Blue Care Network of Michigan

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Group Name / Group ID: MITTEN EDUCATIONAL MANAGEMENT LLC / 00279912
Sub Group Name / Sub Group ID: MITTEN EDUCATIONAL MANAGEMENT LLC / 0001
Class ID: 0002
Plan Description: Medical Regular Member HMO Classic Group
Effective Date: 2019-09-01

Disclaimer: 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 certificate 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 benefit summary and any applicable plan documents, the plan document will control.

DEDUCTIBLE

This health plan has no deductible.

COINSURANCE MAXIMUM

$1,000 per individual; $2,000 per family annual coinsurance maximum. The following do not apply to the coinsurance max if they are includedin your coverage: deductible, infertility services, male mastectomy, reduction mammoplasty, sterilization of male reproductive organs, elective abortion, TMJ, orthognathic surgery, weight reduction procedures,DME, P&O, diabetic supplies and services with a flat dollar copay.

OUT-OF-POCKET MAXIMUM

$6,600 per individual, $13,200 per family out-of-pocket maximum per calendar year

ALLERGY OFFICE VISIT

50% coinsurance for allegy office visits

AMBULANCE EMERGENT

20% coinsurance for emergency ambulance transport when other transportation would endanger a member's life

AMBULANCE NON-EMERGENT

20% coinsurance for non-emergent ambulance transport. Requires priorauthorization by BCN.

DETOX - SUB ABUSE

20% coinsurance for inpatient or residential detox services. $25 copay per visit for outpatient detox services. Requires prior authorization by BCN.

DURABLE MEDICAL EQUIPMENT

50% coinsurance for durable medical equipment. Must be preauthorizedand obtained from a BCN supplier. Breast pump to support breast feeding is covered in full.

EMERGENCY ROOM

$250 copay for emergency room treatment. ER copay waived if admittedas an inpatient. Your inpatient hospital benefit applies. See Inpatient Hospital.

HOME CARE VISITS

$35 copay per day for home care visits

INFERTILITY CARE (CRITERIA REQUIRED)

50% coinsurance for infertility services. Requires prior authorization by BCN. In-vitro fertilization is not covered.

INPATIENT HOSPITAL

20% coinsurance per inpatient hospital admission; unlimited days. See certificate for specific surgical coinsurance.

LAB

Lab and pathology services are covered in full

MENTAL HEALTH INPATIENT

20% coinsurance for inpatient mental health/partial hospitalization per hospital admission. Requires prior authorization by BCN.

MENTAL HEALTH INPATIENT DAYS

Unlimited visits when medically necessary. Requires prior authorization by BCN behavioral health management.

MENTAL HEALTH INPATIENT TIME PERIOD

Coordinated by BCN behavioral health management

MENTAL HEALTH OUTPATIENT

$25 copay per visit for outpatient/intensive outpatient mental health. $25 copay per online mental health visit with a designated online BCN participating provider. Prior authorization not required for routine psychotherapy visits.

MENTAL HEALTH OUTPATIENT VISITS

Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.

MENTAL HEALTH OUTPT ADDL VISITS

Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.

ORTHOGNATHIC SURGERY

50% coinsurance for orthognathic surgery

ORTHOTICS

50% coinsurance for orthotics. Must be preauthorized and obtained from a BCN supplier.

OUTPATIENT SURGERY FACILITY

20% coinsurance for outpatient surgery. Preventive services and screenings as mandated by the Affordable Care Act are covered in full. See certificate for specific surgical coinsurance.

OUTPT FAC VISITS/DIAGNOSTIC SRVCS

20% coinsurance for outpatient diagnostic or therapeutic services. Lab and pathology services, prenatal ultrasound, preventive services and screenings as mandated by the Affordable Care Act are covered in full.

PCP VISITS

$25 copay per primary care physician office visit. Preventive services and screenings as mandated by the Affordable Care Act are covered in full. See BCBSM.com for a complete list of preventive services. $25 copay for medical online visits when performed by a BCN designated online vendor, PCP or participating referral physician.

PHYSICAL THERAPY/REHAB OUTPT

$35 copay per visit for outpatient physical therapy and rehabilitation

PHYSICAL THERAPY/REHAB OUTPT LIMITS

Limited to 60 visits per calendar year for any combination of therapies.

PRE-EXISTING CONDITION

Not applicable

PRE-EXISTING TIME PERIOD

Not applicable

PROSTHETICS

50% coinsurance for prosthetics. Must be obtained from a BCN participating supplier.

SKILLED NURSING FACILITY

20% coinsurance for services in a skilled nursing facility

SKILLED NURSING FACILITY DAYS

Limited to 45 days of skilled nursing care per calendar year in a skilled nursing facility. Requires prior authorization by BCN

SPECIALIST VISITS

$35 copay per specialist office visit when referred. Preventive services and screenings as mandated by the Affordable Care Act are coveredin full. Spinal manipulations limited to 30 combined visits per calendar year when provided by a chiropractor or osteopathic physician.

STERILIZATIONS

50% coinsurance for sterilization of male reproductive organs. Sterilization of female reproductive organs is covered in full.

SUB ABUSE INTERMEDIATE

20% coinsurance for residential/intermediate/partial hospitalization substance use disorder. Requires prior authorization by BCN Behavioral Health management.

SUB ABUSE INTERMEDIATE TIME PERIOD

Coordinated by BCN behavioral health management

SUB ABUSE OUTPATIENT

$25 copay per visit for outpatient/intensive outpatient substance usedisorder. Prior authorization not required for routine psychotherapy visits.

SUB ABUSE OUTPATIENT VISITS

Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.

TEMPOROMANDIBULAR JOINT

50% coinsurance for TMJ services. Requires prior authorization by BCN.

ELECTIVE ABORTIONS

50% coinsurance for first trimester elective abortion. Limited to one procedure per 24 month period.

URGENT CARE CENTER

$35 copay per urgent care visit

WEIGHT REDUCTION (CRITERIA REQUIRED)

50 % coinsurance for weight reduction procedures. Requires prior authorization by BCN. Limited to one procedure per lifetime.

X-RAY

$150 copay for high tech radiology services such as MRI, PET, CAT or MRA when performed in an outpatient facility, free standing facility or office setting. 20% coinsurance for other radiology services. Prenatal ultrasound and other preventive screenings are covered in full.

ANESTHESIA

20% coinsurance for anesthesia

SURGICAL ASSISTANT

Inpatient services performed by a surgical assistant are covered in full. 20% coinsurance for outpatient services performed by a surgical assistant.

SECOND SURGICAL OPINION

$35 copay for second surgical opinion when referred

HOSPICE

Inpatient and outpatient hospice are covered in full. Inpatient carerequires prior authorization.

NEWBORN CARE

20% coinsurance for newborn care in an inpatient setting

IMMUNIZATIONS

Pediatric and adult immunizations as recommended by the Advisory Committee on Immunization Practices are covered in full.

MATERNITY

$25 copay for postnatal maternity visits. Routine prenatal visits arecovered in full. Effective 1/1/23, routine postnatal visits are covered in full.

DIALYSIS

20% coinsurance for dialysis treatment in an inpatient or outpatient facility setting

CHEMOTHERAPY

20% coinsurance for chemotherapy in an inpatient or outpatient facility setting. Chemotherapy drugs are covered in full.

RADIATION THERAPY

20% coinsurance for radiation therapy in an inpatient or outpatient facility setting

AUTISM

$25 copay per visit for applied behavioral analysis. Outpatient rehabilitation benefit applies for autism related speech, physical and occupational therapy with unlimited visits.

DIABETIC SUPPLIES

20% coinsurance for diabetic supplies and equipment. Must be preauthorized and obtained from a BCN supplier.

ALLERGY EVAL/SERUM/TESTING

50% coinsurance for allergy related services with the exception of allergy injections

ALLERGY INJECTIONS

$5 copay per visit for allergy injections

Group Name / Group ID: MITTEN EDUCATIONAL MANAGEMENT LLC / 00279912
Sub Group Name / Sub Group ID: MITTEN EDUCATIONAL MANAGEMENT LLC / 0001
Class ID: 0002
Plan Description: Pharmacy BCN
Effective Date: 2019-09-01

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DEDUCTIBLE

This prescription plan has no deductible.

OUT-OF-POCKET MAXIMUM

$6,600 per individual; $13,200 per family out-of-pocket maximum per year

PRESCRIPTION DRUG COVERAGE WITH CONTRACEPTIVES

Preferred Generic Tier - $10 copay, Non-Preferred Generic Tier - $30 copay, Preferred Brand Tier - $60 copay, Non-Preferred Brand Tier -$80copay, Preferred Specialty Tier - 20% coinsurance (max $200), Non-Preferred Specialty Tier - 20% coinsurance (max $300). Drugs for the treatment of sexual dysfunction 50% coinsurance. 30-day supply. Preventive medications and Preferred Generic Tier contraceptives are covered in full. 90-day retail and mail order covered at 3 times the applicable copay minus $10.