,1250PM,1550DC,AS5,BCNWIG,C110%,CO20,D250,DME5,DSRCW,ER100,HA2707,HHRX,MOPD2C,P&O5,PD34DS,PNSD,PO1SI,SN730,UR20,VACR50,WRCWR