



**Blue Care  
Network  
of Michigan**

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

**CLSSLG with Deductibles**

**00192969-0001-0001 Aggressive Tooling**

**Deductible, Copays and Dollar Maximums**

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

Deductible	\$4,000 individual/\$8,000 family per benefit year
Fixed Dollar Copays	\$5 for allergy injections
	\$30 for office visits
	\$50 for urgent care visits
	\$150 for emergency room visits
	No fixed dollar copay for ambulance services. See below for applicable coinsurance.
	\$45 for referral physician visits
Coinsurance	50% for select services as noted below
	30% 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	\$6,350 per individual/\$12,700 per family

**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**

PCP Office Visits	\$30 Copay
Online Visits	\$30 Copay
Consulting Specialist Care	\$45 Copay

**Emergency Medical Care**

Hospital Emergency Room - Copay waived if admitted	\$150 Copay after deductible
Urgent Care Center	\$50 Copay
Ambulance Services	70% after deductible

**Benefits Selected -**

CI30%,D4000,DSRCW,IMG150,DME5,VACR50,ER150,CO30,6350PM,2060CS,MOPD20,BENYR,P&O5,45RP,UR50,WDRPOV

Medical	00008426	MED
Pharmacy	00005732	

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**Diagnostic Services**

Laboratory and Pathology Tests	100%
Diagnostic Tests and X-rays	70% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	\$150 copay after deductible
Radiation Therapy	70% after deductible

**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) after deductible

**Hospital Care**

General Nursing Care, Hospital Services and Supplies	70% after deductible
Outpatient Surgery - included all related surgical services and anesthesia - see member certificate for specific surgical copays.	70% after deductible

**Alternatives to Hospital Care**

Skilled Nursing Care	70% after deductible
	Up to 45 days per member per benefit year
Hospice Care	100% (When authorized) after deductible
Home Health Care	\$45 copay after deductible

**Surgical Services**

Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	70% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	50% after deductible
Elective Abortion (One procedure per two year period of membership)	50% after deductible
Human Organ Transplants	70% after deductible
Reduction Mammoplasty	50% after deductible
Male Mastectomy	50% after deductible
Temporomandibular Joint Syndrome	50% after deductible
Orthognathic Surgery	50% after deductible
Weight Reduction Procedures (Limited to one procedure per lifetime)	50% after deductible

Benefits Selected -

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**Mental Health Care and Substance Use Disorder Treatment**

Inpatient Mental Health Care	70% after deductible
Inpatient Substance Use Disorder	70% after deductible
Outpatient Mental Health Care includes online visits Note: For diagnostic and therapeutic services, the medical benefit applies.	\$30 Copay
Outpatient Substance Use Disorder	\$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. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	\$45 copay after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visit and preventive benefit.

**Other Services**

Allergy Testing and Therapy	50% after deductible
Allergy Injections	\$5 copay
Chiropractic Spinal Manipulation - when referred	\$45 Copay (up to 30 visits per benefit year)
Outpatient Physical, Speech and Occupational Therapy	\$45 Copay after deductible  One period of treatment for any combination of therapies within 60 consecutive days per benefit year
Infertility Counseling and Treatment (Excludes In-vitro fertilization)	50% after deductible
Durable Medical Equipment (DME)	100%
Prosthetic and Orthotic Appliances (P&O)	100%
Diabetic Supplies	100%
Prescription Drugs	Tier 1 - \$20 copay, Tier 2 - \$60 copay, Tier 3 - \$80 copay, Tier 4 - 20% coinsurance (max copay \$200/prescription), Tier 5 - 20% coinsurance (max copay \$400/ prescription), Tier 4 and 5 Annual Coinsurance Maximum - \$4,800/member/cal year; 30 day supply  Sexual Dysfunction drugs - 50% coinsurance  Women's Contraceptives - Tier 1 - 100%, Tier 2 - Tier 2 Copayment/Coinsurance above applies, Tier 3 - Tier 3 Copayment/Coinsurance above applies
Mail Order Prescription Drugs	Two times the applicable copay up to a 90 day supply
Prescription Drug Deductible	None
Hearing Aid	Not Covered

Benefits Selected -

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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 the 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.**

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