

Blue Care Network

Benefits-at-a-Glance

BCN10, CO20, ER50, UR35, IP10, 10% CR, 500DED, 1500CM

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Preventive Services	
Health Maintenance Exam	Covered – \$20 copay
Annual Gynecological Exam	Covered – \$20 copay PCP; \$20 copay OB/GYN
Pap Smear Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit
Well-Baby and Child Care	Covered – \$20 copay
Immunizations – pediatric and adult	Covered – Office visit copay may apply per member, per visit
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit
Mammography	
Mammography Screening	Covered – Office visit copay may apply per member, per visit
Physician Office Services	
Office Visits	Covered – \$20 copay
Consulting Specialist Care – when referred for other than preventive services	Covered – \$20 copay after deductible
Emergency Medical Care	
Hospital Emergency Room – copay waived if admitted, inpatient hospital benefits apply	Covered – \$50 copay after deductible
Urgent Care Center	Covered – \$35 copay
Ambulance Services – medically necessary	Covered – 90% after deductible, ground and air service, with a 10% copay up to \$1,500 per member, \$3,000 per family per calendar year
Diagnostic Services	
Laboratory and Pathology Tests	Covered – Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered – 90% after deductible, with a 10% copay up to \$1,500 per member, \$3,000 per family per calendar year
Radiation Therapy	Covered – 90% after deductible, with a 10% copay up to \$1,500 per member, \$3,000 per family per calendar year
Maternity Services Provided by a Physician	
Pre-Natal and Post-Natal Care	Covered – \$20 copay
Delivery and Nursery Care	Covered – 90% after deductible, with a 10% copay up to \$1,500 per member, \$3,000 per family per calendar year
Hospital Care	
Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 90% after deductible, with a 10% copay up to \$1,500 per member, \$3,000 per family per calendar year; unlimited days
Outpatient Surgery – see member certificate for specific surgical copay	Covered – 90% after deductible, with a 10% copay up to \$1,500 per member, \$3,000 per family per calendar year

Alternatives to Hospital Care	
Skilled Nursing Care	Covered – 90% after deductible, up to 45 days per calendar year; 10% copay up to \$1,500 per member, \$3,000 per family per calendar year
Hospice Care	Covered – 90% after deductible, with a 10% copay up to \$1,500 per member, \$3,000 per family per calendar year. Outpatient hospice covered in full.
Home Health Care	Covered – \$20 copay after deductible
Surgical Services	
Surgery – includes all related surgical services and anesthesia. See member certificate for specific surgical copays.	Covered – 90% after deductible, with a 10% copay up to \$1,500 per member, \$3,000 per family per calendar year
Voluntary Sterilization	Covered – 50% after deductible on all associated costs
Human Organ Transplants	Covered – 90% after deductible, with a 20% copay up to \$1,500 per member, \$3,000 per family per calendar year; subject to medical criteria
Mental Health Care and Substance Abuse Treatment	
Inpatient Mental Health Care and Substance Abuse Care	Mental Health Care: Covered – 75%, with a 25% copay, up to \$1,000 per member, \$2,000 per family per calendar year, up to 30 days per calendar year Substance Abuse Care: Covered – 50%, one program of treatment per year, up to state mandated dollar limitation which is adjusted annually by the state
Outpatient Mental Health Care	Covered – 50%, up to 20 visits per calendar year
Outpatient Substance Abuse Care	Covered – 50%, one program of treatment per year, up to state mandated dollar limitation which is adjusted annually by the state Note: A program of treatment may include outpatient or intermediate services or both.
Other Services	
Allergy Testing and Therapy	Covered – 50% after deductible
Allergy Injections	Covered – \$5 copay
Chiropractic Spinal Manipulation – when referred	Covered – \$20 copay after deductible
Outpatient Physical, Speech and Occupational Therapy – subject to significant improvement within 60 days	Covered – \$20 copay after deductible, limited to 60 consecutive days per episode for a combination of therapies
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%
Deductible, Copays and Dollar Maximums	
Deductible	\$500 per member / \$1,000 per family per calendar year
Copays	\$5 for allergy injections, \$20 for PCP office visits, \$20 for specialist office visits, \$35 for urgent care visits and \$50 for emergency room visits
• Fixed Dollar Copay	
• Percent Copay	10%, 25% and 50% for select services as noted above
Copay Dollar Maximums	
• Fixed Dollar Copay	None
• Percent Dollar Copay – Medical Services; excludes services with a 50% copay	\$1,500 per member, \$3,000 per family per calendar year
• Percent Dollar Copay – Inpatient Mental Health Care	\$1,000 per member, \$2,000 per family per calendar year
Dollar Maximums	Applies only to Substance Abuse dollar limitation, adjusted annually by the state

The **Deductible** is applicable to all covered services except (1) **preventive services** provided by the member's PCP; (2) **preventive services** obtained as a result of referral from the PCP; (3) routine maternity care; and (4) services paid by a provider or vendor under the delegation of a claim payment arrangement.

Blue Care Network

Benefits-at-a-Glance

BCN65, 65OV20, 65ER50, 65UR35

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Preventive Services	
Health Maintenance Exam	Covered – \$20 copay
Annual Gynecological Exam	Covered – \$20 copay
Pap Smear Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit
Well-Baby and Child Care	Covered – \$20 copay
Immunizations – pediatric and adult	Covered – Office visit copay may apply per member, per visit
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit
Mammography	
Mammography Screening	Covered – Office visit copay may apply per member, per visit
Physician Office Services	
Office Visits	Covered – \$20 copay
Consulting Specialist Care – when referred	Covered – \$20 copay
Emergency Medical Care	
Hospital Emergency Room – copay waived if admitted	Covered – \$50 copay
Urgent Care Center	Covered – \$35 copay
Ambulance Services – medically necessary	Covered – 100%
Diagnostic Services	
Laboratory and Pathology Tests	Covered – Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered – Office visit copay may apply per member, per visit
Radiation Therapy	Covered – Office visit copay may apply per member, per visit
Maternity Services Provided by a Physician	
Pre-Natal and Post-Natal Care	Covered – \$20 copay
Delivery and Nursery Care	Covered – 100%
Hospital Care	
Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 100%; unlimited days (Coordinated with Medicare)
Outpatient Facility Services	Covered – 100% (Coordinated with Medicare)
Alternatives to Hospital Care	
Skilled Nursing Care	Covered – 100%, up to 100 days per benefit period
Hospice Care	Covered – 100% in a facility
Home Health Care	Covered – \$20 copay

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 100% (Coordinated with Medicare)
Voluntary Sterilization	Covered – 100%
Human Organ Transplants	Covered – 100%, subject to medical criteria

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	Mental Health Care: Covered – 100% up to 190 days lifetime maximum Substance Abuse Care: Covered – Limited to a combined maximum aggregate dollar amount per calendar year
Outpatient Mental Health Care	Covered – 100%, up to 20 visits per calendar year
Outpatient Substance Abuse Care	Covered – Limited to a combined maximum aggregate dollar amount per calendar year

Other Services

Allergy Testing and Therapy	Covered – Office visit copay may apply per member, per visit
Allergy Injections	Covered – Office visit copay may apply per member, per visit
Chiropractic Spinal Manipulation – when referred	Covered – \$20 copay
Outpatient Physical, Speech and Occupational Therapy	Covered – \$20 copay
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 100%
Durable Medical Equipment	Covered – 100%
Prosthetic and Orthotic Appliances	Covered – 100%

Deductible, Copays and Dollar Maximums

Deductible	None
Copays	
• Fixed Dollar Copay	\$20 for office visits, \$35 for urgent care and \$50 for emergency room visits
• Percent Copay	None
Copay Dollar Maximums	
• Fixed Dollar Copay	None
• Percent Dollar Copay	None
Dollar Maximums	Applies only to Substance Abuse dollar limitation, adjusted annually by the state

Blue Care Network Rx Prescription Drug Coverage

\$10/\$40 Copay with Contraceptive Coverage

Benefits-at-a-Glance

Covered Services	
Formulary Drug – Generic	Covered – \$10 copay
Formulary Drug – Brand Name	Covered – \$40 copay
Formulary Brand Name when Generic is available	Covered – Difference in cost between brand name drug and generic drug plus \$40
Non-Formulary Drugs	Not Covered
Sexual Dysfunction Drugs	Covered – 50% copay
Mail Order Prescription Drugs	Covered – 2 times the applicable generic, brand or sexual dysfunction copay for a 35 to 90 day supply
Definitions	
BCN Formulary	A list of all prescription drugs which have been approved for use by BCN and which shall be dispensed through participating pharmacies to members.
Brand Name Drugs	Prescription drugs which are manufactured and marketed under a registered trade name or trademark.
Covered Drugs	Prescription drugs (Generic, Brand Name, Compounded Medication, or Health Habit) which are prescribed by a BCN affiliated provider and obtained through a participating pharmacy. Certain covered drugs are a benefit only if a BCN affiliated provider certifies to BCN and BCN agrees that the covered drug in question is medically necessary. Those drugs are not payable without preauthorization by BCN.
Generic Drugs	Prescription drugs which have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark.
Mail Order Prescription Drugs	Up to a 90-day supply of covered drugs
Participating Pharmacy	A network of licensed pharmacies selected by or authorized by BCN

1040DC, MOPD2C

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