

Benefits At A Glance

BCN10

00107441 Mercy Health Partners

This is intended as an easy to read summary. **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/individual, \$2,000/contract/year
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

Diagnostic Services

Laboratory and Pathology Tests	Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	100%
Radiation Therapy	100%

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

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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

Inpatient Physician 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

	MENTAL HEALTH CARE:
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
	SUBSTANCE ABUSE CARE:
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
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.
	NOTE: 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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