Blue Care Network of Michigan

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

Benefits-at-a-Glance
Blue Elect Plus POS - Clergy
00105023 MICHIGAN CATHOLIC CONFERENCE
SF01/SF02
Effective Date: 01/01/2026

This is intended as an easy-to-read summary. **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. **Services must be provided or arranged by 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 **https://bcbsm.com/priorauth**.

Note: Blue Care Network provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

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

Benefits	In Network	Out of Network
Deductible **Note:** The Deductible will apply to certain services as defined below.	$100 per member/$300 per family of 3 or more per calendar year. Members with a family contract of 2 will never each pay more than the individual deductible.	$500 per member/$1,500 per family of 3 or more per calendar year. Members with a family contract of 2 will never each pay more than the individual deductible.
Fixed Dollar Copays	$20 for PCP Office Visits $35 for Specialist Visits $35 for Urgent Care Visits $150 for Emergency Room Visits $50 for Ambulance Services	$35 for Urgent Care Visits $150 for Emergency Room Visits $50 for Ambulance Services
Coinsurance **Note:** Coinsurance applies once the deductible has been met	10% and 50% for select services as noted below 20% for select services as noted below	10% and 50% for select services as noted below 20% 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	$1,000 per member/ $3,000 per family per calendar; Members with a family contract of 2 will never each pay more than the individual out-of-pocket maximum.	$3,000 per member/ $9,000 per family per calendar; Members with a family contract of 2 will never each pay more than the individual out-of-pocket maximum.

Preventive services

Benefits	In Network	Out of Network
Health Maintenance Exam	Covered 100%	Not covered
Annual Gynecological Exam	Covered 100%	Not covered
Pap Smear Screening - laboratory services only	Covered 100%	Not covered
Well-Baby and Well-Child Visits	Covered 100%	Not covered
Immunizations	Covered 100%	Not covered
Prostate Specific Antigen (PSA) Screening - laboratory services only	Covered 100%	Not covered
Routine Colonoscopy	Covered 100%	20% coinsurance of the allowed amount after deductible
Mammography Screening	Covered 100%	20% coinsurance of the allowed amount after deductible
Voluntary Sterilization of Female Reproductive Organs	Not covered	Not covered
Breast Pumps (DME guidelines apply.)	Covered 100%	Not covered
Routine Maternity Prenatal and Postnatal Care	Covered 100%	20% coinsurance of the allowed amount after deductible

Physician office services

Benefits	In Network	Out of Network
PCP Office Visits **Note:** Applicable cost sharing applies when other services are received in the office	$20 copay	20% coinsurance of the allowed amount after deductible
Medical Online Visits - when performed by a professional provider **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.	$20 copay	20% coinsurance of the allowed amount after deductible
Specialist Visits **Note:** Applicable cost sharing applies when other services are received in the office	$35 copay	20% coinsurance of the allowed amount after deductible

Emergency medical care

Benefits	In Network	Out of Network
Hospital Emergency Room - copay waived if admitted, inpatient hospital benefit will apply	$150 copay	$150 copay
Urgent Care Center	$35 copay	$35 copay
Retail Health Clinic	$35 copay	$35 copay
Ambulance Services - medically necessary	$50 copay	$50 copay

Diagnostic services

Benefits	In Network	Out of Network
Laboratory and Pathology Tests	Covered 100%	Covered 100%
Diagnostic Tests and X-rays	20% coinsurance after deductible	20% coinsurance of the allowed amount after deductible

Diagnostic services (continued)

Benefits	In Network	Out of Network
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	20% coinsurance after deductible	20% coinsurance of the allowed amount after deductible
Radiation Therapy	20% coinsurance after deductible	20% coinsurance of the allowed amount after deductible

Maternity services provided by a physician

Benefits	In Network	Out of Network
Routine Prenatal and Postnatal Care Visits	Covered 100%	20% coinsurance of the allowed amount after deductible
Delivery and Nursery Care	20% coinsurance after deductible	20% coinsurance of the allowed amount after deductible

Hospital care

Benefits	In Network	Out of Network
General Nursing Care, Hospital Services and Supplies	20% coinsurance after deductible; unlimited days	20% coinsurance of the allowed amount after deductible when authorized; unlimited days
Outpatient Surgery	20% coinsurance after deductible	20% coinsurance of the allowed amount after deductible

Alternatives to hospital care

Benefits	In Network	Out of Network
Skilled Nursing Care	20% coinsurance after deductible	20% coinsurance of the allowed amount after deductible
Skilled Nursing Care Limit	Limited to 120 days per calendar year, in-network and out-of-network combined.	
Hospice Care	Covered 100% after deductible	20% coinsurance of the allowed amount after deductible
Home Health Care	Covered 100% after deductible	20% coinsurance of the allowed amount after deductible

Surgical services

Benefits	In Network	Out of Network
Surgery - includes all related surgical services and anesthesia. See member certificate for specific surgical copays.	See Hospital Care for surgical copay	See Hospital Care for surgical copay
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	Not covered	Not covered
Human Organ Transplants (subject to medical criteria)	20% coinsurance after deductible	20% coinsurance of the allowed amount after deductible
Reduction Mammoplasty (subject to medical criteria)	50% coinsurance after deductible	50% coinsurance of the allowed amount after deductible
Male Mastectomy (subject to medical criteria)	50% coinsurance after deductible	50% coinsurance of the allowed amount after deductible

Surgical services (continued)

Benefits	In Network	Out of Network
Temporomandibular Joint Syndrome (subject to medical criteria)	50% coinsurance after deductible	50% coinsurance of the allowed amount after deductible
Orthognathic Surgery (subject to medical criteria) - Limited to one procedure per lifetime	50% coinsurance after deductible	50% coinsurance of the allowed amount after deductible
Weight Reduction Procedures	50% coinsurance after deductible	Not covered

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

Benefits	In Network	Out of Network
Inpatient Mental Health Care	10% coinsurance when authorized	10% coinsurance of the billed amount when authorized
Residential Substance Use Disorder	10% coinsurance when authorized	10% coinsurance of the billed amount when authorized
Outpatient Mental Health Care includes telemedicine and online visits **Note:** For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	10% coinsurance	10% coinsurance of the billed amount
Outpatient Substance Use Disorder	10% coinsurance	10% coinsurance of the billed amount

Autism spectrum disorders, diagnoses and treatment

Benefits	In Network	Out of Network
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% coinsurance	10% coinsurance of the billed amount
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	$35 copay	20% coinsurance of the allowed amount 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	In Network	Out of Network
Allergy Testing and Therapy	Covered 100% including allergy injections; office visit copay may apply	50% coinsurance of the allowed amount after deductible, including allergy injections
Chiropractic Spinal Manipulation	$35 copay	Not covered
Chiropractic Spinal Manipulation Limit	24 visits per calendar year	
Outpatient Physical, Speech and Occupational Therapy - subject to meaningful improvement within 60 days	$35 copay	20% coinsurance of the allowed amount after deductible
Outpatient Physical, Speech and Occupational Therapy Limit	Limited to 60 visits per calendar year for any combination of outpatient rehabilitative therapies for in-network and out-of-network combined.	

Other services (continued)

Benefits	In Network	Out of Network
Infertility Counseling and Treatment	50% coinsurance after deductible for infertility counseling. Infertility treatment is not covered.	Not covered
Durable Medical Equipment	Covered 100%	Not covered
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.	Covered 100%	Not covered
Prosthetic and Orthotic Appliances	Covered 100%	Not covered
Hearing Aid	Binaural hearing aids and exam every 36 months covered 100%	Not covered

Prescription drugs

Benefits	In Network	Out of Network
Generic Tier	$10 copay	Not covered
Preferred Brand Tier	$30 copay	Not covered
Nonpreferred Brand Tier	$50 copay	Not covered
Drugs for the Treatment of Sexual Dysfunction	Applicable tiered copay	Not covered
Contraceptives	Not covered	Not covered
Weight Loss Drugs	Weight loss prescription drugs are not covered.	
Mail Order Prescription Drugs	Two times the applicable copay up to a 90 day supply. Specialty drugs are not covered through mail order pharmacies.	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.	Not covered
Specialty Drug Pharmacy	Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs	Not covered
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.	

Prescription drugs (continued)

Benefits	In Network	Out of Network
Prescription Drug Deductible	None	Not applicable
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	

For Internal Purposes Only
Benefits Selected - BEPLGF : 10305F,ASDBPF,AUTOPF,HA2F,MCC21F,MOP2OF,ONVBPF,PDLRF,RXVAR,SMT90F,XWLDF