

## Blue Care Network Benefits-at-a-Glance BCN Basic Package Plan

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 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 – \$25 copay *
Annual Gynecological Exam if Performed by PCP	Covered – \$25 copay *
Pap Smear Screening – laboratory services only	Covered – 80%; 20% copay applies to the annual maximum of \$1,500 per member, \$3,000 per family. Office visit copay may apply per member, per visit (office visit copay does not apply to annual copay maximum)
Well-Baby and Child Care	Covered – \$25 copay *
Immunizations – pediatric and adult	Covered – \$25 copay *
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 80%; 20% copay applies to the annual maximum of \$1,500 per member, \$3,000 per family. Office visit copay may apply per member, per visit (office visit copay does not apply to annual copay maximum)

### Mammography

Mammography Screening	Covered – 80%; 20% copay applies to the annual maximum of \$1,500 per member, \$3,000 per family. Office visit copay may apply per member, per visit (office visit copay does not apply to annual copay maximum)
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### Physician Office Services

Office Visits	Covered – \$25 copay*
Consulting Specialist Care – when referred	Covered – \$35 copay*

### Emergency Medical Care

Hospital Emergency Room – approved diagnosis	Covered – \$100 copay *
Urgent Care Center	Covered – \$35 copay *
Ambulance Services – medically necessary	Covered – \$50 copay applies to the annual maximum of \$1,500 per member, \$3,000 per family

### Diagnostic Services

Laboratory and Pathology Tests	Covered – 80%; 20% copay applies to the annual maximum of \$1,500 per member, \$3,000 per family. Office visit copay may apply per member, per visit (office visit copay does not apply to annual copay maximum)
Diagnostic Tests and X-rays	Covered – 80%; 20% copay applies to the annual maximum of \$1,500 per member, \$3,000 per family. Office visit copay may apply per member, per visit (office visit copay does not apply to annual copay maximum)
Radiation Therapy	Covered – 80%; 20% copay applies to the annual maximum of \$1,500 per member, \$3,000 per family. Office visit copay may apply per member, per visit (office visit copay does not apply to annual copay maximum)

### Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – \$25 copay*
Delivery and Nursery Care	Covered – 80%; 20% copay applies to the annual maximum of \$1,500 per member, \$3,000 per family

### Hospital Care

Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 80%, unlimited days; 20% copay applies to the annual maximum of \$1,500 per member, \$3,000 per family
Outpatient Facility Services	Covered – 80%; 20% copay applies to the annual maximum of \$1,500 per member, \$3,000 per family

\*Copay does not apply to Annual Copayment Maximum

### Alternatives to Hospital Care

Skilled Nursing Care	Covered – 80%, up to 20 days per calendar year; 20% copay applies to the annual maximum of \$1,500 per member, \$3,000 per family
Hospice Care	Covered – 80%; 20% copay applies to the annual maximum of \$1,500 per member, \$3,000 per family
Home Health Care	Covered – 80%, limited to a 60-day period per calendar year; 20% copay applies to the annual maximum of \$1,500 per member, \$3,000 per family

### Surgical Services

Surgery – includes all related surgical services and anesthesia – see member certificate for specific surgical copays	Covered – 80%; 20% copay applies to the annual maximum of \$1,500 per member, \$3,000 per family
Voluntary Sterilization	Covered – 50% on all associated costs*
Human Organ Transplants	Covered – 80%, subject to medical criteria; 20% copay applies to the annual maximum of \$1,500 per member, \$3,000 per family

### Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	<p><b>Mental Health Care:</b> Covered – 50%*, up to 14 days per calendar year</p> <p><b>Substance Abuse Care:</b> Covered – 50%*, up to state mandated dollar limitation which is adjusted annually by the state</p>
Outpatient Mental Health Care	Covered – 50%*, up to 20 visits per calendar year
Outpatient Substance Abuse Care	Covered – 50%*, up to state mandated dollar limitation which is adjusted annually by the state

### Other Services

Allergy Testing and Therapy	Covered – 50%, \$5 copay for allergy injections; both copays apply to the annual maximum of \$1,500 per member, \$3,000 per family
Chiropractic Spinal Manipulation - when referred	Covered – \$35 copay*
Outpatient Physical, Speech and Occupational Therapy – subject to significant improvement within 60 days	Covered – 50%, up to 30 visits for a 60-day period; 50% copay applies to the annual maximum of \$1,500 per member, \$3,000 per family
Infertility Counseling and Treatment	Covered – 50% on all associated costs*
Durable Medical Equipment	Covered – 50%*
Prosthetic and Orthotic Appliances	Covered – 50%*

### Deductible, Copays and Dollar Maximums

<b>Deductible</b>	None
<b>Copays</b>	
• Fixed Dollar Copay	\$5 for allergy injections, \$25 for office visits, \$35 for consulting specialist care and urgent care visits, \$50 for ambulance services, \$100 for emergency room visits
• Percent Copay	20% and 50% for select services as noted above
<b>Copay Dollar Maximums</b>	
• Fixed Dollar and Percent Copay	\$1,500 per member, \$3,000 per family for ambulance services, diagnostic services, inpatient & outpatient hospital services, skilled nursing, hospice, home health care, allergy testing and therapy and outpatient rehabilitation services
<b>Dollar Maximums</b>	Applies only to Substance Abuse dollar limitation, adjusted annually by the state

\*Copay does not apply to Annual Copayment Maximum

BCN-BASIC, BAS25, 35RPOV, UR35, ER100, FCR