	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.)	$500 individual/$1,000 family per calendar year	$2,000 individual/$4,000 family per calendar year
Fixed Dollar Copays	$0 for allergy injections	$0 for allergy injections
	$20 for office visits	$30 for office visits
	$40 for urgent care visits	$45 for urgent care visits
	$100 for emergency room visits	$150 for emergency room visits
	$40 for referral physician visits	$45 for referral physician visits
Coinsurance	10% for select services as noted below	20% for select services as noted below
	10% for allergy testing, serum and related office visits	20% for allergy testing, serum and related office visits
	10% for ambulance services	20% for ambulance services
Annual Coinsurance Maximum (ACM)	$1,500 per member/$3,000 per family per calendar year	$2,000 per member/$4,000 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

Enhanced Benefits : CLSSLG : SDCCR, AS5, ER100, 7255C, MOPD2O, 40RP, SN120, UR40, OMRR, 15ECM, WDEDFC, 6600PM, SPRX0C, 6600PM, D500, DCCRM, CO20, CR10%

Standard Benefits : CLSSLG : SDCCR, AS5, ER150, 15306C, MOPD2O, 45RP, SN120, UR45, OMRR, WDEDFC, 6600PM, SPRX0C, 6600PM, D2000, DCCRM, CO30, CR20%, 2KECM

	Enhanced Benefits (CLSSLG)	Standard Benefits (CLSSLG)
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	$30 Copay
Online Visits	$20 Copay	$30 Copay
Consulting Specialist Care - When referred for other than preventive services. Note: Applicable cost sharing applies when other services are received in the office.	$40 copay	$45 Copay

Enhanced Benefits : CLSSLG : SDCCR, AS5, ER100, 7255C, MOPD2O, 40RP, SN120, UR40, OMRR, 15ECM, WDEDFC, 6600PM, SPRX0C, 6600PM, D500, DCCRM, CO20, CR10%

Standard Benefits : CLSSLG : SDCCR, AS5, ER150, 15306C, MOPD2O, 45RP, SN120, UR45, OMRR, WDEDFC, 6600PM, SPRX0C, 6600PM, D2000, DCCRM, CO30, CR20%, 2KECM

	Enhanced Benefits (CLSSLG)	Standard Benefits (CLSSLG)
Emergency Medical Care		
Hospital Emergency Room - Copay waived if admitted	$100 Copay	$150 Copay
Urgent Care Center	$40 Copay	$45 Copay
Retail Health Clinic	$40 Copay	$45 Copay
Ambulance Services	90% after deductible	80% after deductible
Diagnostic Services		
Laboratory and Pathology Services	100%	100%
Diagnostic Tests and X-rays	90% after deductible	80% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	90% after deductible	80% after deductible
Radiation Therapy	90% after deductible	80% 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	$30 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

Enhanced Benefits : CLSSLG : SDCCR, AS5, ER100, 7255C, MOPD2O, 40RP, SN120, UR40, OMRR, 15ECM, WDEDFC, 6600PM, SPRX0C, 6600PM, D500, DCCRM, CO20, CR10%

Standard Benefits : CLSSLG : SDCCR, AS5, ER150, 15306C, MOPD2O, 45RP, SN120, UR45, OMRR, WDEDFC, 6600PM, SPRX0C, 6600PM, D2000, DCCRM, CO30, CR20%, 2KECM

	Enhanced Benefits (CLSSLG)	Standard Benefits (CLSSLG)
Hospital Care		
General Nursing Care, Hospital Services and Supplies	90% after deductible	80% after deductible
Outpatient Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	90% after deductible	80% after deductible
Alternatives to Hospital Care		
Skilled Nursing Care	90% after deductible	80% after deductible
	Up to 120 days per calendar year	Up to 120 days per calendar year
Hospice Care	100% after deductible	100% after deductible
Home Health Care	$40 copay	$45 copay

Enhanced Benefits : CLSSLG : SDCCR, AS5, ER100, 7255C, MOPD2O, 40RP, SN120, UR40, OMRR, 15ECM, WDEDFC, 6600PM, SPRX0C, 6600PM, D500, DCCRM, CO20, CR10%

Standard Benefits : CLSSLG : SDCCR, AS5, ER150, 15306C, MOPD2O, 45RP, SN120, UR45, OMRR, WDEDFC, 6600PM, SPRX0C, 6600PM, D2000, DCCRM, CO30, CR20%, 2KECM

	Enhanced Benefits (CLSSLG)	Standard Benefits (CLSSLG)
Surgical Services		
Surgery - includes all related surgical services and anesthesia	90% after deductible	80% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	90% after deductible	80% after deductible
Elective Abortion (One procedure per two year period of membership)	Not Covered	Not Covered
Human Organ Transplants	90% after deductible	80% after deductible
Reduction Mammoplasty	90% after deductible	80% after deductible
Male Mastectomy	90% after deductible	80% after deductible
Temporomandibular Joint Syndrome	90% after deductible	80% after deductible
Orthognathic Surgery	90% after deductible	80% after deductible
Weight Reduction Procedures (Limited to one procedure per lifetime)	90% after deductible	80% after deductible
Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)		
Inpatient Mental Health Care	90% after deductible	80% after deductible
Inpatient Substance Use Disorder	90% after deductible	80% 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	$30 Copay
Outpatient Substance Use Disorder	$20 Copay	$30 Copay

Enhanced Benefits : CLSSLG : SDCCR, AS5, ER100, 7255C, MOPD2O, 40RP, SN120, UR40, OMRR, 15ECM, WDEDFC, 6600PM, SPRX0C, 6600PM, D500, DCCRM, CO20, CR10%

Standard Benefits : CLSSLG : SDCCR, AS5, ER150, 15306C, MOPD2O, 45RP, SN120, UR45, OMRR, WDEDFC, 6600PM, SPRX0C, 6600PM, D2000, DCCRM, CO30, CR20%, 2KECM

	Enhanced Benefits (CLSSLG)	Standard Benefits (CLSSLG)
Autism Spectrum Disorders, Diagnoses and Treatment		
Applied behavioral analyses (ABA)	$20 Copay	$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.	$40 copay	$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.

Enhanced Benefits : CLSSLG : SDCCR, AS5, ER100, 7255C, MOPD2O, 40RP, SN120, UR40, OMRR, 15ECM, WDEDFC, 6600PM, SPRX0C, 6600PM, D500, DCCRM, CO20, CR10%

Standard Benefits : CLSSLG : SDCCR, AS5, ER150, 15306C, MOPD2O, 45RP, SN120, UR45, OMRR, WDEDFC, 6600PM, SPRX0C, 6600PM, D2000, DCCRM, CO30, CR20%, 2KECM

	Enhanced Benefits (CLSSLG)	Standard Benefits (CLSSLG)
Other Services		
Allergy Testing and Therapy	90% after deductible	80% after deductible
Allergy Injections	100%	100%
Chiropractic Spinal Manipulation - when referred	$40 copay	$45 Copay
	(up to 30 visits per calendar year)	(up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy	$40 copay	$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)	90% after deductible	80% after deductible
Durable Medical Equipment (DME)	90%	80%
Prosthetic and Orthotic Appliances (P&O)	90%	80%
Diabetic Supplies	90%	80%
Hearing Aid	Not Covered	Not Covered

Enhanced Benefits : CLSSLG : SDCCR, AS5, ER100, 7255C, MOPD2O, 40RP, SN120, UR40, OMRR, 15ECM, WDEDFC, 6600PM, SPRX0C, 6600PM, D500, DCCRM, CO20, CR10%

Standard Benefits : CLSSLG : SDCCR, AS5, ER150, 15306C, MOPD2O, 45RP, SN120, UR45, OMRR, WDEDFC, 6600PM, SPRX0C, 6600PM, D2000, DCCRM, CO30, CR20%, 2KECM

	Enhanced Benefits (CLSSLG)	Standard Benefits (CLSSLG)
Prescription Drugs		
Prescription Drugs	Tier 1 - $7 copay, Tier 2 - $25 copay, Tier 3 - $50 copay; with contraceptives, 30 day supply	Tier 1 - $15 copay, Tier 2 - $30 copay, Tier 3 - $60 copay; with contraceptives, 30 day supply
	Sexual Dysfunction Drugs - 50% coinsurance	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	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	Two times the applicable copay up to a 90 day supply
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

Enhanced Benefits : CLSSLG : SDCCR, AS5, ER100, 7255C, MOPD2O, 40RP, SN120, UR40, OMRR, 15ECM, WDEDFC, 6600PM, SPRX0C, 6600PM, D500, DCCRM, CO20, CR10%

Standard Benefits : CLSSLG : SDCCR, AS5, ER150, 15306C, MOPD2O, 45RP, SN120, UR45, OMRR, WDEDFC, 6600PM, SPRX0C, 6600PM, D2000, DCCRM, CO30, CR20%, 2KECM

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.

For Internal Use Only

Medical Pharmacy	0000E999 0000F498	4312 0052	MED

Enhanced Benefits : CLSSLG : SDCCR, AS5, ER100, 7255C, MOPD2O, 40RP, SN120, UR40, OMRR, 15ECM, WDEDFC, 6600PM, SPRX0C, 6600PM, D500, DCCRM, CO20, CR10%

Standard Benefits : CLSSLG : SDCCR, AS5, ER150, 15306C, MOPD2O, 45RP, SN120, UR45, OMRR, WDEDFC, 6600PM, SPRX0C, 6600PM, D2000, DCCRM, CO30, CR20%, 2KECM