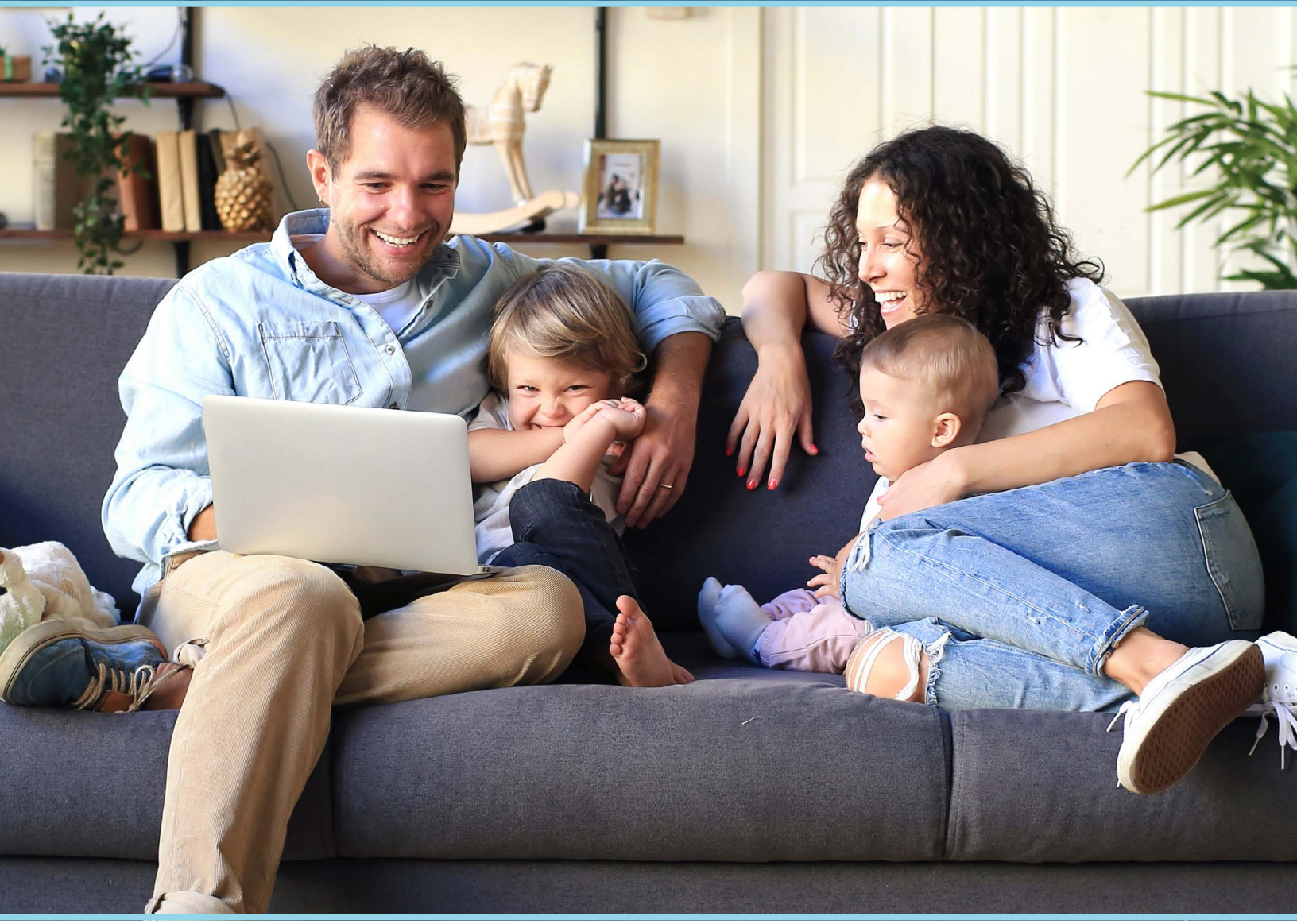
Blue Care Network of Michigan

Get the freedom and flexibility you want in a health care plan



Your guide to our point-of-service plans

Blue Elect Plus℠ POS, Blue Elect Plus HSA℠ POS, Blue Elect Plus HRA℠ POS

READY TO HELP

MICHIGAN

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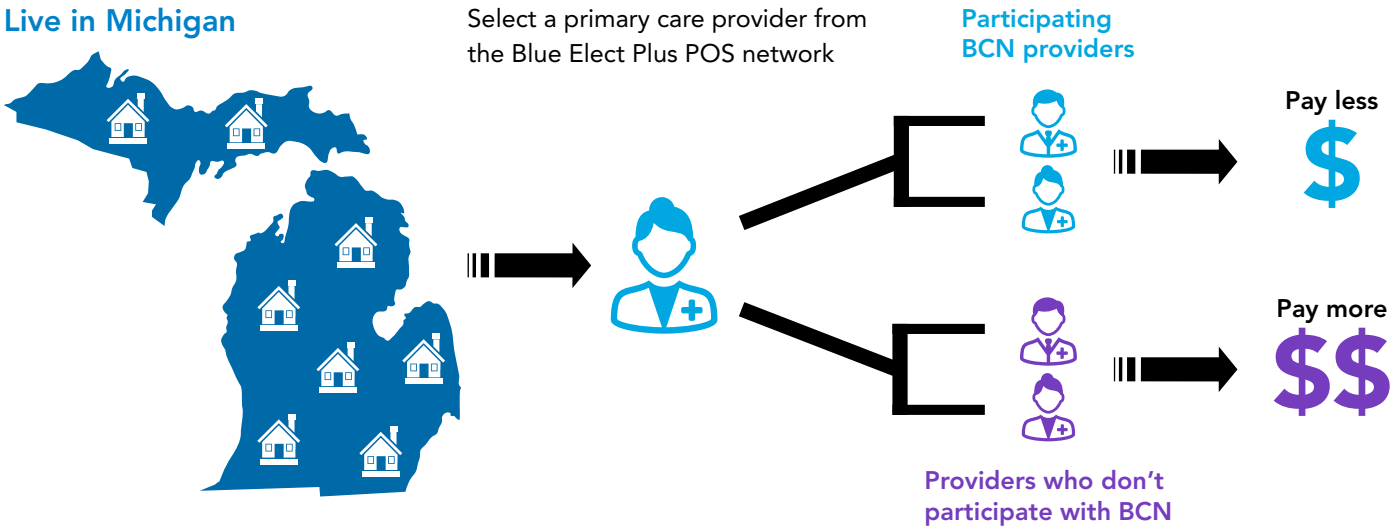
Blue Elect Plus point of service plans provide the freedom of choosing where to go for affordable care — in or out of your plan's network — without a referral.

Here's how it works:

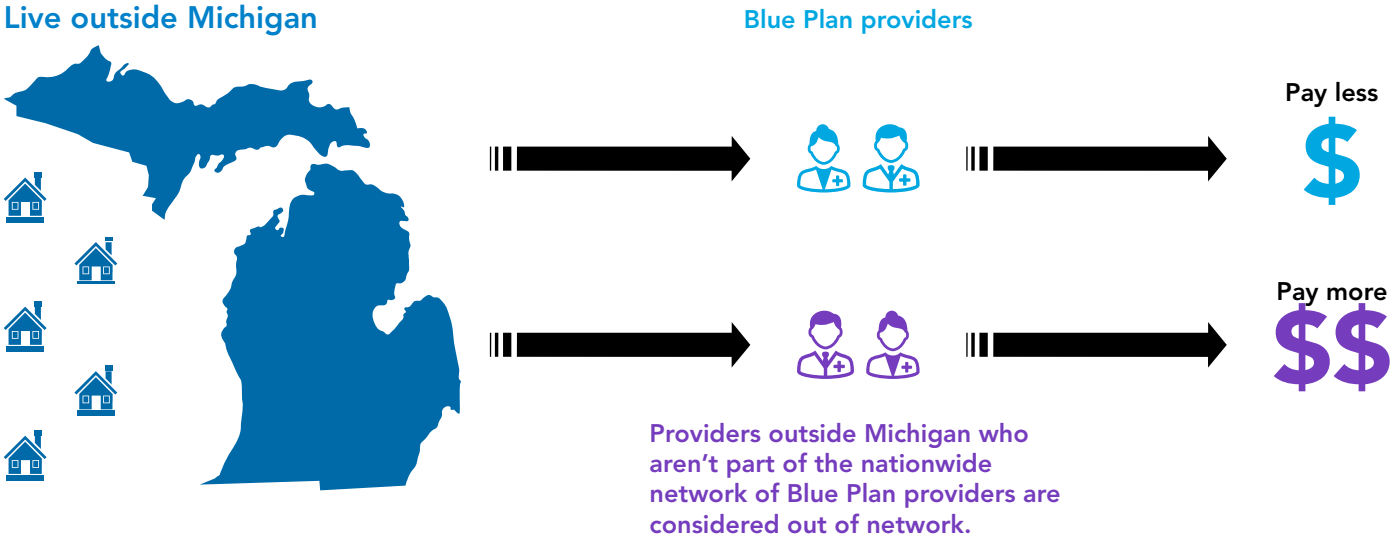
If you live in Michigan

Once you enroll, you'll need to select a BCN primary care provider. You can have one primary care provider for everyone in your family. Or each family member can have their own. For example, you may want your children to see a pediatrician, while adult family members go to an internist. And when you need to see a specialist or another physician, you won't need a referral. You pay less out of pocket for health care services when you see a participating BCN provider.



If you live outside Michigan

Once you enroll, you don't need an assigned primary care provider or a referral to see other health care providers. To receive your lower-cost, in-network benefits, you'll need to see a Blue Plan provider who's based outside Michigan.



Health reimbursement arrangement

A Blue Elect Plus℠ HRA POS plan, is a point-of-service plan, combined with an employer-funded health reimbursement arrangement. If available as an option to you, an HRA is a fund set up by your employer and administered by Blue Care Network.

You share in the cost of services through deductibles, coinsurances and copays. Your HRA can help you pay for deductibles, coinsurances or both.

Your employer will decide how much they'll contribute to your HRA and select the plan design for how your HRA will work.

Talk with your benefits representative to find out which plan design your employer selected.

HRA advantages

- Employer-sponsored funds can be used to pay for employer-defined expenses.
- No debit card needed. Your provider will automatically receive payment for eligible expenses.
- We'll send you an explanation of benefits statement showing you when expenses have been paid from your HRA and the amount.

Health savings account

If you have a Blue Elect Plus HSA℠ POS plan, your employer may offer a health savings account, administered through HealthEquity®.

An HSA is like a 401(k) account for your health care. Use it to pay for current health care expenses and save for future qualified medical expenses, including retiree health expenses.

You'll be able to access money in your account with an HSA Visa® card.

If you're eligible for an HSA, you'll receive a welcome kit from the HSA administrator after you enroll.

HSA advantages

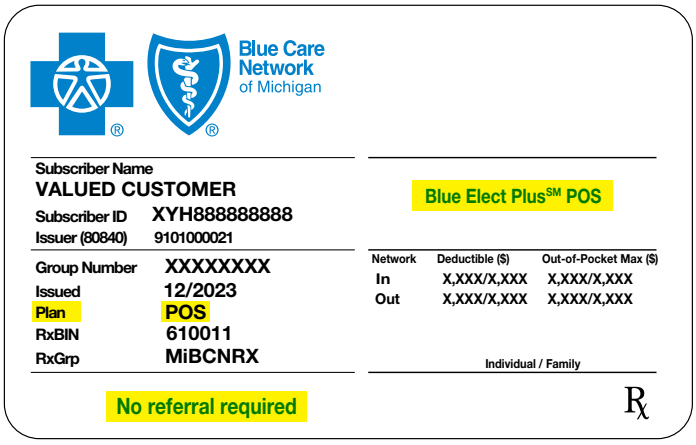
- Contributions, investment earnings and withdrawals for qualified medical expenses are all tax advantaged.
- Contributions that aren't spent roll over from year to year.
- Once the account reaches $2,000 for HealthEquity, you can invest your money.

HealthEquity is an independent company supporting Blue Cross and BCN by providing health care spending account administration services. An independent, FDIC-insured bank holds the health saving account dollars.

What you pay depends on where you go

- **In-network providers** are BCN-participating providers in Michigan and Blue Plan providers outside Michigan. You'll pay less out of pocket when you're seen by these doctors.
- **Out-of-network providers** in Michigan don't participate with BCN. Providers outside Michigan who aren't part of the nationwide network of Blue Plan providers, also are considered out of network. You may get care for services from these providers, but you'll pay more.

You'll be responsible for checking that the provider you see is participating in your plan's network. Call your provider's office to confirm they're in network before receiving care.



Always show your plastic member ID card at your doctor's office as proof of coverage. Make sure to show them the information we've highlighted on the sample ID card above, so the medical services you receive are billed correctly.

Health care providers who aren't in network may bill you for the difference between what we pay and what they charge for their service. You'll be responsible for paying that difference, and this amount won't apply to your deductible (if applicable) or your out-of-pocket maximum. Some out-of-network providers may require you to pay in full at the times you receive the services. You can request reimbursement for our share of the cost.

Know which services require an in-network provider

Some services are only included when received from an in-network provider (see the A list below). But there are also preventive services members can receive in or out of network (see the B list below).

A. Examples of in-network-only services

- Most preventive services as defined by the Affordable Care Act (see List B for exceptions)
- Infertility counseling and treatment
- Adult sterilization
- Durable medical equipment
- Prosthetics and orthotics
- Diabetic supplies
- Weight reduction procedures
- Chiropractic services

B. Examples of preventive services that can be received both in and out of network

- Flu vaccine
- Routine colonoscopy
- Mammography screening
- Routine maternity prenatal and postnatal care

Find a doctor

When you enroll with a Michigan address, you'll select a primary care provider to coordinate your care. If you don't, one will be selected for you. To check if your current doctor is in network, go to **bcbsm.com/find-a-doctor**.

Your plan information at your fingertips

Your online account gives you the control you need to get the most from your benefits right from the start. Once you enroll, set up your secure account at **bcbsm.com/myaccount**. Or search **BCBSM** to download the app. Open the app and select *Register*.

- If you enroll with a Michigan address, find doctors and hospitals in your plan's network and review quality information. If you live outside Michigan, use your account to find Blue Plan providers.
- Review your online *Member Handbook* for coverage information.
- Check your claims, explanation of benefits statements and out-of-pocket balances.
- Compare estimates for costs of health care services.*
- Select your primary care provider, if you enroll with a Michigan address.
- Manage prescriptions, find a pharmacy and compare medication costs, if you have prescription drug coverage.
- Receive real-time notifications for your prior authorization or referral requests.
- Order more member ID cards for adult members on your plan.

Plus get healthful perks

- Exclusive member discounts such as gym memberships, fitness gear and recreation
- Personalized digital resources for your health and well-being

*Not available for members receiving services outside Michigan.

What's a prior authorization?

If you've ever been to the doctor and needed certain health care services or prescription drugs, your doctor may have told you your health care plan needs to authorize the service. A prior authorization is approval from us for certain services, such as hospitalization, certain radiology services and outpatient therapy.

Why do some services need prior authorization?

In some cases, we require authorization to make sure what's being requested is appropriate for your condition and medically necessary. A prior authorization may be required for certain prescription drugs, medical tests, surgeries and other health care services (see the list on the next page). Your plan may also have requirements about where to get certain services.

What services need a prior authorization?

If your health care provider doesn't get a prior authorization, we may not pay for the health care service. That's why it's always a good idea to check if a prior authorization is needed before receiving any services.

The following is a partial list of health care services that need prior authorization. **Once you enroll, you can check your online account or call the number on the back of your member ID card for a complete list. Or check with your doctor to see if prior authorization is required for a health care service.**

- Musculoskeletal services, including pain management
- Sterilization procedures
- Chiropractic services
- Cosmetic procedures, such as removing scars or excess tissue from your eyes or abdomen
- Gender reassignment surgery
- Inpatient care
- Mental health or substance use disorders: inpatient hospitalizations, partial hospitalization services and treatment in a freestanding substance use disorder facility
- Physical, speech and occupational therapy
- Skilled nursing facility care
- Transplant services, including those for organ, bone marrow and stem cell transplants

Who's responsible for submitting a prior authorization?

For in-network services, the doctor coordinates the authorization process. **When you see a doctor who's not in network, you're responsible for having the out-of-network health care provider call the number on the back of your member ID card to request prior authorization.** We'll begin the review process once we receive the request.

What if my prior authorization request is denied?

If the authorization request is denied, you have the right to appeal the decision. You'll receive a letter that says your request was denied and the reason, along with information that explains how you can appeal.

When your primary care provider is unavailable, you have these other options for care:

Primary care provider	24-Hour Nurse Line	Virtual Care*	Walk-in clinics	
			Retail health clinics	Urgent care centers
AVERAGE WAIT TIME FOR CARE 30 minutes	**AVERAGE WAIT TIME FOR CARE** 1 minute	**AVERAGE WAIT TIME FOR CARE** 10 minutes	**AVERAGE WAIT TIME FOR CARE** 30 to 60 minutes	
APPOINTMENT REQUIRED? Yes	**APPOINTMENT REQUIRED?** No	**APPOINTMENT REQUIRED?** Medical care: No Mental health care: Yes	**APPOINTMENT REQUIRED?** No	
AVAILABILITY In person, by phone, virtually	**AVAILABILITY** By phone	**AVAILABILITY** Virtually using the Teladoc Health® app	**AVAILABILITY** In person	
TREATMENT Start here when you want to talk with a doctor you know and trust. • High-quality, comprehensive care • Knows you and your medical history and coordinates all your care • May offer virtual care, same-day appointments, extended hours and other services	**TREATMENT** When you have questions about an illness or injury, anytime day or night • No cost • Available by phone anytime, anywhere in the U.S. • Care provided by a registered nurse	**TREATMENT** When you need to see a U.S. board-certified doctor for a minor illness or injury or talk with a licensed therapist about stress, grief and other life challenges • Receive care anywhere in the U.S. through virtual visits • Use your smartphone, tablet or computer to get virtual care	**TREATMENT** For a quick, in-person evaluation to get minor health care and a prescription at one location • Evening and weekend hours • Convenient locations • Care provided by physician assistants and certified nurse practitioners, overseen by a U.S. board-certified doctor	**TREATMENT** When your symptoms are a little more complicated and you need convenient, in-person care • Evening and weekend hours • Convenient locations • May offer labs and X-rays • Care provided by U.S. board-certified doctors, nurses and nurse practitioners, depending on severity of symptoms
	Phone: **1-855-624-5214**	**Sign up**** You'll need to sign up for Teladoc Health to get virtual care. **Virtual Care App:** Get the Teladoc Health app **Web:** Go to bcbsm.com/virtualcare **Phone: 1-800-835-2362**	**Emergency room** If you're experiencing a life-threatening condition, you should immediately call **911** or go to the nearest emergency room.	

To learn more about your choices for care when it's not an emergency, visit bcbsm.com/findcare.

*Virtual Care isn't included with all plans.

**Add your health plan information during sign-up. You may be charged incorrectly if you don't enter your plan information.

This information isn't intended to be medical advice. In an emergency, call **911** or go to an emergency room near you.

For language assistance, visit **bcbsm.com/language**. To view our nondiscrimination policy, visit **bcbsm.com/nondiscrimination**.

Teladoc Health is an independent company that provides Virtual Care Solutions for Blue Cross Blue Shield of Michigan and Blue Care Network.

Coverage that travels

When you're a point-of-service member, you're always covered for emergency care — across the country and around the world. Just show your member ID card.

Because some BCN plans pay only urgent and emergency services outside Michigan, check your coverage before receiving care. Refer to your *Certificate of Coverage* and related riders once you enroll in your plan. Or call Customer Service at the number on the back of your member ID card to understand how travel coverage works.

Nationwide access

As a BCN member, you can receive benefits when you're outside Michigan, but still in the U.S. So can your eligible family members. You have access to a nationwide network of Blue Plan providers. For more information, call **1-800-810-BLUE (2583)**.

Always carry your BCN ID card for access to service. You may have to pay your usual out-of-pocket expenses (deductible, copays and coinsurance) for services. But you shouldn't have any other up-front health care expenses if you use a Blue Plan provider.

Once you enroll, set up your online account at **bcbsm.com/myaccount**. When you do, you can easily refer to your *Certificate of Coverage* and related riders for your benefit details when you travel. Or you call the Customer Service number on the back of your member ID card.

Pharmacy coverage when you travel

If your plan includes pharmacy coverage, your member ID card is accepted at thousands of pharmacies nationwide, including most major chains, that participate with Blue Cross plans.

See the table below for how to get the care you need when you're away from home. Talk with your primary care provider before traveling to address any health concerns.

If you're traveling	And you need	Here's what you do
In your home state	EMERGENCY CARE Symptoms are severe enough that someone with average health knowledge believes immediate medical attention is needed.	Call **911** or go to the nearest emergency room.
	URGENT CARE Condition requires medical evaluation within 48 hours.	Go to the nearest urgent care center. To locate an urgent care center: visit **bcbsm.com/find-a-doctor** and select your BCN plan; use your online account or our mobile app; call Customer Service at **1-800-662-6667**.
	NONURGENT CARE	If you live in Michigan, call your primary care provider to coordinate services that don't require immediate attention. If you're enrolled with an address outside Michigan, contact a Blue Plan provider for in-network benefits.
In the United States but outside the state in which you live	EMERGENCY CARE	Call **911** or go to the nearest emergency room.
	URGENT CARE	Go to the nearest urgent care center. To locate an urgent care center: Visit **bcbsm.com/find-a-doctor** and select your BCN plan; use your online account or our mobile app; call Customer Service or call **1-800-810-BLUE (2583)**.
	ROUTINE CARE	Call Customer Service at **1-800-662-6667** for details about your health benefits and required prior authorization. To locate a Blue Plan provider, visit **bcbsm.com/find-a-doctor** and select your BCN plan; use your online account or our mobile app; call Customer Service, or call **1-800-810-BLUE (2583)**.
	OTHER SERVICES Such as elective surgeries, hospitalizations, mental health and substance use disorder services	
Outside the United States	EMERGENCY CARE	Go to the nearest emergency room. (You may be required to pay for services and then seek BCN reimbursement. *Get an itemized bill and medical records to speed reimbursement.*)

The information provided here is for members who are traveling or temporarily located outside the state in which they live. Refer to your *Certificate of Coverage* and riders once you enroll in your plan to see your benefit coverage when you travel. Or, for details, call the BCN Customer Service number on the back of your member ID card.

The Blue Cross and Blue Shield Association is an association of independent, locally operated Blue Cross and Blue Shield companies.

Our prescription drug plan offers convenience and value

If your plan includes BCN prescription drug coverage, you have access to more than 2,200 pharmacies in Michigan and 65,000 pharmacies nationwide, including most major chains.

Because prescription drugs can be costly, we encourage the use of generic drugs, which work the same as their brand-name equivalents.

Our value-based drug plan categories further help reduce costs by offering some brand-name medications at generic copayment rates. And we offer copay discounts when you get up to 90-day supplies of certain medications.

Safety is paramount

We may require prior authorization for certain prescription drugs so you receive the most appropriate drug therapy. We review them and make our decisions based on current medical information and the recommendations of our Pharmacy and Therapeutics Committee — a group of doctors, pharmacists and other health care experts.

The drugs we review are those that:

- Have dangerous side effects
- Are harmful when combined with other drugs
- Should only be used for certain health conditions
- Are often misused or abused

Coverage depends on your plan

- **Ask your employer which plan is available to you.**
- **Visit bcbsm.com/bcndruglists, and look for the drug list offered with your plan.**
- **Once enrolled, find the drug list for your plan, and any special requirements for coverage, by logging in to your online account at bcbsm.com.**

We also look at drugs that are prescribed when other equally effective drugs are available at a lower cost.

Specialty drugs must be filled through Walgreens Specialty Pharmacy.

Walgreens Specialty Pharmacy, an independent company, provides specialty pharmacy services to Blue Cross Blue Shield of Michigan and Blue Care Network members.

You've selected your primary care provider and you have a specialist for care; then one or the other leaves your plan's network. What now?

If you enroll with a Michigan address and your provider no longer participates in the BCN network, you may qualify to continue receiving care from the provider for 90 days, or until your course of treatment is finished. You may qualify as a continuing care patient with your named provider if any of these conditions apply:

- You're undergoing treatment for a serious or complex condition or terminal illness.
- You're undergoing a course of institutional or inpatient care.
- You're scheduled for a nonelective surgery (and postoperative care) with that provider or facility.
- You're pregnant and undergoing a course of treatment for the pregnancy.

If these conditions don't apply, you may receive health care services from an out-of-network provider at the out-of-network rate.

If you live outside Michigan, you can submit a request for continued care with your current provider. However, you may pay more for health care services.

Submitting a request for continuity of care

To request continued care from your specialist, **your request must be submitted within the first 90 days following your plan's start date or within 90 days of your specialist leaving BCN.**

Once we receive your request, we'll provide you and your doctor with a written notification about the status. To submit a request, call the Customer Service number on the back of your member ID card.

Common definitions

Copayment (or copay)
A set dollar amount you pay for a health care service or prescription, usually when you receive it (for example, $20 for a primary provider visit or $35 for an urgent care visit).

Deductible
A set dollar amount (apart from your premiums) that you have to pay for most health care services before your plan begins to pay. The deductible may not apply to all services.

Coinsurance
Your share of the cost of a health care service, a percentage of what BCN pays for the service. You typically start paying coinsurance after you've met your health plan's deductible, if applicable (for example, you pay 20% of the BCN allowed amount and we pay 80%).

Out-of-pocket maximum
The most you'll have to pay during a plan year for health care services you receive. Your out-of-pocket maximum includes your deductible, copay and coinsurance.

A guide to your health care costs

Knowing what you'll pay for health care services before you get care is important in understanding how your plan works. In the following example, Jill's costs are based on her single-person Blue Elect Plus POS plan with a $2,000 deductible and 20% coinsurance and copayments for various services. These payments may change according to different health plans. The costs for services are estimates. You can look up estimated costs for a wide range of health care services by logging in to your online account at **bcbsm.com**.

Member: Jill **Age:** 35 **Plan:** Blue Elect Plus POS

Jill's plan	In network	Out of network
Annual deductible	$2,000	$4,000
Out-of-pocket maximum	$7,350	$14,700
Coinsurance	20%	40%

The chart on the following pages serves as an example of Jill's out-of-pocket costs for in-network and out-of-network services.

In network

If Jill sees an in-network provider, she pays	BCN pays
JANUARY: Jill visits her primary provider for her annual physical | Provider's cost: $40	
$0 As a preventive service, the annual wellness visit is fully covered.* No copay is required, and nothing is applied to the in-network out-of-pocket maximum.	$40
MARCH: Jill visits her primary provider for a cold | Provider's cost: $85	
$20 copay Jill's responsible for the copay. Her deductible doesn't apply.	$65
APRIL: Jill takes a trip to the emergency room after falling | Provider's cost: $3,500	
$250 ER copay Jill's deductible doesn't apply.	$3,250
MAY: Jill takes a trip to urgent care for difficulty breathing | Provider's cost: $120	
$35 urgent care copay Jill's deductible doesn't apply.	$85
MAY: Jill receives prescription antibiotics for a sinus infection | Provider's cost: $50	
$15 generic drug copay	$35
AUGUST: Jill visits the dermatologist | Provider's cost: $100	
$50 specialist office visit copay Jill's deductible doesn't apply.	$50
AUGUST: Jill gets a wrist X-ray (outpatient procedure) | Provider's cost: $600	
20% coinsurance after deductible Jill pays **$600 toward her in-network deductible**.	$0
SEPTEMBER: Jill has surgery (inpatient admission) | Provider's cost: $15,000	
20% coinsurance after deductible Jill pays $1,400 toward her in-network deductible and another $2,720 for coinsurance.	$10,880
TOTAL COSTS | Provider cost: $19,495	
$5,115 is the total amount Jill has paid toward her $7,350 in-network out-of-pocket maximum.	**$14,380**

*For a list of preventive services, visit **healthcare.gov/coverage/preventive-care-benefits/**. Blue Cross Blue Shield of Michigan and Blue Care Network don't own or control this website.

Out of network

If Jill sees an out-of-network provider, she pays	BCN pays
Annual physicals aren't an included benefit when provided by out-of-network providers. Jill pays $40. Nothing is applied to her out-of-network, out-of-pocket maximum.	$0
Since primary care providers are only in network, the specialist benefit would apply. Jill pays **$85 toward her out-of-network deductible**.	$0
$250 ER copay Jill's deductible doesn't apply.	$3,250
$35 urgent care copay Jill's deductible doesn't apply.	$70
Prescriptions aren't covered out of network. Jill pays $50. Nothing goes toward her out-of-network, out-of-pocket maximum.	$0
40% coinsurance after deductible Jill pays **$100 toward her out-of-network deductible**.	$0
40% coinsurance after deductible Jill pays **$600 toward her out-of-network deductible**.	$0
40% coinsurance after deductible Jill pays $3,215 toward her out-of-network deductible and another $4,714 for coinsurance.	$7,071
$9,014 is the total amount Jill has paid toward her $14,700 out-of-network out-of-pocket maximum.**	**$10,391**

**Because Jill pays $90 for services that weren't included by out-of-network providers, this amount doesn't apply to her out-of-network, out-of-pocket maximum.
Note: An out-of-network provider can bill you the balance if the portions you pay and we pay don't equal the full cost of the provider's service. You're responsible for the remaining balance. This amount won't apply to your out-of-network deductible, coinsurance or out-of-pocket maximum.

We Speak Your Language

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 877-469-2583 TTY: 711 or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se ofrecen, sin costo alguno, ayuda y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 877-469-2583 TTY: 711 o hable con su proveedor.

تنبيه: إذا كنت تتحدث الإنجليزية، فإن خدمات المساعدة اللغوية المجانية متوفرة لك. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل برقم 877-469-2583 TTY: 711 أو تحدث إلى مزود الخدمة الخاص بك.

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。请致电 877-469-2583 (TTY: 711) 或咨询您的服务提供商。

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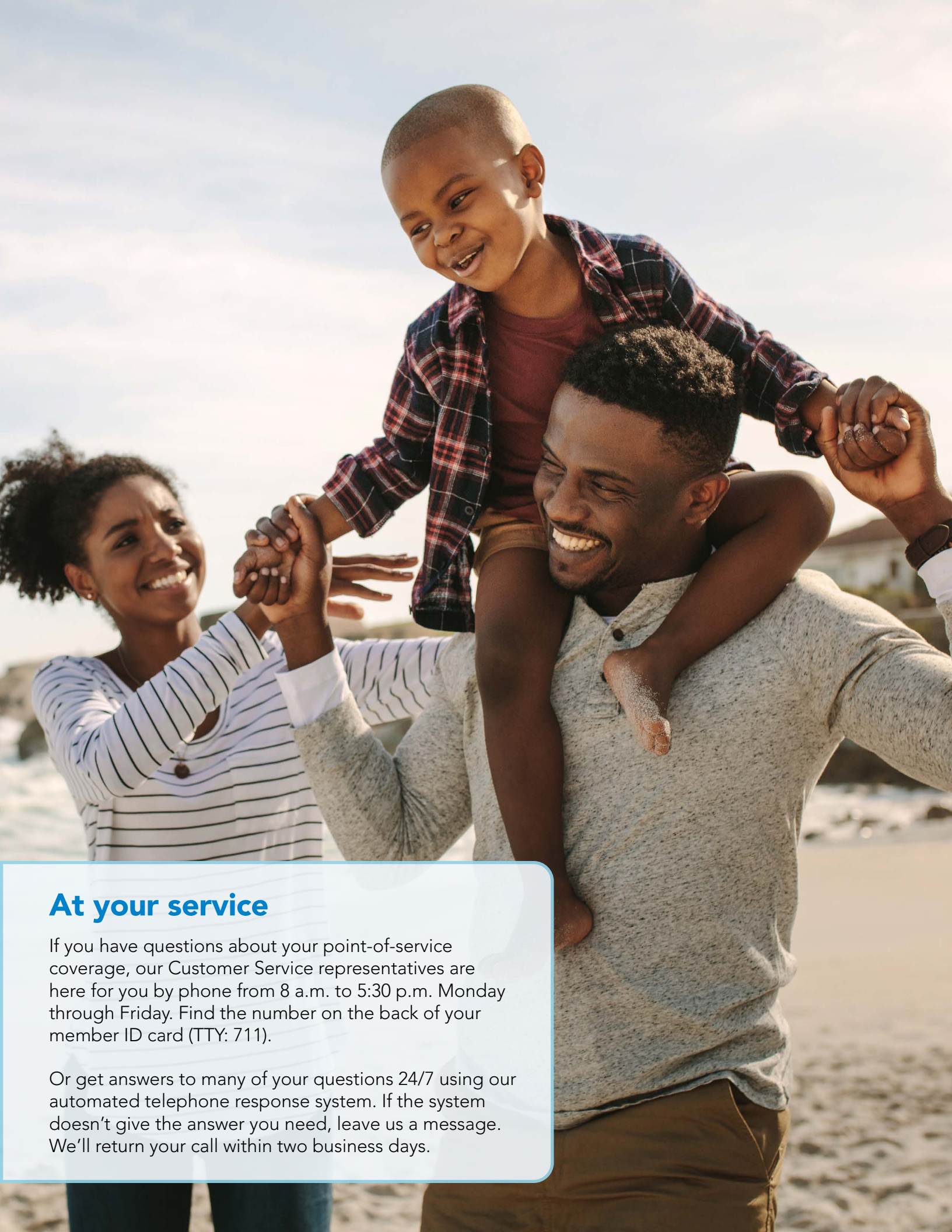

At your service

If you have questions about your point-of-service coverage, our Customer Service representatives are here for you by phone from 8 a.m. to 5:30 p.m. Monday through Friday. Find the number on the back of your member ID card (TTY: 711).

Or get answers to many of your questions 24/7 using our automated telephone response system. If the system doesn't give the answer you need, leave us a message. We'll return your call within two business days.

Find us online

bcbsm.com | news.bcbsm.com | facebook.com/MiBCN

mibluedaily.com | aHealthierMichigan.org | x.com/bcbsm | youtube.com/bcbsmnews

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