Blue Care Network of Michigan

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

Benefits-at-a-Glance
BCN Student Health Plan
00401167-0001-0001 WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE
Effective Date: 07/01/2021

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.*

Deductible, Copays and Dollar Maximums	
Deductible	$500 individual/$1,000 family per calendar year
Fixed Dollar Copays	$5 for Allergy Injections
	$30 for office visits
	$60 for urgent care visits
	$100 for emergency room visits
	$30 for referral physician visits
Coinsurance	50% for select services as noted below
	20% for select services as noted below
Annual Coinsurance Maximum (ACM)	None
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays	$2,500 per individual/$5,000 per family

Benefits Selected - : CI20%,D500,DPRCOS,VACR50,ER100,CO30,2500PM,2500PM,PS6468,90D3XS,UR60,PVSN

Preventive Services	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening	100%
Well-Baby and Child Care	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening	100%
Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Female Sterilization	100%
Breast Pumps (DME guidelines apply.)	100%
Maternity Pre-Natal care	100%

Physician Office Services	
Office Visits- Note: Applicable cost sharing applies when other services are received in the office.	$30 Copay
Medical Online Visits	$30 Copay
Consulting Specialist Care - when referred for other than preventive services	$30 Copay

Emergency Medical Care	
Hospital Emergency Room - copay waived if admitted	$100 Copay
Urgent Care Center	$60 Copay
Ambulance Services - medically necessary	80%

Diagnostic Services	
Laboratory and Pathology Tests	100%
Diagnostic Tests and X-rays	80%
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	80%
Radiation Therapy	80%

Maternity Services Provided by a Physician	
Post-Natal and Non-routine Pre-Natal Care (See Preventive Services section for routine Pre-Natal Care)	$30 Copay
Delivery and Nursery Care	100% for professional services; see hospital care for facility charges

Hospital Care	
General Nursing Care, Hospital Services and Supplies	80%
Outpatient Surgery	80%

Alternatives to Hospital Care	
Skilled Nursing Care	80%
Hospice Care	100%
Home Health Care	$30 Copay

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Surgical Services

Surgery - included all related surgical services and anesthesia.	80%
Voluntary Male Sterilization	50%
First Trimester Termination (One procedure per two year period of membership)	50% after deductible
Human Organ Transplants	80%
Reduction Mammoplasty	50%
Male Mastectomy	50%
Temporomandibular Joint Syndrome	50%
Orthognathic Surgery	50%
Weight Reduction Procedures (Limited to one procedure per lifetime)	50%

Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)

Inpatient Mental Health Care	80%
Inpatient Substance Use Disorder	80%
Outpatient Mental Health Care	$30 Copay
Outpatient Substance Abuse	$30 Copay

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	$30 Copay
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18; Physical, speech and occupational therapy for autism is unlimited	$30 Copay
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visit and preventive benefit.

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Other Services

Allergy Testing and Therapy	50%
Allergy Injections	$5 copay
Chiropractic Spinal Manipulation - when referred	$30 Copay
Rehab Services - subject to meaningful improvement within 90 days; Outpatient PT/OT - limited to a combined benefit max of 30 visits per calendar year; ST - limited to 30 visits per calendar year	$30 Copay
Habilitative Services- Outpatient Physical and Occupational Therapy limited to a combined benefit maximum of 30 visits per calendar year; Outpatient Speech Therapy limited to 30 days per calendar year	100%
Outpatient Cardiac and Pulmonary Rehabilitation; limited to a benefit maximum of 30 visits per calendar year	100%
Infertility Counseling and Treatment; on all associated costs (excluding In-vitro fertilization)	50%
Outpatient Physical, Speech and Occupational Therapy- subject to meaningful improvement within 60 days	50%
Prosthetic and Orthotic Appliances (P&O)	50%
Diabetic Supplies	50%
Pediatric Vision - Eye Exam and prescription glasses (chosen from a select collection) imited to once per calendar year through the last day of the year in which an individual turns age 19	100%
Prescription Drugs	Tier 1A - $6 copay, Tier 1B - $40 copay, Tier 2 - $60 copay, Tier 3 - $80 copay, Tier4 - 20% coinsurance (max $200 copay)/Tier5 - 20% Coinsurance (max $300 copay) 30 day supply
	Sexual Dysfunction - Not Covered
	Female contraceptives - Tier 1A - Covered in full, Tier 1B - $40 copay, Tier 2 - $60 copay, Tier 3 - $80 copay
	Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.
Hearing Aid	Not covered

Prescription Drugs

Prescription Drugs	Tier 1A - $6 copay, Tier 1B - $40 copay, Tier 2 - $60 copay, Tier 3 - $80 copay, Tier4 - 20% coinsurance (max $200 copay)/Tier5 - 20% Coinsurance (max $300 copay) 30 day supply
	Sexual Dysfunction - Not Covered
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	Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.
Mail Order Prescription Drugs	30 day supply or less - applicable tiered copay / coinsurance; 31-90 day supply - 3x's the 30 day copay/coinsurance minus $10
Prescription Drug Deductible	None
	Effective 1/1/20 -Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs

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Medical Pharmacy	0000H774 0000G659	STU1 4X14	MED

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