Blue Care Network of Michigan

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

HDHPLG

00135854 Garden City Public Schools

Deductible, Copays and Dollar Maximums

Deductible - Combined for both medical and drug coverage.	$1,350 for a one-person contract/$2,700 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)

	Deductible - The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract
Fixed Dollar Copays	None
Coinsurance	50% for select services as noted below
Out of Pocket Maximum	$2,350 for a one-person contract. $4,700 for a family contract (2 or more members) each calendar year
	Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays

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	100% after deductible. Deductible does not apply to preventive services and routine maternity care
Online Visits	100% after deductible. Deductible does not apply to preventive services and routine maternity care
Consulting Specialist Care	100% after deductible. Deductible does not apply to preventive services and routine maternity care

Emergency Medical Care

Hospital Emergency Room	100% after deductible
Urgent Care Center	100% after deductible
Ambulance Services	100% after deductible

Benefits Selected - DME5,1350HD,2350OM,OMRR,P136HD,90D3X,P&O5

Diagnostic Services

Laboratory and Pathology Tests	100% after deductible
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 (See Preventive Services section for routine Pre-Natal Care)	100% (Deductible applies for non-routine maternity care)
Delivery and Nursery Care	100% after deductible

Hospital Care

General Nursing Care, Hospital Services and Supplies	100% after deductible
Outpatient Surgery	100% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	100% after deductible
	Up to 45 days per calendar year
Hospice Care	100% after deductible
Home Health Care	100% after deductible

Surgical Services

Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	100% after deductible
Voluntary Sterilization	Male - 50% after deductible
Elective Abortion (One procedure per two year period of membership)	Not Covered
Human Organ Transplants	100% 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

Benefits Selected - DME5,1350HD,2350OM,OMRR,P136HD,90D3X,P&O5

Mental Health Care and Substance Use Disorder Treatment

Inpatient Mental Health Care	100% after deductible
Inpatient Substance Use Disorder	100% after deductible
Outpatient Mental Health Care includes online visits Note: For diagnostic and therapeutic services, the medical benefit applies.	100% after deductible
Outpatient Substance Use Disorder	100% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment

Applied Behavioral analysys (ABA) treatment	100% 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.	100% 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	100% after deductible
Allergy Injections	100% after deductible
Chiropractic Spinal Manipulation - when referred	100% after deductible
	(up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy	100% after deductible
	60 visits per calendar year for any combination of therapies
Infertility Counseling and Treatment (Excludes In-vitro fertilization)	50% after deductible
Durable Medical Equipment	100% after deductible
Prosthetic and Orthotic Appliances	100% after deductible
Diabetic Supplies	100% after deductible
Prescription Drugs	Tier 1A - $10 after deductible, Tier 1B - $30 after deductible, T2- $60 after deductible, T3- $80 after deductible, T4- 20% coinsurance after deductible (max $200), T5- 20% coinsurance after deductible (max $300); 30 day supply
	Sexual Dysfunction drugs - 50% coinsurance after deductible
	Contraceptives – T1A- 100% (deductible does not apply), Tier 1B - $30 after deductible, T2 - $60 after deductible, T3-$80 after deductible; 30 day supply
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 after deductible
Prescription Drug Deductible	Prescription drug deductible integrated with the medical deductible
Hearing Aid	Not covered

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This is intended as an easy-to-read summary. **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-Gl 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 - DME5,1350HD,2350OM,OMRR,P136HD,90D3X,P&O5