

Benefits At A Glance

Healthy Blue LivingSM

00107441-5500 Trinity Health Home Office

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 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)

ER100, WPT, MHSAP, CO20, 102040, XSDRX, MOPD20, WAS, UR50

Standard Benefits (BCN10)

1000CM, 30%CR, 500DED, ER125, WPT, MHSAP, CO30, 1550, XSDRX, MOPD2C, WAS, UR60

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 a 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 |
| Fixed Dollar Copays | \$5 for allergy injections | \$5 for allergy injections |
| | \$20 for office visits | \$30 for office visits |
| | \$50 for urgent care visits | \$60 for urgent care visits |
| | \$100 for emergency room visits | \$125 for emergency room visits |
| | \$25 for ambulance service | No fixed dollar copay for ambulance services. See below for applicable coinsurance amount. |
| | | No fixed dollar copay for inpatient hospital admission. See below for applicable coinsurance amount. |
| | \$20 for referral physician visits | \$30 for referral physician visits |
| Percent Copay | 25% and 50% for selected services as noted below | 25%, 30% and 50% for select services as noted below |
| Copay Dollar Maximums | | |
| Fixed Dollar Copay | None | None |
| Percent Copay - Inpatient Mental Health | None | None |
| Percent Copay - Medical Services | \$1,000/member, \$2,000/contract/calendar year | \$1,000/member, \$2,000/contract/calendar year (Does not apply to flat dollar or 50% coinsurance) |
| Dollar Maximums | None except as noted below for individual services | None except as noted below for individual services |

Preventive Services

| | | |
|---|--|--|
| Health Maintenance Exam | \$20 Copay | \$30 Copay |
| Annual Gynecological Exam | \$20 Copay | \$30 Copay |
| Pap Smear Screening | Office visit copay may apply per member, per visit | Office visit copay may apply per member, per visit |
| Well-Baby and Child Care | \$20 Copay | \$30 Copay |
| Immunizations - pediatric and adult | Office visit copay may apply per member, per visit | Office visit copay may apply per member, per visit |
| Prostate Specific Antigen (PSA) Screening | Office visit copay may apply per member, per visit | Office visit copay may apply per member, per visit |

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Mammography

| | | |
|-----------------------|------|------|
| Mammography Screening | 100% | 100% |
|-----------------------|------|------|

Physician Office Services

| | | |
|--|------------|-----------------------------|
| Office Visits | \$20 Copay | \$30 Copay |
| Consulting Specialist Care - when referred | \$20 Copay | \$30 Copay after deductible |

Emergency Medical Care

| | | |
|---|------------------------------------|--|
| Hospital Emergency Room (copay waived if admitted, if applicable) | \$100 Copay | \$125 Copay after deductible |
| Urgent Care Center | \$50 Copay | \$60 Copay |
| Ambulance Services - medically necessary | \$25 Copay ground and air services | 70%, with a 30% coinsurance after deductible |

Diagnostic Services

| | | |
|-----------------------------------|--|--|
| Laboratory and Pathology Tests | Office visit copay may apply per member, per visit | Office visit copay may apply per member, per visit |
| Diagnostic Tests and X-rays | Office visit copay may apply per member, per visit | 70%, with a 30% coinsurance after deductible |
| High Technology Radiology Imaging | Office visit copay may apply per member, per visit | 70%, with a 30% coinsurance after deductible |
| Radiation Therapy | Office visit copay may apply per member, per visit | 70%, with a 30% coinsurance after deductible |

Maternity Services Provided by a Physician

| | | |
|-------------------------------|--|---|
| Pre-Natal and Post-Natal Care | \$20 Copay | \$30 Copay |
| Delivery and Nursery Care | 100% (For professional services. See Hospital Care for facility charges) | 100% (For professional services. See Hospital Care for facility charges) after deductible |

Hospital Care

| | | |
|--|--|--|
| General Nursing Care, Hospital Services and Supplies | 75% with a 25% coinsurance/adm, max \$1000/ind, \$2000/cont/yr; unlimited days | 70%, with a 30% coinsurance after deductible |
| Outpatient Surgery | 75% with a 25% coinsurance/adm, max \$1000/ind, \$2000/cont/yr | 70%, with a 30% coinsurance after deductible |

Alternatives to Hospital Care

| | | |
|----------------------|--|--|
| Skilled Nursing Care | 100% | 70%, with a 30% coinsurance after deductible |
| | Up to 45 days per member per calendar year | Up to 45 days per member per calendar year |
| Hospice Care | 100% | 100% after deductible |
| Home Health Care | \$20 Copay | \$30 Copay after deductible |

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Surgical Services

| | | |
|--|--|--|
| Surgery - included all related surgical services and anesthesia - see member certificate for specific surgical copays. | See Hospital Care for inpatient and outpatient copay | See Hospital Care for inpatient and outpatient copay |
| Voluntary Sterilization | Not Covered | Not Covered after deductible |
| Human Organ Transplants (subject to medical criteria) | 75% with a 25% coinsurance/adm, max \$1000/ind, \$2000/cont/yr | 70%, with a 30% coinsurance after deductible |

Mental Health Care and Substance Abuse Treatment

| | | |
|--------------------------------|--|--|
| Inpatient Mental Health Care | For the copay, please see General Nursing Care in the Hospital Care Section | For the copay, please see General Nursing Care in the Hospital Care Section |
| Inpatient Substance Abuse Care | For the copay, please see General Nursing Care in the Hospital Care Section | For the copay, please see General Nursing Care in the Hospital Care Section |
| Outpatient Mental Health Care | For the copay, please see Office Vist copay in the Physician Office Services section | For the copay, please see Office Vist copay in the Physician Office Services section |
| Outpatient Substance Abuse | For the copay, please see Office Vist copay in the Physician Office Services section | For the copay, please see Office Vist copay in the Physician Office Services section |

Other Services

| | | |
|--|---|---|
| Allergy Testing and Therapy | \$5 copay for allergy injections; 50% for testing and therapy | \$5 copay for allergy injections; 50% for testing and therapy after deductible |
| Chiropractic Spinal Manipulation - when referred | \$20 Copay | \$30 Copay after deductible |
| Outpatient Physical, Speech and Occupational Therapy | \$20 copay, (60 consecutive days/episode) | \$30 Copay, (60 consecutive days/episode) after deductible |
| Infertility Counseling and Treatment (excludes In-vitro Fertilization) | 50% on all associated costs | 50% on all associated costs after deductible |
| Durable Medical Equipment | 50% | 50% |
| Prosthetic and Orthotic Appliances | 50% | 50% |
| Weight Reduction Procedures | 50% | 50% after deductible |
| Prescription Drugs | Generic - \$10 copay or 50% whichever is less, Brand - \$20 copay or 50% whichever is less, Non-Formulary - \$40 copay or 50%, whichever is less. 34-day supply | Generic - \$15 copay or 50%, whichever is less, Brand - \$50 copay or 50%, whichever is less; without contraceptives, 34-day supply |
| | Sexual Dysfunction drugs not covered | Sexual Dysfunction drugs not covered |
| Mail Order Prescription Drugs | Two times the applicable copay up to a 90 day supply | Two times the applicable copay up to a 90 day supply |
| Prescription Drug Deductible | None | None |
| Hearing Aid | Not Covered | Not Covered |

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