

Blue Care Network Benefits-at-a-Glance Deductible Package DED 1

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 – \$10 copay
Annual Gynecological Exam	Covered – \$10 copay
Pap Smear Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit
Well-Baby and Child Care	Covered – \$10 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 – \$10 copay
Consulting Specialist Care – when referred for other than preventive services	Covered – \$10 copay after deductible

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted, inpatient hospital benefits apply	Covered – \$75 copay after deductible
Urgent Care Center	Covered – \$35 copay
Ambulance Services – medically necessary	Covered – 90% after deductible, ground and air service, with a 10% 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
Diagnostic Tests and X-rays	Covered – 90% after deductible, with a 10% copay up to \$1,500 per member, \$3,000 per family per calendar year
Radiation Therapy	Covered – 90% after deductible, with a 10% copay 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 – \$10 copay
Delivery and Nursery Care	Covered – 90% after deductible, with a 10% copay up to \$1,500 per member, \$3,000 per family per calendar year

Hospital Care

Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 90% after deductible, with a 10% copay up to \$1,500 per member, \$3,000 per family per calendar year; unlimited days
Outpatient Surgery – see member certificate for specific surgical copays	Covered – 90% after deductible, with a 10% copay up to \$1,500 per member, \$3,000 per family per calendar year

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 90% after deductible, up to 45 days per calendar year; 10% copay up to \$1,500 per member, \$3,000 per family per calendar year
Hospice Care	Covered – 90% after deductible, with a 10% copay up to \$1,500 per member, \$3,000 per family per calendar year
Home Health Care	Covered – \$10 copay after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia. See member certificate for specific surgical copays.	Covered – 90% after deductible, with a 10% copay up to \$1,500 per member, \$3,000 per family per calendar year
Voluntary Sterilization	Covered – 50% after deductible on all associated costs
Human Organ Transplants	Covered – 90% after deductible, with a 10% copay 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	<p>Mental Health Care: Covered – 75%, with a 25% copay, up to \$1,000 per member, \$2,000 per family per calendar year, up to 30 days per calendar year</p> <p>Substance Abuse Care: Covered – 50%, one program of treatment per year, 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	<p>Covered – 50%, one program of treatment per year, up to state mandated dollar limitation which is adjusted annually by the state</p> <p>Note: A program of treatment may include outpatient or intermediate services or both.</p>

Other Services

Allergy Testing and Therapy	Covered – 50% after deductible
Allergy Injections	Covered – \$5 copay
Chiropractic Spinal Manipulation – when referred	Covered – \$10 copay after deductible
Outpatient Physical, Speech and Occupational Therapy – subject to significant improvement within 60 days	Covered – \$10 copay after deductible, limited to 60 consecutive days per episode
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%

Deductible, Copays and Dollar Maximums

Deductible	\$250 per member / \$500 per family per calendar year
Copays	
• Fixed Dollar Copay	\$10 for office visits, \$35 for urgent care visits, \$75 for emergency room visits and \$5 for allergy injections
• Percent Copay	10%, 25% and 50% for select services as noted above
Copay Dollar Maximums	
• Fixed Dollar Copay	None
• Percent Dollar Copay – Medical Services; excludes services with a 50% copay	\$1,500 per member, \$3,000 per family per calendar year
• Percent Dollar Copay – Inpatient Mental Health Care	\$1,000 per member, \$2,000 per family per calendar year
Dollar Maximums	Applies only to Substance Abuse dollar limitation, adjusted annually by the state

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