Blue Care Network of Michigan

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

Group Name / Group ID: CMG HEALTH MANAGEMENT SERVICES LLC / 00283328
Sub Group Name / Sub Group ID: CMG HEALTH MANAGEMENT SERVICES LLC / 0001
Class ID: 0001
Plan Description: Medical Healthy Living - Enhanced
Effective Date: 2020-07-01

Disclaimer: 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 certificate and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this benefit summary and any applicable plan documents, the plan document will control.

DEDUCTIBLE

$500 per individual; $1,000 per family deductible per calendar year

COINSURANCE MAXIMUM

This plan has no coinsurance maximum.

OUT-OF-POCKET MAXIMUM

$1,000 per individual; $2,000 per family out-of-pocket maximum per calendar year

ALLERGY OFFICE VISIT

50% coinsurance for allergy office visits

AMBULANCE EMERGENT

$25 copay after deductible for emergency ambulance transport when other transportation would endanger a member's life

AMBULANCE NON-EMERGENT

$25 copay after deductible for non-emergent ambulance transport. Requires prior authorization by BCN.

DETOX - SUB ABUSE

Detox services provided inpatient are covered in full after deductible. $20 copay per visit for outpatient detox services. Requires priorauthorization by BCN.

DURABLE MEDICAL EQUIPMENT

50% coinsurance for durable medical equipment. Must be preauthorizedand obtained from a BCN supplier. Breast pump to support breast feeding is covered in full.

EMERGENCY ROOM

$250 copay after deductible for emergency room treatment. ER copay waived if admitted as an inpatient. Your inpatient hospital benefit applies. See Inpatient Hospital.

HOME CARE VISITS

$30 copay after deductible per day for home care visits

INFERTILITY CARE (CRITERIA REQUIRED)

50% coinsurance after deductible for infertility services. Requires prior authorization by BCN. In-vitro fertilization is not covered.

INPATIENT HOSPITAL

Inpatient hospital admission is covered in full after deductible; unlimited days. See certificate for specific surgical coinsurance.

LAB

Lab and pathology services are covered in full.

MENTAL HEALTH INPATIENT

Inpatient mental health/partial hospitalization per hospital admission is covered in full after deductible. Requires prior authorization by BCN.

MENTAL HEALTH INPATIENT DAYS

Unlimited visits when medically necessary. Requires prior authorization by BCN Behavioral Health management.

MENTAL HEALTH INPATIENT TIME PERIOD

Coordinated by BCN Behavioral Health management

MENTAL HEALTH OUTPATIENT

$20 copay per visit for outpatient/intensive outpatient mental health. $20 copay per online mental health visit with a designated online BCN participating provider. Prior authorization not required for routine psychotherapy visits.

MENTAL HEALTH OUTPATIENT VISITS

Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.

MENTAL HEALTH OUTPT ADDL VISITS

Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.

ORTHOGNATHIC SURGERY

50% coinsurance after deductible for orthognathic surgery

ORTHOTICS

50% coinsurance for orthotics. Must be preauthorized and obtained from a BCN supplier.

OUTPATIENT SURGERY FACILITY

Outpatient surgery is covered in full after deductible. Preventive services and screenings as mandated by the Affordable Care Act are covered in full. See certificate for specific surgical coinsurance.

OUTPT FAC VISITS/DIAGNOSTIC SRVCS

Outpatient diagnostic or therapeutic services are covered in full after deductible. Lab and pathology services, prenatal ultrasound, preventive services and screenings as mandated by the Affordable Care Act are covered in full.

PCP VISITS

$20 copay per primary care physician office visit. Preventive services and screenings as mandated by the Affordable Care Act are covered in full. See BCBSM.com for a complete list of preventive services. $20 copay per visit with a designated online BCN participating provider.

PHYSICAL THERAPY/REHAB OUTPT

$30 copay after deductible per visit for outpatient physical therapy and rehabilitation

PHYSICAL THERAPY/REHAB OUTPT LIMITS

Limited to 60 visits per calendar year for any combination of therapies.

PRE-EXISTING CONDITION

Not applicable

PRE-EXISTING TIME PERIOD

Not applicable

PROSTHETICS

50% coinsurance for prosthetics. Must be preauthorized and obtained from a BCN supplier.

SKILLED NURSING FACILITY

Services in a skilled nursing facility are covered in full after deductible.

SKILLED NURSING FACILITY DAYS

Limited to 45 days of skilled nursing care per calendar year in a skilled nursing facility. Requires prior authorization by BCN.

SPECIALIST VISITS

$30 copay per specialist office visit when referred. Preventive services and screenings as mandated by the Affordable Care Act are coveredin full. Spinal manipulations are limited to 30 combined visits per calendar year when provided by a chiropractor or osteopathic physician.

STERILIZATIONS

50% coinsurance after deductible for male sterilization. Female sterilization is covered in full.

SUB ABUSE INTERMEDIATE

Inpatient partial hospitalization substance use disorder is covered in full after deductible. Requires prior authorization by BCN Behavioral Health management.

SUB ABUSE INTERMEDIATE TIME PERIOD

Coordinated by BCN Behavioral Health management

SUB ABUSE OUTPATIENT

$20 copay per visit for outpatient/intensive outpatient substance usedisorder. Prior authorization not required for routine psychotherapy visits.

SUB ABUSE OUTPATIENT VISITS

Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.

TEMPOROMANDIBULAR JOINT

50% coinsurance after deductible for TMJ services. Requires prior authorization by BCN.

ELECTIVE ABORTIONS

50% coinsurance after deductible for first trimester elective abortion. Limited to one procedure per 24 month period.

URGENT CARE CENTER

$35 copay per urgent care visit

WEIGHT REDUCTION (CRITERIA REQUIRED)

50% coinsurance after deductible for weight reduction procedures. Requires prior authorization by BCN. Limited to one procedure per lifetime.

X-RAY

$150 copay after deductible for high tech radiology services such as MRI, PET, CAT or MRA when performed in an outpatient facility, free standing facility or office setting. Other radiology services are covered in full after deductible. Prenatal ultrasound and other preventivescreenings are covered in full.

ANESTHESIA

Anesthesia is covered in full after deductible.

SURGICAL ASSISTANT

Services performed by a surgical assistant are covered in full after deductible.

SECOND SURGICAL OPINION

$30 copay for second surgical opinion when referred

HOSPICE

Inpatient and outpatient hospice are covered in full after deductible. Inpatient care requires prior authorization.

NEWBORN CARE

Newborn care in an inpatient setting is covered in full after deductible.

IMMUNIZATIONS

Pediatric and adult immunizations as recommended by the Advisory Committee on Immunization Practices are covered in full.

MATERNITY

$20 copay for postnatal maternity visits. Prenatal visits are covered in full.

DIALYSIS

Dialysis treatment in an inpatient or outpatient facility setting is covered in full after deductible.

CHEMOTHERAPY

Chemotherapy in an inpatient or outpatient facility setting is covered in full after deductible. Chemotherapy drugs are covered in full.

RADIATION THERAPY

Radiation therapy in an inpatient or outpatient facility setting is covered in full after deductible.

AUTISM

$20 copay per visit for applied behavioral analysis. Outpatient therapy cost sharing applies for autism related speech, physical and occupational therapy with unlimited visits.

DIABETIC SUPPLIES

Diabetic supplies and equipment are covered in full. Must be preauthorized and obtained from a BCN supplier.

ALLERGY EVAL/SERUM/TESTING

50% coinsurance after deductible for allergy related services with the exception of allergy injections

ALLERGY INJECTIONS

$5 copay per visit for allergy injections