

Blue Care Network of Michigan Benefits-at-a-Glance for Continuing Care Corp. – 00-10744-7000

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 – \$15 copay
Annual Gynecological Exam	Covered – \$15 copay
Pap Smear Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit
Well-Baby and Child Care	Covered – \$15 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 – \$15 copay
Consulting Specialist Care – when referred	Covered – \$15 copay

Emergency Medical Care

Hospital Emergency Room – copay waived when admitted; applicable hospital copay will apply	Covered – \$50 copay
Urgent Care Center	Covered – \$25 copay or 50% whichever is less
Ambulance Services – medically necessary	Covered – 100%, ground and air services

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 – \$15 copay
Delivery and Nursery Care	Covered – \$500 copay or 50%, whichever is less/admission

Hospital Care

Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – \$500 copay or 50%, whichever is less/admission
Outpatient Facility Services	
<ul style="list-style-type: none"> ▪ Outpatient Surgery – see member certificate for specific outpatient surgical copays ▪ Non-Surgical Services 	Covered - 100%
	Covered – 100%

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100%, up to 45 days per calendar year
Hospice Care	Covered - 100% in a facility, \$15/home visit
Home Health Care	Covered – \$15 copay

Surgical Services

Surgery – includes all related surgical services and anesthesia – see member certificate for specific surgical copays.	Covered – \$500 copay or 50%, whichever is less/admission
Voluntary Sterilization	Not Covered
Human Organ Transplants	Covered – \$500 copay or 50%, whichever is less/admission, subject to medical criteria

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	Mental Health Care: Covered – 100%, up to 30 days per calendar year Substance Abuse Care: Covered – 50%, one program per 12 month period
Outpatient Mental Health Care	Covered – 50%, up to 20 visits per calendar year
Outpatient Substance Abuse Care	Covered – 50%, up to 20 visits per calendar year

Other Services

Allergy Testing and Therapy	Covered – 100%
Chiropractic Spinal Manipulation – when referred	Covered – \$15 copay
Outpatient Physical, Speech and Occupational Therapy	Covered – \$15 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, \$15 office visits, \$25 for urgent care visits, \$50 for emergency room visits, \$500 copay or 50%, whichever is less/admission for hospital admission, \$0 for outpatient surgery \$0 for ambulance, and \$15 for referral physician visits
• Percent Copay	50% for selected services as noted above
Copay Dollar Maximums	
• Fixed Dollar Copay	None
• Percent Copay	None
Dollar Maximums	None

BCN5,OV15,ER50,WAS,WPT(benefit doesn't show on summary),UR25,500HC,AS5,PD10/20/40

9-28-05