



**Blue Care
Network
of Michigan**

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

HDHPLG

00419183-0001-0002 ADVANCE EMPLOYMENT SERVICES LLC

Deductible, Copays and Dollar Maximums

Deductible - Combined for both medical and drug coverage.	\$4,000 for a one-person contract/\$8,000 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)
	The Deductible paid by all Members will be combined to satisfy the family Deductible. However, one individual Member cannot contribute more than the individual Deductible amount toward the family Deductible.
Fixed Dollar Copays	None
Coinsurance	50% for select services as noted below
Out of Pocket Maximum	\$6,350 for a one-person contract. \$12,700 for a family contract (2 or more members) each calendar year
	Out of Pocket Maximum – An individual member can't contribute in excess of the individual OOPM amount. The remaining members in the family contract must combine to meet the Family OOPM.

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	50% after deductible
Online Visits	50% after deductible
Consulting Specialist Care	50% after deductible

Emergency Medical Care

Hospital Emergency Room	50% after deductible
Urgent Care Center	50% after deductible
Retail Health Clinic	50% after deductible
Ambulance Services	50% after deductible

Benefits Selected - HDHPLG : VACR50,EDEPM,EDEPM,50COHD,4000HD,630MHD,4000HD,630MHD,P50CHD,MOPD20

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Diagnostic Services

Laboratory and Pathology Services	50% after deductible
Diagnostic Tests and X-rays	50% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	50% after deductible
Radiation Therapy	50% 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)	50% deductible does not apply to routine services
Delivery and Nursery Care	50% after deductible

Hospital Care

General Nursing Care, Hospital Services and Supplies	50% after deductible
Outpatient Surgery	50% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	50% after deductible Up to 45 days per calendar year
Hospice Care	50% after deductible
Home Health Care	50% after deductible

Surgical Services

Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	50% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Male - 50% after deductible
Elective Abortion (One procedure per two year period of membership)	50% after deductible
Human Organ Transplants	50% 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	50% after deductible

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

Inpatient Mental Health Care	50% after deductible
Inpatient Substance Use Disorder	50% 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.	50% after deductible
Outpatient Substance Use Disorder	50% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment

Applied Behavioral analysis (ABA) treatment	50% 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.	50% 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	50% after deductible
Chiropractic Spinal Manipulation - when referred	50% after deductible (up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy	50% after deductible One period of treatment for any combination of therapies within 60 consecutive days per calendar year. NOTE: Effective 1/1/20 - the limit will be updated to 60 visits per calendar year for any combination of outpatient rehabilitation therapies.
Infertility Counseling and Treatment (Excludes In- vitro fertilization)	50% after deductible
Durable Medical Equipment	50% after deductible
Prosthetic and Orthotic Appliances	50% after deductible
Diabetic Supplies	50% after deductible
Hearing Aid	Not covered

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Prescription Drugs

Prescription Drugs	50% after deductible; 30 day supply
	Contraceptives - Tier 1 - 100% (deductible does not apply), Tier 2 - 50% after deductible, Tier 3 - 50% after deductible
Mail Order Prescription Drugs	Two times the applicable copay after deductible up to a 90 day supply
Prescription Drug Deductible	Prescription drug deductible integrated with the medical deductible
	Effective 1/1/20 -Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs

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 Specialty 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.**

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.

For Internal Use Only

Medical	0000C092	4ZG1	MED
Pharmacy	0000C136	4ZX8	

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