

Benefits At A Glance

Healthy Blue LivingSM

00107441-3200 Mercy Health Partners

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 (BCN5)
AS5, DME20%, ER50, WPT, 250HC, MHSAP, CO10, 102040, XSDRX, MOPD20, PO20%, WAS, UR25

Standard Benefits (BCN10)
500CM, 10%CR, 250DED, ER100, WPT, MHSAP, CO20, 1550, XSDRX, MOPD2C, WAS, UR50

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	\$250 per member/\$500 per contract per calendar year
Fixed Dollar Copays	\$0 for allergy injections	\$5 for allergy injections
	\$10 for office visits	\$20 for office visits
	\$25 for urgent care visits	\$50 for urgent care visits
	\$50 for emergency room visits	\$100 for emergency room visits
		No fixed dollar copay for ambulance services. See below for applicable coinsurance amount.
	\$250 for inpatient hospital admission	No fixed dollar copay for inpatient hospital admission. See below for applicable coinsurance amount.
	\$10 for referral physician visits	\$20 for referral physician visits
Percent Copay	50%/20% for selected services as noted below	10%, 25% and 50% for select services as noted below
Copay Dollar Maximums		
Fixed Dollar Copay	\$750 per individual per calendar year, \$1000 per contract per calendar year for inpatient admission.	None
Percent Copay - Inpatient Mental Health	None	None
Percent Copay - Medical Services	None	\$500/member, \$1,000/contract/calendar year (Does not apply to flat dollar or 50% coinsurance)
Dollar Maximums	None	None except as noted below for individual services

Preventive Services

Health Maintenance Exam	\$10 Copay	\$20 Copay
Annual Gynecological Exam	\$10 Copay	\$20 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	\$10 Copay	\$20 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%
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Physician Office Services

Office Visits	\$10 Copay	\$20 Copay
Consulting Specialist Care - when referred	\$10 Copay	\$20 Copay after deductible

Emergency Medical Care

Hospital Emergency Room (copay waived if admitted, if applicable)	\$50 Copay	\$100 Copay after deductible
Urgent Care Center	\$25 Copay	\$50 Copay
Ambulance Services - medically necessary	100%, ground and air services	90%, with a 10% 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	90%, with a 10% coinsurance after deductible
High Technology Radiology Imaging	Office visit copay may apply per member, per visit	90%, with a 10% coinsurance after deductible
Radiation Therapy	Office visit copay may apply per member, per visit	90%, with a 10% coinsurance after deductible

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	\$10 Copay	\$20 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	\$250 copay/admission, up to \$750 per individual per calendar year, \$1000 per contract per calendar year, unlimited days	90%, with a 10% coinsurance after deductible
Outpatient Surgery - see member certificate for specific outpatient surgical copays	100%	90%, with a 10% coinsurance after deductible

Alternatives to Hospital Care

Skilled Nursing Care	100%	90%, with a 10% 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	\$10 Copay	\$20 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
Elective Termination (First Trimester Termination of Pregnancy - one in each two-year period of membership)	Not Covered	
Human Organ Transplants (subject to medical criteria)	\$250 copay/admission, up to \$750/individual, \$1000/contract/year, unlimited days	90%, with a 10% 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	100%; Office visit copay may apply per member per visit	\$5 copay for allergy injections; 50% for testing and therapy after deductible
Chiropractic Spinal Manipulation - when referred	\$10 Copay	\$20 Copay after deductible
Outpatient Physical, Speech and Occupational Therapy	\$10 copay, (60 consecutive days/episode)	\$20 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	80% with a 20% coinsurance	50%
Prosthetic and Orthotic Appliances	80% with a 20% coinsurance	50%
Weight Reduction Procedures	100%	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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