Deductible, Copays and Dollar Maximums

Deductible	None
Fixed Dollar Copays	$5 for allergy injections
	$10 for office visits
	$10 for urgent care visits
	$25 for emergency room visits
	$10 for referral physician visits
Coinsurance	50% for select services as noted below
Annual Coinsurance Maximum (ACM)	None
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

Emergency Medical Care

Hospital Emergency Room - Copay waived if admitted	$25 Copay
Urgent Care Center	$10 Copay
Ambulance Services	100%

Benefits Selected - ER25,WMS,10OVCR,6350PM,1020DC,UR10,WRCWR

Diagnostic Services

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

Maternity Services Provided by a Physician

Post-Natal and Non-routine Pre-Natal Care (See Preventive Services section for routine Pre-Natal Care)	$10 copay
Delivery and Nursery Care	100% (For professional services. See Hospital Care for facility charges)

Hospital Care

General Nursing Care, Hospital Services and Supplies	100%
Outpatient Surgery - included all related surgical services and anesthesia - see member certificate for specific surgical copays.	100%

Alternatives to Hospital Care

Skilled Nursing Care	100%
	Up to 45 days per member per calendar year
Hospice Care	100% (When authorized)
Home Health Care	$10 copay

Surgical Services

Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	100%
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Male - Not Covered
Elective Abortion (One procedure per two year period of membership)	Not Covered
Human Organ Transplants	100%
Reduction Mammoplasty	50%
Male Mastectomy	50%
Temporomandibular Joint Syndrome	50%
Orthognathic Surgery	50%
Weight Reduction Procedures (Limited to one procedure per lifetime)	100%

Benefits Selected - ER25,WMS,10OVCR,6350PM,1020DC,UR10,WRCWR

Mental Health Care and Substance Abuse Treatment

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

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	$10 copay
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18	$10 copay
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%
Allergy Injections	$5 copay
Chiropractic Spinal Manipulation - when referred	$10 copay
	(up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy	$10 copay
	One period of treatment for any combination of therapies within 60 consecutive days per calendar year
Infertility Counseling and Treatment (Excludes In-vitro fertilization)	50%
Durable Medical Equipment (DME)	50%
Prosthetic and Orthotic Appliances (P&O)	50%
Diabetic Supplies	50%
Prescription Drugs	Tier 1 - $10 copay, Tier2 - $20 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	Not covered
Prescription Drug Deductible	None
Hearing Aid	Not Covered

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.**

Benefits Selected - ER25,WMS,10OVCR,6350PM,1020DC,UR10,WRCWR

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