Blue Care Network of Michigan

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

CLSSLG with Deductibles

00419183-0001-0001 ADVANCE EMPLOYMENT SERVICES LLC

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.)	$1,000 individual/$2,000 family per calendar year
Fixed Dollar Copays	$5 for allergy injections
	$20 for office visits
	$50 for urgent care visits
	$150 for emergency room visits
	$40 for referral physician visits
Coinsurance	50% for select services as noted below
	20% for select services as noted below
Annual Coinsurance Maximum (ACM)	$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
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$6,600 per individual/$13,200 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%

Benefits Selected - CLSSLG :
25ECM,CI20%,D1000,DSR20%,IMG150,VACR50,ER150,CO20,6600PM,6600PM,P625CL,90D3X,40RP,UR50,WDRPOV

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Physician Office Services	
PCP Office Visits - Note: Applicable cost sharing applies when other services are received in the office.	$20 Copay
Online Visits	$20 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

Emergency Medical Care	
Hospital Emergency Room - Copay waived if admitted	$150 Copay after deductible
Urgent Care Center	$50 Copay
Retail Health Clinic	$50 Copay
Ambulance Services	80% after deductible

Diagnostic Services	
Laboratory and Pathology Services	100%
Diagnostic Tests and X-rays	80% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	$150 copay after deductible
Radiation Therapy	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
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	80% after deductible
Outpatient Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	80% after deductible

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Alternatives to Hospital Care	
Skilled Nursing Care	80% after deductible
	Up to 45 days per member per calendar year
Hospice Care	100% after deductible
Home Health Care	$40 copay after deductible

Surgical Services	
Surgery - includes all related surgical services and anesthesia	80% 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	80% 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

Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)	
Inpatient Mental Health Care	80% after deductible
Inpatient Substance Use Disorder	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
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.	$40 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.

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Other Services	
Allergy Testing and Therapy	50% after deductible
Allergy Injections	$5 copay
Chiropractic Spinal Manipulation - when referred	$40 copay
	(up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy	$40 copay 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 (DME)	50%
Prosthetic and Orthotic Appliances (P&O)	50%
Diabetic Supplies	80%
Hearing Aid	Not Covered

Prescription Drugs	
Prescription Drugs	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
	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
Prescription Drug Deductible	None
	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.*

For Internal Use Only

Medical Pharmacy	0000A038 0000A184	4408 4X10	MED

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