



**Blue Care
Network
of Michigan**

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

Healthy Blue LivingSM

00103623 DPSCD - ECONOMY PLAN

Enhanced Benefits (CLSSLG)

Standard Benefits (CLSSLG)

Deductible, Copays and Dollar Maximums

Deductible -(Coinsurance and select fixed dollar copays as defined by your plan documents, apply once the deductible has been met.)	\$1,500 individual/\$3,000 family per calendar year	\$4,000 individual/\$8,000 family per calendar year
Fixed Dollar Copays	\$5 for allergy injections	\$5 for allergy injections
	\$20 for office visits	\$35 for office visits
	\$35 for urgent care visits	\$50 for urgent care visits
	\$250 for emergency room visits	\$250 for emergency room visits
	\$30 for referral physician visits	\$45 for referral physician visits
Coinsurance	50% for select services as noted below	50% for select services as noted below
	20% for select services as noted below	30% for select services as noted below
Annual Coinsurance Maximum (ACM)	\$1,500 per member/\$3,000 per family per calendar year	\$2,500 per member/\$5,000 per family per calendar year
	Services that DO NOT apply to the ACM: Deductible, Flat Dollar Copays, Infertility, Male Mastectomy, Reduction Mammoplasty, Male Sterilization, Elective Abortion, TMJ, Orthognathic Surgery, Weight Reduction, DME, P&O, Diabetic Supplies, Prescription Drugs	Services that DO NOT apply to the ACM: Deductible, Flat Dollar Copays, Infertility, Male Mastectomy, Reduction Mammoplasty, Male Sterilization, Elective Abortion, TMJ, Orthognathic Surgery, Weight Reduction, DME, P&O, Diabetic Supplies, Prescription Drugs
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	\$6,600 per individual/\$13,200 per family	\$6,600 per individual/\$13,200 per family

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Preventive Services

Health Maintenance Exam	100%	100%
Annual Gynecological Exam	100%	100%
Pap Smear Screening	100%	100%
Well-Baby and Child Care	100%	100%
Immunizations	100%	100%
Prostate Specific Antigen (PSA) Screening	100%	100%
Routine Colonoscopy	100%	100%
Mammography Screening	100%	100%
Voluntary Female Sterilization	100%	100%
Breast Pumps (DME guidelines apply.)	100%	100%
Maternity Pre-Natal care	100%	100%

Physician Office Services

PCP Office Visits - Note: Applicable cost sharing applies when other services are received in the office.	\$20 Copay	\$35 Copay
Online Visits	\$20 Copay	\$35 Copay
Consulting Specialist Care - When referred for other than preventive services. Note: Applicable cost sharing applies when other services are received in the office.	\$30 Copay	\$45 Copay after deductible

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Emergency Medical Care

Hospital Emergency Room - Copay waived if admitted	\$250 Copay after deductible	\$250 Copay after deductible
Urgent Care Center	\$35 Copay	\$50 Copay
Retail Health Clinic	\$35 Copay	\$50 Copay
Ambulance Services	80% after deductible	70% after deductible

Diagnostic Services

Laboratory and Pathology Services	100%	100%
Diagnostic Tests and X-rays	80% after deductible	70% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	\$150 copay after deductible	\$150 copay after deductible
Radiation Therapy	80% after deductible	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)	\$20 Copay	\$35 Copay
Delivery and Nursery Care	100% For professional services. (See Hospital Care for facility charges) after deductible	100% For professional services. (See Hospital Care for facility charges) after deductible

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Hospital Care

General Nursing Care, Hospital Services and Supplies	80% after deductible	70% after deductible
Outpatient Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	80% after deductible	70% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	80% after deductible	70% after deductible
	Up to 45 days per member per calendar year	Up to 45 days per member per calendar year
Hospice Care	100% after deductible	100% after deductible
Home Health Care	\$30 Copay after deductible	\$45 copay after deductible

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Surgical Services

Surgery - includes all related surgical services and anesthesia	80% after deductible	70% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	50% after deductible	50% after deductible
Elective Abortion (One procedure per two year period of membership)	Not Covered	Not Covered
Human Organ Transplants	80% after deductible	70% after deductible
Reduction Mammoplasty	50% after deductible	50% after deductible
Male Mastectomy	50% after deductible	50% after deductible
Temporomandibular Joint Syndrome	50% after deductible	50% after deductible
Orthognathic Surgery	50% after deductible	50% after deductible
Weight Reduction Procedures (Limited to one procedure per lifetime)	50% after deductible	50% after deductible

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

Inpatient Mental Health Care	80% after deductible	70% after deductible
Inpatient Substance Use Disorder	80% after deductible	70% 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.	\$20 Copay	\$35 Copay
Outpatient Substance Use Disorder	\$20 Copay	\$35 Copay

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Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA)	\$20 Copay	\$35 Copay after deductible
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	\$45 copay
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.

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Other Services

Allergy Testing and Therapy	50% after deductible	50% after deductible
Allergy Injections	\$5 copay	\$5 copay
Chiropractic Spinal Manipulation - when referred	\$30 Copay	\$45 Copay after deductible
	(up to 30 visits per calendar year)	(up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy	\$30 Copay after deductible	\$45 Copay
	60 visits per calendar year for any combination of therapies	60 visits per calendar year for any combination of therapies
Infertility Counseling and Treatment (Excludes In-vitro fertilization)	50% after deductible	50% after deductible
Durable Medical Equipment (DME)	50%	50%
Prosthetic and Orthotic Appliances (P&O)	50%	50%
Diabetic Supplies	80%	70%
Hearing Aid	Not Covered	Not Covered

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Prescription Drugs

Prescription Drugs	Tier 1A - \$4 copay, Tier 1B - \$15 copay, Tier 2 - \$40 copay, Tier 3 - \$80 copay, Tier 4 - 20% coinsurance (Max \$200), Tier 5 - 20% coinsurance (Max \$300)	Tier 1A - \$6 copay, Tier 1B - \$25 copay, Tier 2 - \$50 copay, Tier 3 - \$80 copay, Tier 4 - 20% coinsurance (Max \$200), Tier 5 - 20% coinsurance (Max \$300)
	Sexual Dysfunction Drugs - 50% Coinsurance	Sexual Dysfunction drugs - 50% coinsurance
	Female Contraceptives - Tier 1A - Covered in Full, Tier 1B - \$15 copay, Tier 2 - \$40 copay, Tier 3 - \$80 copay	Female Contraceptives - Tier 1A - Covered in full, Tier 1B - \$25 copay, Tier 2 - \$50 copay, Tier 3 - \$80 copay
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	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	None
	Effective 1/1/20 -Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs	Effective 1/1/20 -Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs

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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 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 and shall be construed under the jurisdiction and according to the laws of the State of Michigan for fully insured plans. **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 bcbsm.com/importantinfo. Select *Approving covered services*.

Healthy Blue Living subscribers must complete program requirements within the first 90 days of enrollment or re-enrollment. To qualify for or maintain enhanced benefits, the subscriber needs to complete a health assessment and qualification form during the first 90 days and follow their primary care physician's recommendations for a healthy lifestyle. If a tobacco user, must enroll in the BCN-sponsored tobacco cessation program within 120 days of the start of the plan year. If BMI is greater than or equal to 30, must select and begin participating in a weight management program within 120 days of the start of the plan year.

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