

Benefits At A Glance

BCN10

00107441-0920 & 0921 St Joseph Mercy Oakland Union

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.**

Deductible, Copays and Dollar Maximums

Deductible	None
Fixed Dollar Copays	\$5 for allergy injections
	\$20 for office visits
	\$50 for urgent care visits
	\$100 for emergency room visits
	\$25 for ambulance service
	\$20 for referral physician visits
Percent Copay	25% and 50% for selected services as noted below
Copay Dollar Maximums	
Fixed Dollar Copay	None
Percent Copay - Inpatient Mental Health	\$1,000 per individual/\$2,000 per contract
Percent Copay - Medical Services	\$1,000/member, \$2,000/contract/calendar year
Dollar Maximums	None except as noted below for individual services

Preventive Services

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

Mammography

Mammography Screening	100%
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Physician Office Services

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

Emergency Medical Care

Hospital Emergency Room (copay waived if admitted, if applicable)	\$100 Copay
Urgent Care Center	\$50 Copay
Ambulance Services - medically necessary	\$25 Copay ground and air services

CO20,ER100,UR50,WAS,WPT,IP10,102040,XSDRX,MOPD20

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Diagnostic Services

Laboratory and Pathology Tests	Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Office visit copay may apply per member, per visit
High Technology Radiology Imaging	Office visit copay may apply per member, per visit
Radiation Therapy	Office visit copay may apply per member, per visit

Maternity Services Provided by a Physician

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

Hospital Care

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

Alternatives to Hospital Care

Skilled Nursing Care	100%
	Up to 45 days per member per calendar year
Hospice Care	100%
Home Health Care	\$20 Copay

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
Voluntary Sterilization	Not Covered
Human Organ Transplants (subject to medical criteria)	75% with a 25% coinsurance/adm, max \$1000/ind, \$2000/cont/yr

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care	75% with a 25% coinsurance/admission, max \$1,000 per individual/\$2,000 per contract Limited to 30 days per calendar year
Inpatient Substance Abuse Care	50% coinsurance, one program of treatment per year, up to state mandated dollar limitation, which is adjusted annually by the state. A program of treatment may include outpatient or intermediate services or both.
Outpatient Mental Health Care	50% coinsurance, up to 20 visits per calendar year
Outpatient Substance Abuse	50% coinsurance, one program of treatment per year, up to state mandated dollar limitation, which is adjusted annually by the state. A program of treatment may include outpatient or intermediate services or both.

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Other Services

Allergy Testing and Therapy	\$5 copay for allergy injections; 50% for testing and therapy
Chiropractic Spinal Manipulation - when referred	\$20 Copay
Outpatient Physical, Speech and Occupational Therapy	\$20 copay, (60 consecutive days/episode)
Infertility Counseling and Treatment (excludes In-vitro Fertilization)	50% on all associated costs
Durable Medical Equipment	50%
Prosthetic and Orthotic Appliances	50%
Weight Reduction Procedures	50%
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
	Sexual Dysfunction drugs not covered
Mail Order Prescription Drugs	Two times the applicable copay up to a 90 day supply
Prescription Drug Deductible	None
Hearing Aid	Not Covered

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