BCBSM Blue Care Network HMO Plan (a Traditional HMO Plan)

Blue Care Network of Michigan

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

CLSSLG with Deductibles

Livingston Education Service Agency

Deductible, Copays and Dollar Maximums

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

Deductible	$500 individual/$1,000 family per calendar year
Fixed Dollar Copays	$5 for allergy injections
	$20 for office visits
	$35 for urgent care visits
	$150 for emergency room visits
	$25 for ambulance
	$30 for referral physician visits
Coinsurance	50% 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	$1,000 per individual/$2,000 per family (includes pharmacy cost sharing)

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	$20 Copay
Online Visits	$20 Copay
Consulting Specialist Care	$30 Copay

Emergency Medical Care

Hospital Emergency Room - Copay waived if admitted	$150 Copay after deductible
Urgent Care Center	$35 Copay
Ambulance Services	$25 copay for ground and air services after deductible

Benefits Selected -
AMB25,D500,DSRCW,IMG150,ER150,CO20,1000PM,OMRR,P103CL,90D3X,30RP,UR35,WDRPOV

Medical	0000D177	MED

Diagnostic Services

Laboratory and Pathology Tests	100%
Diagnostic Tests and X-rays	100% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	$150 copay after deductible
Radiation Therapy	100% 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)	$20 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	100% after deductible
Outpatient Surgery - included all related surgical services and anesthesia - see member certificate for specific surgical copays.	100% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	100% after deductible
	Up to 45 days per member per calendar year
Hospice Care	100% (When authorized) after deductible
Home Health Care	$30 Copay after deductible

Surgical Services

Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	100% 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)	Not Covered
Human Organ Transplants	100% 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

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Mental Health Care and Substance Use Disorder Treatment

Inpatient Mental Health Care	100% after deductible
Inpatient Substance Use Disorder	100% after deductible
Outpatient Mental Health Care includes online visits Note: For diagnostic and therapeutic services, the medical benefit applies.	$20 Copay
Outpatient Substance Use Disorder	$20 Copay

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	$20 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.	$30 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	$30 Copay
	(up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy	$30 Copay after deductible
Outpatient Physical, Speech and Occupational Therapy	$30 Copay after deductible
	60 visits per calendar year for any combination of therapies
Infertility Counseling and Treatment (Excludes In-vitro fertilization)	50% after deductible
Durable Medical Equipment (DME)	50%
Prosthetic and Orthotic Appliances (P&O)	50%
Diabetic Supplies	100%
Prescription Drugs	Tier 1A - $10, Tier 1B - $30, T2- $60, T3- $80, T4- 20 coinsurance (max $200), T5- 20% coinsurance (max $300) 30 day supply
	Sexual Dysfunction Drugs - 50% coinsurance
	Contraceptives – T1A- 100%, Tier 1B - $30, T2 - $60, T3-$80; 30 day supply
Mail Order Prescription Drugs	30 day supply or less - applicable tiered copay / coinsurance; 31-90 day supply - 3x's the 30 day copay/coinsurance minus $10
Prescription Drug Deductible	None
Hearing Aid	Not Covered

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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-Gl 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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