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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 and/or copay amounts required by the plan. 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 LivingSM members must complete program requirements within first 90 days of enrollment or re-enrollment . To qualify or maintain enhanced benefits, the subscriber and covered spouse need to complete a health risk appraisal and qualification form during the first 90 days and follow their primary care physician's recommendations for a healthy lifestyle. If a smoker, must enroll in the smoking cessation program, Quit The Nic, within 120 days of enrollment or re-enrollment.

Enhanced Benefits
 BCN10, CO20, ER100, UR50, IP10,WAS,WPT,
 \$10/20/40, MOPD2X

Standard Benefits
 BCN10, OV30, ER100, UR60, 30%CR, 500D, 1000CM,
 IP10, WAS,WPT, \$15/50PD, MOPD2X

Deductible, Copays and Dollar Maximums

Note: 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

Deductible	None	\$500 per member, \$1,000 per contract per calendar year
Copays	\$5 for allergy injections, \$20 for office visits, \$50 for urgent care visits and \$100 for emergency room visits	\$5 for allergy injections, \$30 for office visits, \$60 for urgent care visits and \$100 for emergency room visits
• Fixed Dollar Copay		
• Percent Copay (Coinsurance)	25% and 50% of approved amount for select services	25%, 30% and 50% of approved amount for select services
Copay Dollar Maximums		
• Fixed Dollar Copay	None	None
• Percent Copay (Coinsurance)		
– Medical Services – excludes services with a flat dollar and 50% copay	Inpatient hospital services and outpatient surgery \$1,000 per member, \$2,000 per contract per calendar year	\$1,000 per member, \$2,000 per contract per calendar year
– Inpatient Mental Health Services	\$1,000 per member, \$2,000 per contract per calendar year	\$1,000 per member, \$2,000 per contract per calendar year
Dollar Maximums	Applies only to Substance Abuse dollar limitation, adjusted annually by the state	

Preventive Services

Health Maintenance Exam	Covered – \$20 copay	Covered – \$30 copay
Annual Gynecological Exam	Covered – \$20 copay	Covered – \$30 copay
Pap Smear Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit	Covered – Office visit copay may apply per member, per visit
Well-Baby and Child Care	Covered – \$20 copay	Covered – \$30 copay
Immunizations – pediatric and adult	Covered – Office visit copay may apply per member, per visit	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	Covered – Office visit copay may apply per member per visit



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Mammography

Mammography Screening	Covered – 100%	Covered – 100%
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Physician Office Services

PCP Office Visits	Covered – \$20 copay	Covered – \$30 copay
Consulting Specialist Care – when referred	Covered – \$20 copay	Covered – \$30 copay after deductible

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted, inpatient hospital copays apply	Covered - \$100 copay	Covered - \$100 copay after deductible
Urgent Care Center	Covered - \$50 copay	Covered - \$60 copay
Ambulance Services – medically necessary	Covered – \$25 copay, ground and air	Covered – 70% after deductible, ground and air services, with a 30% coinsurance

Diagnostic Services

Laboratory and Pathology Tests	Covered – Office visit copay may apply per member, per visit	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	Covered – 70% after deductible, with a 30% coinsurance
Radiation Therapy	Covered – Office visit copay may apply per member, per visit	Covered – 70% after deductible, with a 30% coinsurance

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – \$20 copay	Covered – \$30 copay
Delivery and Nursery Care	Covered – 100% for professional services; see hospital care below for facility charges.	Covered – 100% after deductible for professional services; see hospital care below for facility charges.

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 75%, with a 25% coinsurance; unlimited days	Covered – 70% after deductible, with 30% coinsurance, unlimited days
Outpatient Surgery – see member certificate for specific surgical copay	Covered – 75%, with 25% coinsurance	Covered – 70% after deductible, with a 30% coinsurance



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Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100% , up to 45 days per calendar year	Covered – 70% after deductible, up to 45 days per calendar year; 30% coinsurance
Hospice Care	Covered – 100%	Covered – 100% after deductible
Home Health Care	Covered – \$20 copay	Covered – \$30 copay after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia – see member certificate for specific surgical copays	See Hospital Care for inpatient and outpatient copays	See Hospital Care for inpatient and outpatient copays
Voluntary Sterilization	Not Covered	Not Covered
Pregnancy Termination	Not Covered	Not Covered
Human Organ Transplants	Covered – 75%, with a 25% coinsurance, subject to medical criteria	Covered – 70% after deductible, with a 30% coinsurance, 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% coinsurance, up to \$1,000 per member, \$2,000 per family per calendar year, up to 30 days per calendar year	Mental Health Care: Covered – 75% with a 25% coinsurance, 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 adjusted annually by the state. Note: A program of treatment may include outpatient or intermediate services or both.	Substance Abuse Care: Covered – 50%, one program of treatment per year, up to state mandated dollar limitation adjusted annually by the state. Note: A program of treatment may include outpatient or intermediate services or both.
Outpatient Mental Health Care	Covered – 50%, up to 20 visits per calendar year	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 that is adjusted annually by the state.	Covered – 50%, one program of treatment per year, up to state mandated dollar limitation that is adjusted annually by the state.

Other Services

Allergy Testing and Therapy	Covered – 50%, \$5 copay for allergy injections	Covered – 50% after deductible, \$5 copay for allergy injections
Chiropractic Spinal Manipulation (when referred)	Covered - \$20 copay	Covered - \$30 copay after deductible
Outpatient Physical, Speech and Occupational Therapy (subject to significant improvement within 60 days)	Covered – \$20 copay, limited to 60 consecutive days per episode for a combination of therapies	Covered – \$30 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% on all associated costs	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%	Covered – 50%



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Prescription Drugs

	Enhanced Benefits \$10/20/40, MOPD2X	Standard Benefits \$15/50PD, MOPD2X
Formulary Drugs	Covered - \$10 Copay	Covered - \$15 Copay
Formulary Drugs – Brand Name	Covered - \$20 Copay	Covered - \$50 Copay
Formulary Brand Name when Generic is available	Covered – Difference in cost between brand name drug and generic plus \$20	Covered – Difference in cost between brand name drug and generic plus \$50
Non-Formulary Drugs	Covered - \$40 Copay	Not Covered
Mail Order Prescription Drugs	Covered - \$20 generic copay, \$40 brand copay, and \$80 non-formulary copay up to a 90 day supply	Covered - \$30 generic copay, \$100 brand copay up to a 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

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