



Location/Subgroup: CONCORD ACADEMY OF PETOSKEY  
 Group-Subgroup-Class: 00263552-0001-0001

## BCN HRA <sup>SM</sup> HMO Platinum \$5000

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 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.

### Member's Responsibility: Deductible, Copays, Coinsurance and Dollar Maximums

Note: The Deductible will apply to certain services as defined below.

**Deductible** \$5,000 per individual/\$10,000 per family per benefit year

Note: Coinsurance and select fixed dollar copays apply once the deductible has been met.

**Fixed dollar copays** \$20 for office visits, \$40 for specialist visits, \$50 for urgent care visits, \$150 for emergency room visits, \$150 for high tech imaging and \$5 for allergy injections

**Coinsurance** 20% and 50% for select services as noted below

**Annual Coinsurance Maximum** None

**Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug cost-sharing amounts** \$6,350 per member/\$12,700 per family per benefit year

### Preventive Services - as defined by the Affordable Care Act and included in your Certificate of Coverage

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%
Routine Colonoscopy	Covered – 100%
Mammography Screening	Covered – 100%
Voluntary Female Sterilization	Covered – 100%
Breast Pumps	Covered – 100%
Maternity Pre-Natal Care	Covered – 100%

### Physician Office Services

PCP Office Visits	Covered – \$20 copay
Note: Applicable cost sharing applies when other services are received in the office	
Medical Online Visits	Covered – 100%
Consulting Specialist Care – when referred for other than preventive services	Covered – \$40 copay
Note: Applicable cost sharing applies when other services are received in the office	



UNIVERSITY OF MICHIGAN  
MEDICAL CENTER

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### Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered – \$150 copay after deductible
Urgent Care Center	Covered – \$50 copay
Retail Health Clinic	Covered – \$50 copay
Ambulance Services – medically necessary	Covered – 80% after deductible

### Diagnostic Services

Laboratory and Pathology Services	Covered – 100%
Diagnostic Tests and X-rays	Covered – 80% after deductible
High Technology Imaging (MRI, CAT, PET)	Covered – \$150 copay after deductible
Radiation Therapy	Covered – 80% after deductible

### Maternity Services Provided by a Physician

Post-Natal Care. See Preventive Services section for Pre-Natal Care	Covered – \$20 copay
Delivery and Nursery Care	Covered – 100% after deductible for professional services; see Hospital Care for facility charges

### Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 80% after deductible; unlimited days
Outpatient Surgery – See member certificate for select surgical coinsurance	Covered – 80% after deductible

### Alternatives to Hospital Care

Skilled Nursing Care	Covered – 80% after deductible up to 45 days per benefit year
Hospice Care	Covered – 100% after deductible when authorized
Home Health Care	Covered – \$40 copay after deductible

### Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 80% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – 50% after deductible
Elective Abortion (One procedure per two-year period of membership)	Not Covered
Human Organ Transplants (subject to medical criteria)	Covered – 80% after deductible
Reduction mammoplasty (subject to medical criteria)	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 50% after deductible

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

Inpatient Mental Health Care and Substance Use Disorder	Covered – 80% after deductible
Outpatient Mental Health Care includes online visits Note: For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	Covered – \$20 copay



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

**Outpatient Substance Use Disorder** Covered – \$20 copay

## Autism Spectrum Disorders, Diagnoses and Treatment

**Applied behavioral analyses (ABA) treatment through age 18** Covered – \$20 copay  
**Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCN approved autism evaluation center (AAEC) prior to seeking ABA treatment.

**Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18** Covered – \$40 copay after deductible  
 Unlimited visits for physical, speech and occupational therapy for autism spectrum disorder diagnosis

**Other covered services, including mental health services, for Autism Spectrum Disorder** See your outpatient mental health, medical office visits and preventive benefit

## Other Services

**Allergy Testing and serum** Covered – 50% after deductible

**Allergy office visits** Covered – 50%

**Allergy Injections** Covered – \$5 copay

**Chiropractic Spinal Manipulation – when referred** Covered – \$40 copay; up to 30 visits per benefit year

**Rehabilitative Services – subject to meaningful improvement within 90 days** Covered – \$40 copay after deductible

- Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year
- Outpatient Speech Therapy – limited to 30 visits per calendar year

**Habilitative Services** Covered – \$40 copay after deductible

- Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year
- Outpatient Speech Therapy – limited to 30 visits per calendar year

**Outpatient Cardiac and Pulmonary Rehabilitation** Covered – \$40 copay after deductible; limited to a benefit maximum of 30 visits per benefit year

**Infertility Counseling and Treatment (excluding In-vitro fertilization)** Covered – 50% after deductible on all associated costs

**Durable Medical Equipment** Covered – 50%

**Prosthetic and Orthotic Appliances** Covered – 50%

**Diabetic Supplies** Covered – 80%

**Pediatric Vision** Covered – 100%

- Eye Exam – Limited to once per calendar year through the last day of the year in which an individual turns age 19
- Prescription Glasses – Frames (chosen from a select collection) and lenses are covered once in a calendar year through the last day of the year in which an individual turns age 19



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## Other Services

### Prescription Drugs

**Note:** When a manufacturer coupon is used through the BCN high cost drug discount program, the amount paid after the discount applies toward the out-of-pocket maximum.

Tier 1A – Value Generics Covered – \$6 copay  
 Tier 1B – Generics Covered – \$25 copay  
 Tier 2 Preferred Brand Covered – \$50 copay  
 Tier 3 Non-Preferred Brand Covered – \$80 copay  
 Tier 4 Preferred Specialty Covered – 20% Coinsurance of the BCN Approved Amount (Maximum Copayment \$200) - Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.  
 Tier 5 Non-Preferred Specialty Covered – 20% Coinsurance of the BCN Approved Amount (Maximum Copayment \$300) – Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.  
 Drugs for sexual dysfunction, weight loss, cough & cold Not Covered  
 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.  
 Contraceptives Covered – Tier 1A – 100% , Tier 1B – \$25 copay, Tier 2 - \$50 copay, Tier 3 - \$80 copay  
 Preventive Drugs Covered – 100%  
 90 Day Retail: 84-90 day supply Covered – Three times applicable copay minus \$10