	Enhanced Benefits (CLSSLG)	Standard Benefits (CLSSLG)
Deductible, Copays and Dollar Maximums	**Note:** The **Deductible** will apply to certain services as defined below.	
Deductible	None	$250 individual/$500 family per calendar year
Fixed Dollar Copays	$0 for allergy injections	$0 for allergy injections
	$10 for office visits	$20 for office visits
	$10 for urgent care visits	$20 for urgent care visits
	$50 for emergency room visits	$100 for emergency room visits
	$10 for referral physician visits	$20 for referral physician visits
Coinsurance	50% for select services as noted below	50% for select services as noted below
Annual Coinsurance Maximum (ACM)	None	None
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$1,250 per individual/$2,500 per family	$1,250 per individual/$2,500 per family

Enhanced Benefits : CLSSLG : PD520C, HHRX, MOPD2O, P&O5, PO1SI, SN730, UR10, DSRCW, WRCWR, 1250PM, PD34DS, 100MSR, 10OVCR, VACR50, BCNWIG, AS5, DME5, ER50, HA2707

Standard Benefits : CLSSLG : AS5, DME5, ER100, HA2707, 1550DC, HHRX, MOPD2O, P&O5, PO1SI, SN730, UR20, DSRCW, WRCWR, 1250PM, PD34DS, 100MSR, D250, CO20, VACR50, BCNWIG

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	Enhanced Benefits (CLSSLG)	Standard Benefits (CLSSLG)
Preventive Services		
Health Maintenance Exam	100%	100%
Annual Gynecological Exam	100%	100%
Pap Smear Screening	100%	100%
Well-Baby and Child Care	100%	100%
Immunizations	100%	100%
Prostate Specific Antigen (PSA) Screening	100%	100%
Routine Colonoscopy	100%	100%
Mammography Screening	100%	100%
Voluntary Female Sterilization	100%	100%
Breast Pumps (DME guidelines apply.)	100%	100%
Maternity Pre-Natal care	100%	100%
Physician Office Services		
PCP Office Visits	$10 copay	$20 Copay
Online Visits	$10 Copay	$20 Copay
Consulting Specialist Care	$10 copay	$20 Copay after deductible
Emergency Medical Care		
Hospital Emergency Room - Copay waived if admitted	$50 Copay	$100 Copay after deductible
Urgent Care Center	$10 Copay	$20 Copay
Ambulance Services	100%	100% after deductible

Enhanced Benefits : CLSSLG : PD520C, HHRX, MOPD2O, P&O5, PO1SI, SN730, UR10, DSRCW, WRCWR, 1250PM, PD34DS, 100MSR, 10OVCR, VACR50, BCNWIG, AS5, DME5, ER50, HA2707

Standard Benefits : CLSSLG : AS5, DME5, ER100, HA2707, 1550DC, HHRX, MOPD2O, P&O5, PO1SI, SN730, UR20, DSRCW, WRCWR, 1250PM, PD34DS, 100MSR, D250, CO20, VACR50, BCNWIG

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	Enhanced Benefits (CLSSLG)	Standard Benefits (CLSSLG)
Diagnostic Services		
Laboratory and Pathology Tests	100%	100%
Diagnostic Tests and X-rays	100%	100% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	100%	100% after deductible
Radiation Therapy	100%	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)	$10 copay	$20 Copay
Delivery and Nursery Care	100% For professional services. (See Hospital Care for facility charges)	100% For professional services. (See Hospital Care for facility charges) after deductible
Hospital Care		
General Nursing Care, Hospital Services and Supplies	100%	100% after deductible
Outpatient Surgery - included all related surgical services and anesthesia - see member certificate for specific surgical copays.	100%	100% after deductible

Enhanced Benefits : CLSSLG : PD520C, HHRX, MOPD2O, P&O5, PO1SI, SN730, UR10, DSRCW, WRCWR, 1250PM, PD34DS, 100MSR, 10OVCR, VACR50, BCNWIG, AS5, DME5, ER50, HA2707

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	Enhanced Benefits (CLSSLG)	Standard Benefits (CLSSLG)
Alternatives to Hospital Care		
Skilled Nursing Care	100%	100% after deductible
	Up to 730 days per lifetime	Up to 730 days per lifetime
Hospice Care	100% (When authorized)	100% (When authorized) after deductible
Home Health Care	$10 copay	$20 Copay after deductible
Surgical Services		
Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	100%	100% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	100%	100% after deductible
Elective Abortion (One procedure per two year period of membership)	50% after deductible	50% after deductible
Human Organ Transplants	100%	100% after deductible
Reduction Mammoplasty	50%	50% after deductible
Male Mastectomy	50%	50% after deductible
Temporomandibular Joint Syndrome	50%	50% after deductible
Orthognathic Surgery	50%	50% after deductible
Weight Reduction Procedures (Limited to one procedure per lifetime)	100%	100% after deductible

Enhanced Benefits : CLSSLG : PD520C, HHRX, MOPD2O, P&O5, PO1SI, SN730, UR10, DSRCW, WRCWR, 1250PM, PD34DS, 100MSR, 10OVCR, VACR50, BCNWIG, AS5, DME5, ER50, HA2707

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	Enhanced Benefits (CLSSLG)	Standard Benefits (CLSSLG)
Mental Health Care and Substance Use Disorder Treatment		
Inpatient Mental Health Care	100%	100% after deductible
Inpatient Substance Use Disorder	100%	100% after deductible
Outpatient Mental Health Care includes online visits Note: For diagnostic and therapeutic services, the medical benefit applies.	$10 copay	$20 Copay after deductible
Outpatient Substance Use Disorder	$10 copay	$20 Copay after deductible
Autism Spectrum Disorders, Diagnoses and Treatment		
Applied behavioral analyses (ABA) treatment	$10 copay	$20 Copay 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.	$10 copay	$20 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.	See your outpatient mental health, medical office visit and preventive benefit.

Enhanced Benefits : CLSSLG : PD520C, HHRX, MOPD2O, P&O5, PO1SI, SN730, UR10, DSRCW, WRCWR, 1250PM, PD34DS, 100MSR, 10OVCR, VACR50, BCNWIG, AS5, DME5, ER50, HA2707

Standard Benefits : CLSSLG : AS5, DME5, ER100, HA2707, 1550DC, HHRX, MOPD2O, P&O5, PO1SI, SN730, UR20, DSRCW, WRCWR, 1250PM, PD34DS, 100MSR, D250, CO20, VACR50, BCNWIG

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	Enhanced Benefits (CLSSLG)	Standard Benefits (CLSSLG)
Other Services		
Allergy Testing and Therapy	100%	100% after deductible
Allergy Injections	100%	100%
Chiropractic Spinal Manipulation - when referred	$10 copay	$20 Copay after deductible
	(up to 30 visits per calendar year)	(up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy	$10 copay	$20 Copay after deductible
	One period of treatment for any combination of therapies within 60 consecutive days per calendar year	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%	50% after deductible
Durable Medical Equipment (DME)	100%	100%
Prosthetic and Orthotic Appliances (P&O)	100%	100%
	100% coverage for prosthetic, orthotic and corrective appliances for unattached shoe inserts, when medically necessary.	100% coverage for prosthetic, orthotic and corrective appliances for unattached shoe inserts, when medically necessary.
Diabetic Supplies	100%	100%
Prescription Drugs	Tier 1 - $5 copay, Tier 2 - $20 copay; with contraceptives, 30 day supply	Tier 1 - $15 copay, Tier 2 - $50 copay; with contraceptives; 30 day supply
	Sexual Dysfunction Drugs - 50% coinsurance	Sexual Dysfunction Drugs - 50% coinsurance
	Women's Contraceptives - Tier 1 - 100%, Tier 2 - Tier 2 Copayment/Coinsurance above applies	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	Two times the applicable copay up to a 90 day supply

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Standard Benefits : CLSSLG : AS5, DME5, ER100, HA2707, 1550DC, HHRX, MOPD2O, P&O5, PO1SI, SN730, UR20, DSRCW, WRCWR, 1250PM, PD34DS, 100MSR, D250, CO20, VACR50, BCNWIG

Medical Hearing	0000D969 0000B314	MED

	Enhanced Benefits (CLSSLG)	Standard Benefits (CLSSLG)
Prescription Drug Deductible	None	None
Hearing Aid	Monaural benefit maximum - $1,507; Binaural benefit maximum - $2,707	Monaural benefit maximum - $1,507; Binaural benefit maximum - $2,707

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-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.**

Healthy Blue Living subscribers must complete program requirements within the first 90 days of enrollment or re-enrollment. To qualify for or maintain enhanced benefits, the subscriber needs to complete a health assessment and qualification form during the first 90 days and follow their primary care physician's recommendations for a healthy lifestyle. If a tobacco user, must enroll in the BCN-sponsored tobacco cessation program within 120 days of the start of the plan year. If BMI is greater than or equal to 30, must select and begin participating in a weight management program within 120 days of the start of the plan year.

Enhanced Benefits : CLSSLG : PD520C, HHRX, MOPD2O, P&O5, PO1SI, SN730, UR10, DSRCW, WRCWR, 1250PM, PD34DS, 100MSR, 10OVCR, VACR50, BCNWIG, AS5, DME5, ER50, HA2707

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