Blue Care Network of Michigan

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

HDHPLG

Holly Schools Option 2

Deductible, Copays and Dollar Maximums

Deductible - Combined for both medical and drug coverage. The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract	$1,300 individual/$2,600 family per benefit year
Fixed Dollar Copays	None
Coinsurance	50% for select services as noted below
	20% for select services as noted below
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays	$2,300 per individual/$4,600 per family per benefit year

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	80% after deductible
Consulting Specialist Care	80% after deductible

Emergency Medical Care

Hospital Emergency Room	80% after deductible
Urgent Care Center	80% after deductible
Ambulance Services	80% after deductible

Diagnostic Services

Laboratory and Pathology Tests	80% after deductible
Diagnostic Tests and X-rays	80% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	80% after deductible
Radiation Therapy	80% after deductible

Benefits Selected - 20COHD,1300HD,23OMHD,P1048D,MOPD2O,BENYR

Maternity Services Provided by a Physician

Post-Natal and Non-routine Pre-Natal Care (See Preventive Services section for routine Pre-Natal Care)	80% after deductible (Does not apply to routine services)
Delivery and Nursery Care	80% after deductible

Hospital Care

General Nursing Care, Hospital Services and Supplies	80% after deductible
Outpatient Surgery	80% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	80% after deductible
	Up to 45 days per benefit year
Hospice Care	80% after deductible
Home Health Care	80% after deductible

Surgical Services

Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	80% after deductible
Voluntary Sterilization	Male - 50% after deductible
Elective Abortion (One procedure per two year period of membership)	Not Covered
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	50% after deductible

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care	80% after deductible
Inpatient Substance Abuse Care	80% after deductible
Outpatient Mental Health Care	80% after deductible
Outpatient Substance Abuse	80% after deductible

Benefits Selected - 20COHD,1300HD,23OMHD,P1048D,MOPD2O,BENYR

Autism Spectrum Disorders, Diagnoses and Treatment

Applied Behavioral analysys (ABA) treatment	80% after deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18	80% 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	80% after deductible
Allergy Injections	80% after deductible
Chiropractic Spinal Manipulation - when referred	80% after deductible
	(up to 30 visits per benefit year)
Outpatient Physical, Speech and Occupational Therapy	80% after deductible
	One period of treatment for any combination of therapies within 60 consecutive days per benefit year
Infertility Counseling and Treatment (Excludes In-vitro fertilization)	50% after deductible
Durable Medical Equipment	50% after deductible
Prosthetic and Orthotic Appliances	50% after deductible
Diabetic Supplies	80% after deductible
Prescription Drugs	Tier 1 - $10 after deductible, T2- $40 after deductible, T3- $80 after deductible, ED-50% after ded; Contraceptives - 100% (deductible does not apply), T2 - $40 after deductible, T3-$80 after deductible; 30 day supply
Mail Order Prescription Drugs	Two times the applicable copay after deductible up to a 90 day supply
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.**

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