Blue Care Network of Michigan

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

BCNSTU with Deductibles

00401167 Wayne State University School of Medicine

Deductible, Copays and Dollar Maximums

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

Deductible Note: Coinsurance and select fixed dollar copays apply once the deductible has been met.	$500 individual/$1,000 family per calendar year
Fixed Dollar Copays	$5 for Allergy Injections
	$30 for office visits
	$60 for urgent care visits
	$100 for emergency room visits
	$30 for referral physician visits
Percent Copay	50% for select services as noted below
	20% 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 – including prescription drug copays	$2,500 per individual/$5,000 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%

Physician Office Services

PCP Office Visits	$30 Copay
Online Visits	$30 Copay
Consulting Specialist Care - when referred for other than preventive services	$30 Copay after deductible

Benefits Selected - CI20%,D500,DPRCOS,VACR50,ER100,CO30,2500PM,2500PM,P640CS,90D3X,UR60,PVSN

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Emergency Medical Care

Hospital Emergency Room - copay waived if admitted	$100 Copay after deductible
Urgent Care Center	$60 Copay
Ambulance Services - medically necessary	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)	80% 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)	$30 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 - see member certificate for specific surgical copays.	80% after deductible

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	$30 Copay after deductible

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Surgical Services

Surgery - included all related surgical services and anesthesia - see member certificate for specific surgical copays.	80% after deductible
Voluntary Male Sterilization	50% after deductible
First Trimester Termination (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

Mental Health Care and Substance Use Disorder Treatment

Inpatient Mental Health Care	80% after deductible
Inpatient Substance Use Disorder	80% after deductible
Outpatient Mental Health Care	$30 Copay after deductible
Outpatient Substance Use Disorder	$30 Copay after deductible

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	$30 Copay after deductible
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18; Physical, speech and occupational therapy for autism is unlimited	$30 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; up to 30 visits per calendar year	$30 Copay after deductible
Rehab Services - subject to meaningful improvement within 90 days; Outpatient PT/OT - limited to a combined benefit max of 30 visits per calendar year; ST - limited to 30 visits per calendar year	$30 Copay after deductible
Habilitative Services- Outpatient Physical and Occupational Therapy limited to a combined benefit maximum of 30 visits per calendar year; Outpatient Speech Therapy limited to 30 days per calendar year	100% after deductible
Outpatient Cardiac and Pulmonary Rehabilitation; limited to a benefit maximum of 30 visits per calendar year	100% after deductible
Infertility Counseling and Treatment; on all associated costs (excluding In-vitro fertilization)	50% after deductible
Outpatient Physical, Speech and Occupational Therapy- subject to meaningful improvement within 60 days	50%
Prosthetic and Orthotic Appliances (P&O)	50%
Diabetic Supplies	50%
Pediatric Vision - Eye Exam and prescription glasses (chosen from a select collection) imited to once per calendar year through the last day of the year in which an individual turns age 19	100%
Prescription Drugs	Tier 1A - $6 copay, Tier 1B - $40 copay, Tier 2 - $60 copay, Tier 3 - $80 copay, Tier4 - 20% coinsurance (max $200 copay)/Tier5 - 20% Coinsurance (max $300 copay) 30 day supply
	Sexual Dysfunction - Not Covered
	Female contraceptives - Tier 1A - Covered in full, Tier 1B - $40 copay, Tier 2 - $60 copay, Tier 3 - $80 copay
Prescription Drug Deductible	None
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.**

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