

Benefits-at-a-Glance for Healthy *Blue* Living Package 5



**Blue Care
Network
of Michigan**

MiBCN.com

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
BCN10, IP10, CO20, ER75, UR35, 20%CR, 250DED,
1000CM

Standard Benefits
BCN10, IP10, CO20, ER100, UR35, 30%CR, 1500D,
1500CM

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 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	\$250 per member, \$500 per contract per calendar year	\$1,500 per member, \$3,000 per contract per calendar year
Copays	\$5 for allergy injections, \$20 for office visits, \$35 for urgent care visits and \$75 for emergency room visits	\$5 for allergy injections, \$20 for office visits, \$35 for urgent care visits and \$100 for emergency room visits
• Fixed Dollar Copay		
• Percent Copay (Coinsurance)	20%, 25% and 50% of approved amount for select services	25%, 30% and 50% of approved amount for select services
Copay Dollar Maximums		
• Fixed Dollar Copay	None	None
• Percent Copay (Coinsurance)		
– Medical Services – excludes services with a flat dollar and 50% copay	\$1,000 per member, \$2,000 per contract per calendar year	\$1,500 per member, \$3,000 per contract per calendar year
– Inpatient Mental Health Services	\$1,000 per member, \$2,000 per contract per calendar year	\$1,000 per member, \$2,000 per contract per calendar year
Dollar Maximums	Applies only to Substance Abuse dollar limitation, adjusted annually by the state	Applies only to Substance Abuse dollar limitation, adjusted annually by the state

Preventive Services

Health Maintenance Exam	Covered – \$20 copay	Covered – \$20 copay
Annual Gynecological Exam	Covered – \$20 copay	Covered – \$20 copay
Pap Smear Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit	Covered – Office visit copay may apply per member, per visit
Well-Baby and Child Care	Covered – \$20 copay	Covered – \$20 copay
Immunizations – pediatric and adult	Covered – Office visit copay may apply per member, per visit	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	Covered – Office visit copay may apply per member per visit

Mammography

Mammography Screening	Covered – 100%	Covered – 100%
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Physician Office Services

Office Visits	Covered – \$20 copay	Covered – \$20 copay
Consulting Specialist Care – when referred	Covered – \$20 copay after deductible	Covered – \$20 copay after deductible

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted, inpatient hospital copays apply	Covered - \$75 copay after deductible	Covered - \$100 copay after deductible
Urgent Care Center	Covered - \$35 copay	Covered - \$35 copay
Ambulance Services – medically necessary	Covered – 80% after deductible, ground and air services, with a 20% coinsurance up to \$1,000 per member, \$2,000 per family per calendar year	Covered – 70% after deductible, ground and air services, with a 30% copay up to \$1,500 per member, \$3,000 per family per calendar year

Diagnostic Services

Laboratory and Pathology Tests	Covered – Office visit copay may apply per member, per visit	Covered – Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered – 80% after deductible, with a 20% coinsurance up to \$1,000 per member, \$2,000 per family per calendar year	Covered – 70% after deductible, with a 30% coinsurance up to \$1,500 per member, \$3,000 per family per calendar year
Radiation Therapy	Covered – 80% after deductible, with a 20% coinsurance up to \$1,000 per member, \$2,000 per family per calendar year	Covered – 70% after deductible, with a 30% coinsurance up to \$1,500 per member, \$3,000 per family per calendar year

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – \$20 copay	Covered – \$20 copay
Delivery and Nursery Care	Covered – 100% after deductible for professional services; see hospital care below for facility charges.	Covered – 100% after deductible for professional services; see hospital care below for facility charges.

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 80% after deductible, with 20% coinsurance up to \$1,000 per member, \$2,000 per family per calendar year; unlimited days	Covered – 70% after deductible, with a 30% coinsurance up to \$1,500 per member, \$3,000 per family per calendar year; unlimited days
Outpatient Surgery – see member certificate for specific surgical copay	Covered – 80% after deductible, with a 20% coinsurance up to \$1,000 per member, \$2,000 per family per cal. year	Covered – 70% after deductible, with a 30% coinsurance up to \$1,500 per member, \$3,000 per family per calendar year

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 80% after deductible, up to 45 days per calendar year; 20% coinsurance up to \$1,000 per member, \$2,000 per family per calendar year	Covered – 70% after deductible, up to 45 days per calendar year; 30% coinsurance up to \$1,500 per member, \$3,000 per family per calendar year
Hospice Care	Covered – 100% after deductible	Covered – 100% after deductible
Home Health Care	Covered – \$20 copay after deductible	Covered – \$20 copay after deductible

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Surgical Services

Surgery – includes all related surgical services and anesthesia – see member certificate for specific surgical copays	See Hospital Care for inpatient and outpatient copays	See Hospital Care for inpatient and outpatient copays
Voluntary Sterilization	Covered – 50% after deductible on all associated costs	Covered – 50% after deductible on all associated costs
Human Organ Transplants	Covered – 80% after deductible, with a 20% coinsurance up to \$1,000 per member, \$2,000 per family per calendar year; subject to medical criteria	Covered – 70% after deductible, with a 30% coinsurance up to \$1,500 per member, \$3,000 per family per calendar year; subject to medical criteria

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	Mental Health Care: Covered – 75% with a 25% coinsurance, up to \$1,000 per member, \$2,000 per family per calendar year, up to 30 days per calendar year	Mental Health Care: Covered – 75% with a 25% coinsurance, up to \$1,000 per member, \$2,000 per family per calendar year, up to 30 days per calendar year
	Substance Abuse Care: Covered – 50%, one program of treatment per year, up to state mandated dollar limitation adjusted annually by the state. Note: A program of treatment may include outpatient or intermediate services or both.	Substance Abuse Care: Covered – 50%, one program of treatment per year, up to state mandated dollar limitation adjusted annually by the state. Note: A program of treatment may include outpatient or intermediate services or both.
Outpatient Mental Health Care	Covered – 50%, up to 20 visits per calendar year	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 that is adjusted annually by the state.	Covered – 50%, one program of treatment per year, up to state mandated dollar limitation that is adjusted annually by the state.

Other Services

Allergy Testing and Therapy	Covered – 50% after deductible, \$5 copay for allergy injections	Covered – 50% after deductible, \$5 copay for allergy injections
Chiropractic Spinal Manipulation (when referred)	Covered - \$20 copay after deductible	Covered - \$20 copay after deductible
Outpatient Physical, Speech and Occupational Therapy (subject to significant improvement within 60 days)	Covered – \$20 copay after deductible, limited to 60 consecutive days per episode for a combination of therapies	Covered – \$20 copay after deductible, limited to 60 consecutive days per episode for a combination of therapies
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible on all associated costs	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%	Covered – 50%

March 09