

Blue Care Network Benefits-at-a-Glance for St. Joseph Mercy Non-Union 00-107441-0920-0922, 0940, 5500

This is intended as an easy-to-read summary. It is not a contract. An official description of benefits is contained in applicable Blue Care Network of Michigan 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.

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
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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; hospital copay will apply	Covered – \$100 copay
Urgent Care Center	Covered – \$50 copay
Ambulance Services – medically necessary	Covered – \$25 copay

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 – 25% copay/adm, max \$1000/ind, \$2000/cont/yr

Hospital Care

Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 25% copay/adm, max \$1000/ind, \$2000/cont/yr
Outpatient Facility Services	Covered – 25% copay/adm, max \$1000/ind, \$2000/cont/yr
<ul style="list-style-type: none"> ▪ Outpatient Surgery – see member certificate for specific outpatient surgical copays ▪ Non-Surgical Services 	Covered - \$10 copay

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100%, up to 45 days per calendar year
Hospice Care	Covered - 100%, in a facility; \$20 copay/home visit
Home Health Care	Covered – \$20 copay

Surgical Services

Surgery – includes all related surgical services and anesthesia – see member certificate for specific surgical copays	Covered – 25% copay/adm, max \$1000/ind, \$2000/cont/yr
Voluntary Sterilization	Not Covered
Human Organ Transplants	Covered – 25% copay/adm, max \$1000/ind, \$2000/cont/yr, subject to medical criteria

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	Mental Health Care: 25% copay/adm, max\$1000/\$2000, up to 30 days/yr 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%, \$5 copay for allergy injections
Chiropractic Spinal Manipulation	Covered – \$20 copay
Outpatient Physical, Speech and Occupational Therapy	Covered – \$20 copay, 60 consecutive days/episode
Infertility Counseling and Treatment (excludes In-vitro Fertilization)	Covered – 50% on all associated costs
Durable Medical Equipment	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%
Prescription Drugs	\$10 generic/\$20 brand/\$40 open formulary w/o C
Mail Order Prescription Drugs	Mail Order 2X the applicable copay/90 day supply
Prescription Drug Deductible	

Deductible, Copays and Dollar Maximums

Deductible	None
Copays	
• Fixed Dollar Copay	\$5 for allergy injections, \$20 office visits, \$50 for urgent care visits, \$100for emergency room visits, \$25 for ambulance service, and, \$20 for referral physician visits.
• Percent Copay	25% and 50% for select services noted
Copay Dollar Maximums	
• Fixed Dollar Copaye	None
▪ Percent Copay – Inpatient Mental Health	\$1000/individual, \$2000/contract/year
• Percent Copay – Medical Facility Services	\$1000/individual, \$2000/contract/year
Dollar Maximums	None except as noted above for individual services

BCN10,OV20,ER100,IP10,WAS,WPT(benefit doesn't show on summary),UR50,PD10/20/40,MOPD2X

9-28-05