Blue Care Network of Michigan

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

CLSSLG with Deductibles

Flint Community Schools

Deductible, Copays and Dollar Maximums

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

Deductible	None
Fixed Dollar Copays	$5 for allergy injections
	$10 for office visits
	$25 for urgent care visits
	$100 for emergency room visits
	$250 for inpatient hospital admission
	$250 for outpatient surgery
	$10 for referral physician visits
Coinsurance	50% for select services as noted below
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$6,350 per individual/$12,700 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. Limited to no more than one per 24 month period.)	100%
Maternity Pre-Natal care	100%

Physician Office Services

Office Visits	$10 copay
Consulting Specialist Care	$10 copay after deductible

Emergency Medical Care

Hospital Emergency Room - Copay waived if admitted	$100 Copay after deductible
Urgent Care Center	$25 Copay
Ambulance Services	100% after deductible

Benefits Selected - DSRCW,DME5,ER100,HC250,10OVCR,6350PM,250OP,1525DC,MOPD2C,P&O5,UR25

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Diagnostic Services

Laboratory and Pathology Tests	100%
Diagnostic Tests and X-rays	100% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	100% after deductible
Radiation Therapy	100% after deductible

Maternity Services Provided by a Physician

Post-Natal and Non-routine Pre-Natal Care	$10 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	$250 copay per admission after deductible
Outpatient Surgery - included all related surgical services and anesthesia - see member certificate for specific surgical copays.	$250 or 50% of the reimbursement amount, whichever is less 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	$10 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
First Trimester Termination of Pregnancy (One procedure per two year period of membership)	50% after deductible
Human Organ Transplants	$250 copay per admission 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 Abuse Treatment

Inpatient Mental Health Care	100% after deductible
Inpatient Substance Abuse Care	100% after deductible
Outpatient Mental Health Care	$10 copay after deductible
Outpatient Substance Abuse	$10 copay after deductible

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment - Limited to 25 hours per week for line therapy for children through age 18	$10 copay after deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18	$10 copay after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit

Other Services

Allergy Testing and Therapy	50% after deductible
Allergy Injections	$5 copay
Chiropractic Spinal Manipulation - when referred (up to 30 visits per calendar year)	$10 copay after deductible
Outpatient Physical, Speech and Occupational Therapy (One period of treatment for any combination of therapies within 60 consecutive days per calendar year)	$10 copay after deductible
Infertility Counseling and Treatment (Excludes In-vitro fertilization)	50% after deductible
Durable Medical Equipment	100%
Prosthetic and Orthotic Appliances	100%
Diabetic Supplies	100%
Prescription Drugs	Tier 1 - $15 copay, Tier 2 - $25 copay; with contraceptives, 30 day supply
	Sexual Dysfunction Drugs - 50% coinsurance
	Women's Contraceptives - Tier 1 - 100%, Tier 2 - Tier 2 Copayment/Coinsurance above applies
Mail Order Prescription Drugs	Two times the applicable copay up to a 90 day supply
Prescription Drug Deductible	None
Hearing Aid	Not Covered

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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 the 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 **Services must be provided or arranged by member's primary care physician or health plan.**

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