



**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 20% 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%

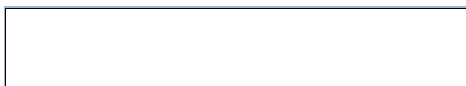
**Physician Office Services**

PCP Office Visits	80% after deductible
Online 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

Benefits Selected - DME5,20COHD,1350HD,2350OM,OMRR,P415DL,90D3X,P&O5



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**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

**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 calendar 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

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**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 includes online visits Note: For diagnostic and therapeutic services, the medical benefit applies.	80% after deductible
Outpatient Substance Use Disorder	80% after deductible

**Autism Spectrum Disorders, Diagnoses and Treatment**

Applied Behavioral analysis (ABA) treatment	80% 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.	80% 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	80% after deductible
Allergy Injections	80% after deductible
Chiropractic Spinal Manipulation - when referred	80% after deductible (up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy	80% 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	80% after deductible
Prescription Drugs	Tier 1A - \$4 copay after ded, Tier 1B - \$15 copay after ded, Tier 2 - \$40 copay after ded, Tier 3 - \$80 copay after ded, Tier 4 - 20% coinsurance after ded (max \$200)/Tier 5 - 20% coinsurance after ded (max \$300); 30 day supply Sexual Dysfunction drugs - 50% coinsurance after deductible
Mail Order Prescription Drugs	Female contraceptives - Tier 1A - Covered in full, Tier 1B - \$15 copay after ded, Tier 2 - \$40 copay after ded, Tier 3 - \$80 copay after ded 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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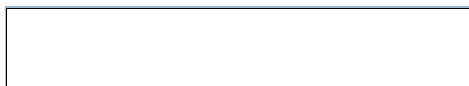
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This is intended as an easy-to-read summary. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. 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-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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