

# GROUP PLAN OPTIONS

(2 - 49 enrolled)

Effective  
October 1, 2011



**Blue Care  
Network  
of Michigan**

A nonprofit corporation and independent licensee  
of the Blue Cross and Blue Shield Association



**Blue Care  
Network**  
of Michigan

A nonprofit corporation and independent licensee  
of the Blue Cross and Blue Shield Association



The charts in this brochure are intended as an easy-to-read summary and provide only a general overview of your benefits. This 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, copay and/or coinsurance 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, except for Blue Elect Plus<sup>SM</sup> option plans.

The information in this document is based on BCN's current interpretation of the Patient Protection and Affordable Care Act. Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This benefit summary is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

## Blue Care Network of Michigan products for groups of 2 to 49 contracts

### BCN5 and BCN Basic

Preventive, routine, urgent and emergency care are the foundation of our standard plans. Members select a primary care physician who provides and coordinates their care.

### Blue Elect Plus<sup>SM</sup>

Our new product offers the value of managed care plus flexibility. Members can self-refer to any doctor.

Members pay the least when a doctor in BCN's network provides their care. They pay the most when the doctor does not participate with BCN or any Blues plan.

### Deductible plans

Employers can customize their plans by selecting deductibles that are appropriate for their group. We offer several options with and without coinsurance. Groups can add a Healthy Blue HMO HRA\*.

### Healthy Blue Living<sup>SM</sup>

The innovative and popular plan rewards members with lower out-of-pocket costs if they pursue healthy lifestyles. The plan focuses on six areas individuals can control that have a big impact on health: weight, blood pressure, blood sugar, cholesterol, tobacco use and depression.

### Healthy Blue Living Rewards<sup>SM</sup>

Our extension of HBL is the first HMO plan of its kind in Michigan that takes it one step further by tying rewards to achieving health goals. The difference? HBL members are rewarded if they commit to working toward certain health targets, while HBLR members are further rewarded if they actually achieve measurable health goals.

### Healthy Blue HMO HRA<sup>SM</sup>

Groups may combine our quality deductible HMO health plan with a health reimbursement arrangement. An HRA is a tax-free account created and funded by employers to help their employees pay for qualified medical expenses.

Healthy Blue HMO HRA gives members a full spectrum of health care at a great value by increasing member responsibility for health care decisions and expenses. Employees are motivated to become more informed health care consumers and to learn how to accommodate present and future health care needs.

**NEW!** Effective October 1, 2011

### Custom network saves on premiums

**PCP Focus** is a custom network plan for cost-conscious buyers. It's the newest item in BCN's portfolio. It offers efficient managed care through a tailored primary care physician network. Groups that pair this network plan with BCN 5 or a deductible plan save up to 10 percent in premiums. Those who combine PCP Focus with Healthy Blue Living or Healthy Blue Living Rewards save up to an additional 5 percent in premiums.

PCP Focus is available to groups of 2 to 49 located in Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw and Wayne counties. It offers members living in these seven counties a number of PCPs to choose from plus the flexibility to see almost any BCN specialist in the state.



\*Not available with Healthy Blue Living, Healthy Blue Living Rewards, Tiered Copay and Blue Elect Plus plans



## Definitions

The **plan year** is the one-year period (12 months) designated by the group and Blue Care Network of Michigan. It begins on the date determined by the group and BCN.

The **deductible** is the amount the member must pay before BCN will pay for covered services under the “Your Benefits” section of the member certificate.

The deductible renews each calendar year or plan year. Any deductible paid during the last three months of the calendar year or plan year will be carried over into the new calendar year or plan year.

The **copayment** is a fixed amount of the BCN-approved amount the member must pay directly to a provider of covered services for those services and supplies. The member must pay this amount at the time he or she receives services. The copays are listed in the member’s Certificate of Coverage or rider. Copays for “basic health services” shall not exceed 50 percent of the approved amount, per State of Michigan law.

The **coinsurance** is a percentage of the BCN-approved amount the member must pay directly to a provider of covered services for those services and supplies. The coinsurance amounts are listed in the member’s Certificate of Coverage or rider.

**Note:** If the member has a coinsurance for particular services as well as a deductible, he or she will first be responsible for the payment of the deductible. The coinsurance will be based on the remaining balance of the BCN-approved amount. BCN will make payment to the provider only after the coinsurance and deductible have been paid.

The annual coinsurance maximum applies to specific services listed in the member’s certificate or rider. Once the member reaches the maximum, he or she does not pay coinsurance for the rest of the year.

## Enrollment guidelines

All documents that constitute the terms and agreements between BCN and your organization must be submitted to your Blue Cross Blue Shield of Michigan/BCN sales representative or independent agent at least 25 days before a new group’s effective date or 45 days before an existing group’s effective date.

## Eligibility guidelines

Enrollment requirements are determined by the number of eligible employees in your group as reported on your payroll record in the preceding and current calendar years. Eligible employees who elect BCBSM coverage will be counted toward your participation requirement. The following participation calculation applies to groups of 50 or fewer eligible employees and determines if your group meets the BCBSM/BCN participation percentage requirement:

**Adjusted eligible employees** is the number of eligible employees minus those that opt out of coverage minus those covered by spouse, other employer or a prior retirement plan.

**Participation percentage** is the BCBSM and BCN eligible employees enrolled divided by the adjusted eligible employees.

## Participation requirements

The following table identifies the participation percentage requirements that apply to groups of 50 or fewer as defined in Public Act 88 of 2003:

Group Size	Renewal and new business participation percentage requirement
10 or fewer eligible employees	100 percent
11 to 25 eligible employees	75 percent
26 to 50 eligible employees	50 percent

## Dental and vision options

Sponsored-group size	Nonsponsored-group size	Dental	Vision
2+	10+	Traditional Plus Dental plans 1,2,3,5,6,7	Blue Vision <sup>SM</sup> 12-12-12 BVFL
		Community Dental plans 2,3,4,5	Blue Vision 24-24-24 BVFLE
		Exclusive Dental Plan I	
2+ Medical contracts	25+ Medical contracts		Blue Vision Choice <sup>SM</sup> (Voluntary) 12-12-24, BVFLL, BVC \$10/\$25
10+ Dental contracts		<b>Voluntary</b> <ul style="list-style-type: none"> <li>Blue Dental PPO Plus</li> <li>Blue Dental PPO</li> <li>Blue Dental EPO</li> </ul>	
		<b>Optional</b> <ul style="list-style-type: none"> <li>50% Orthodontics with \$1,000 max</li> <li>Waive the waiting period (Proof of prior dental coverage required)</li> </ul>	

## Coverage changes

Groups can make a coverage change (group-wide change) once per plan year. The change cannot take place in the last quarter of a group's plan year.

Upon request, BCN will supply the following information:

- A disclosure of BCN's right to change premium rates and the factors that may affect premium rates.
- The provisions of coverage relating to renewability.
- The premiums available under all health insurance coverage for which your company is qualified.

**Blue Care Network**  
**Benefits-at-a-glance**

**\$1,000 DEDUCTIBLE with coinsurance**

BCN10, 1000D, C020, 30RP, WDRPOV, UR50,  
ER150, MHSAP, IMG150

Coinsurance Options: 20% or 30%

Physician office services	
Routine office visits	\$20 copay per visit
Consulting specialist care (when referred)	\$30 copay per visit
Preventive services	
Periodic physical exam	Covered in full
Newborn, well-child assessments and examinations	Covered in full
Immunizations	Covered in full
Mammography screening	Covered in full
Pap smears (lab services)	Covered in full
Prostate specific antigen screening (lab services)	Covered in full
Diagnostic and therapeutic procedures	
Laboratory tests	Covered in full <sup>1</sup>
Diagnostic x-rays	20% or 30% coinsurance after deductible <sup>2</sup>
High tech imaging	\$150 copay after deductible
Radiation therapy	20% or 30% coinsurance after deductible <sup>2</sup>
Maternity services provided by a physician	
Prenatal and postnatal care	\$20 copay per visit
Delivery in hospital and well-baby care in hospital	Covered in full after deductible
Inpatient hospital care	
Number of days of care	Unlimited
In-hospital general nursing care, surgery (including all related surgical services, anesthesia, lab, x-rays and drugs)	20% or 30% coinsurance after deductible <sup>2</sup>
Emergency medical care	
Hospital emergency room (copay waived if admitted)	\$150 copay after deductible
Urgent care center	\$50 copay
Ground and air ambulance services (when medically necessary)	20% or 30% coinsurance after deductible <sup>2</sup>
Mental health care	
Outpatient visits	\$20 copay per visit after deductible
Inpatient psychiatric hospital services (Services covered when authorized by BCN)	20% or 30% coinsurance after deductible <sup>2</sup>
Alcoholism & substance abuse services	
Outpatient treatment	\$20 copay per visit after deductible
Intermediate/residential treatment (Services covered when authorized by BCN)	20% or 30% coinsurance after deductible <sup>2</sup>
Detoxification (Services covered when authorized by BCN)	20% or 30% coinsurance after deductible <sup>2</sup>
Skilled nursing care	
Skilled nursing facility care	45 days per calendar year; 20% or 30% coinsurance after deductible <sup>2</sup>
Other services	
Prothetics, orthotics, corrective appliances and durable medical equipment (when medically necessary)	Covered in full (HRA plans only) or 50% coinsurance
Infertility counseling/treatment (excluding In-vitro fertilization)	50% coinsurance after deductible on all associated costs
Allergy testing, evaluation and serum; injections	50% coinsurance after deductible, \$5 injections
Outpatient rehabilitation services (subject to significant improvement within 60 days)	Limited to 60 consecutive days per episode; \$30 copay per visit after deductible

<sup>1</sup> Office visit copay may apply per member, per visit

<sup>2</sup> Applies to the annual coinsurance maximum of \$1,500 per member, \$3,000 per family

<b>DEDUCTIBLE without coinsurance</b> BCN10, 2000D, C030, 45RP, WDRPOV, UR50, ER150, I0MHP, IMG150, WHC10	<b>DEDUCTIBLE with 20% coinsurance</b> BCN10, C030, 45RP, IMG150 20%CR, 1500CM, WDRPOV, UR50, ER150, MHSAP Deductible options: 500DED, 1000D, 2000D, 3000D, 4000D, 5000D, 7500D	<b>DEDUCTIBLE with 30% coinsurance</b> BCN10, C030, 45RP, 30%CR, 1500CM, WDRPOV, UR50, ER150, MHSAP, IMG150 Deductible options: 2000D, 3000D, 4000D, 5000D, 7500D
\$30 copay per visit	\$30 copay per visit	\$30 copay per visit
\$45 copay per visit	\$45 copay per visit	\$45 copay per visit
Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full
Covered in full <sup>1</sup>	Covered in full <sup>1</sup>	Covered in full <sup>1</sup>
Covered in full <sup>1</sup> after deductible	20% coinsurance after deductible <sup>2</sup>	30% coinsurance after deductible <sup>2</sup>
\$150 copay after deductible	\$150 copay after deductible	\$150 copay after deductible
Covered in full <sup>1</sup> after deductible	20% coinsurance after deductible <sup>2</sup>	30% coinsurance after deductible <sup>2</sup>
\$30 copay per visit	\$30 copay per visit	\$30 copay per visit
Covered in full after deductible	Covered in full after deductible	Covered in full after deductible
Unlimited	Unlimited	Unlimited
Covered in full after deductible	20% coinsurance after deductible <sup>2</sup>	30% coinsurance after deductible <sup>2</sup>
\$150 copay after deductible	\$150 copay after deductible	\$150 copay after deductible
\$50 copay	\$50 copay	\$50 copay
\$25 copay after deductible	20% coinsurance after deductible <sup>2</sup>	30% coinsurance after deductible <sup>2</sup>
\$30 copay per visit after deductible	\$30 copay per visit after deductible	\$30 copay per visit after deductible
Covered in full after deductible	20% coinsurance after deductible <sup>2</sup>	30% coinsurance after deductible <sup>2</sup>
\$30 copay per visit after deductible	\$30 copay per visit after deductible	\$30 copay per visit after deductible
Covered in full after deductible	20% coinsurance after deductible <sup>2</sup>	30% coinsurance after deductible <sup>2</sup>
Covered in full after deductible	20% coinsurance after deductible <sup>2</sup>	30% coinsurance after deductible <sup>2</sup>
45 days per calendar year; Covered in full after deductible	45 days per calendar year; 20% coinsurance after deductible <sup>2</sup>	45 days per calendar year; 30% coinsurance after deductible <sup>2</sup>
Covered in full (HRA plans only) or 50% coinsurance	Covered in full (HRA plans only) or 50% coinsurance	Covered in full (HRA plans only) or 50% coinsurance
50% coinsurance after deductible on all associated costs	50% coinsurance after deductible on all associated costs	50% coinsurance after deductible on all associated costs
50% coinsurance after deductible, \$5 injections	50% coinsurance after deductible, \$5 injections	50% coinsurance after deductible, \$5 injections
Limited to 60 consecutive days per episode, \$45 copay per visit after deductible	Limited to 60 consecutive days per episode, \$45 copay per visit after deductible	Limited to 60 consecutive days per episode, \$45 per visit copay after deductible

<sup>1</sup> Office visit copay may apply per member, per visit

<sup>2</sup> Applies to the annual coinsurance maximum of \$1,500 per member, \$3,000 per family

Note: Plan year option available only to HRA plans

# Blue Care Network

Benefits-at-a-glance



## Physician office services

Routine office visits

Consulting specialist care

## Preventive services

Periodic physical exam

Newborn, well-child assessments and examinations

Immunizations

Mammography screening

Pap smears (lab services)

Prostate specific antigen screening (lab services)

## Diagnostic and therapeutic procedures

Laboratory tests

Diagnostic x-rays

High tech imaging

Radiation therapy

## Maternity services provided by a physician

Prenatal and postnatal care

Delivery in hospital and well-baby care in hospital

## Inpatient hospital care

Number of days of care

In-hospital general nursing care, surgery  
(including all related surgical services, anesthesia, lab, x-rays and drugs)

## Emergency medical care

Hospital emergency room (copay waived if admitted)

Urgent care center

Ground and air ambulance services (when medically necessary)

## Mental health care

Outpatient visits

Inpatient psychiatric hospital services  
(Services covered when authorized by BCN)

## Alcoholism & substance abuse services

Outpatient treatment

Intermediate/residential treatment  
(Services covered when authorized by BCN)

Detoxification  
(Services covered when authorized by BCN)

## Skilled nursing care

Skilled nursing facility care

## Other services

Prothetics, orthotics, corrective appliances and durable medical equipment (when medically necessary)

Infertility counseling/treatment  
(excluding In-vitro fertilization)

Allergy testing, evaluation and serum; injections

Outpatient rehabilitation services  
(subject to significant improvement within 60 days)



Blue Elect Plus Option 2		Blue Elect Plus Option 3	
BEP, IN20C0, IN35RP, UR50, ER150		BEP, IN30C0, IN45RP, UR60, ER150	
Deductible Options: \$1,000/\$2,000 In-Network, \$2,000/\$4,000 Out-of-Network; \$2,000/\$4,000 In-Network, \$4,000/\$8,000 Out-of-Network; \$3,000/\$6,000 In-Network, \$6,000/\$12,000 Out-of-Network		Deductible Options: \$1,000/\$2,000 In-Network, \$2,000/\$4,000 Out-of-Network; \$2,000/\$4,000 In-Network, \$4,000/\$8,000 Out-of-Network; \$3,000/\$6,000 In-Network, \$6,000/\$12,000 Out-of-Network	
In network	Out of network <sup>8</sup>	In network	Out of network <sup>8</sup>
\$20 copay per visit	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible	\$30 copay per visit	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible
\$35 copay per visit	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible	\$45 copay per visit	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible
Covered in full	Not covered	Covered in full	Not covered
Covered in full	Not covered	Covered in full	Not covered
Covered in full	Not covered	Covered in full	Not covered
Covered in full	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible	Covered in full	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible
Covered in full	Not covered	Covered in full	Not covered
Covered in full	Not covered	Covered in full	Not covered
Covered in full <sup>1</sup>	Covered in full <sup>1</sup>	Covered in full <sup>1</sup>	Covered in full <sup>1</sup>
20% <sup>2</sup> or 30% <sup>9</sup> coinsurance after deductible	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible	20% <sup>2</sup> or 30% <sup>9</sup> coinsurance after deductible	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible
\$150 copay	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible	\$150 copay	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible
20% <sup>2</sup> or 30% <sup>9</sup> coinsurance after deductible	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible	20% <sup>2</sup> or 30% <sup>9</sup> coinsurance after deductible	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible
\$20 copay per visit	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible	\$30 copay per visit	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible
20% <sup>2</sup> or 30% <sup>9</sup> coinsurance after deductible	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible	20% <sup>2</sup> or 30% <sup>9</sup> coinsurance after deductible	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible
Unlimited	Unlimited	Unlimited	Unlimited
20% <sup>2</sup> or 30% <sup>9</sup> coinsurance after deductible	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible	20% <sup>2</sup> or 30% <sup>9</sup> coinsurance after deductible	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible
\$150 copay		\$150 copay	
\$50 copay		\$60 copay	
\$50 copay		\$50 copay	
\$20 copay per visit	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible	\$30 copay per visit	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible
20% <sup>2</sup> or 30% <sup>9</sup> coinsurance after deductible	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible	20% <sup>2</sup> or 30% <sup>9</sup> coinsurance after deductible	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible
\$20 copay per visit	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible	\$30 copay per visit	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible
20% <sup>2</sup> or 30% <sup>9</sup> coinsurance after deductible	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible	20% <sup>2</sup> or 30% <sup>9</sup> coinsurance after deductible	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible
20% <sup>2</sup> or 30% <sup>9</sup> coinsurance after deductible	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible	20% <sup>2</sup> or 30% <sup>9</sup> coinsurance after deductible	40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible
45 days per calendar year, 20% <sup>2</sup> or 30% <sup>9</sup> coinsurance after deductible (In-network and out-of-network days count toward limit)	45 days per calendar year, 40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible (In-network and out-of-network days count toward limit)	45 days per calendar year, 20% <sup>2</sup> or 30% <sup>9</sup> coinsurance after deductible (In-network and out-of-network days count toward limit)	45 days per calendar year, 40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible (In-network and out-of-network days count toward limit)
Covered in full	Not covered	Covered in full	Not covered
50% coinsurance after deductible on all associated costs	Not covered	50% coinsurance after deductible on all associated costs	Not covered
Covered in full including injections	50% coinsurance after deductible including injections	Covered in full including injections	50% coinsurance after deductible including injections
Limited to 60 consecutive days per episode, \$35 copay (Limit is combined for in-network and out-of-network services)	Limited to 60 consecutive days per episode, 40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible (Limit is combined for in-network and out-of-network services)	Limited to 60 consecutive days per episode, \$45 copay (Limit is combined for in-network and out-of-network services)	Limited to 60 consecutive days per episode, 40% <sup>7</sup> or 50% <sup>11</sup> coinsurance after deductible (Limit is combined for in-network and out-of-network services)

<sup>1</sup> Office visit copay may apply per member, per visit

<sup>2</sup> Applies to the annual coinsurance maximum of \$1,500 per member, \$3,000 per family

<sup>7</sup> Applies to the annual coinsurance maximum of \$3,000 per member, \$6,000 per family

<sup>8</sup> Out-of-network cost sharing is based on the BCN-approved amount. The member is responsible for any amount charged by the non-participating provider that exceeds the BCN-approved amount.

<sup>9</sup> Applies to the annual coinsurance maximum of \$2,500 per member, \$5,000 per family

<sup>11</sup> Applies to the annual coinsurance maximum of \$5,000 per member, \$10,000 per family

<b>Blue Care Network</b> Benefits-at-a-glance	<b>BCN5</b>
<b>Physician office services</b>	
Routine office visits	\$20 copay per visit
Consulting specialist care (when referred)	\$40 copay per visit
<b>Preventive services</b>	
Periodic physical exam	Covered in full
Newborn, well-child assessments and examinations	Covered in full
Immunizations	Covered in full
Mammography screening	Covered in full
Pap smears (lab services)	Covered in full
Prostate specific antigen screening (lab services)	Covered in full
<b>Diagnostic and therapeutic procedures</b>	
Laboratory tests	Covered in full <sup>1</sup>
Diagnostic x-rays	Covered in full <sup>1</sup>
High tech imaging	Covered in full <sup>1</sup>
Radiation therapy	Covered in full <sup>1</sup>
<b>Maternity services provided by a physician</b>	
Prenatal and postnatal visits	\$20 copay per visit
Delivery in hospital and well-baby care in hospital	Covered in full
<b>Inpatient hospital care</b>	
Number of days of care	Unlimited
In-hospital physician care, general nursing care, surgery (including all related surgical services, anesthesia, lab, x-rays and drugs)	\$250 per admission <sup>4</sup>
<b>Emergency medical care</b>	
Hospital emergency room (copay waived if admitted)	\$150
Urgent care center	\$50 copay
Ground and air ambulance services (when medically necessary)	Covered in full
<b>Mental health care</b>	
Outpatient visits	Nonparity: 20 visits per year, 50% coinsurance
	Parity: \$20 copay per visit
Inpatient psychiatric hospital services (Services covered when authorized by BCN)	Nonparity: 30 days per calendar year, covered in full
	Parity: Covered in full
<b>Alcoholism &amp; substance abuse services</b>	
Outpatient treatment	Nonparity: 50% coinsurance
	Parity: \$20 copay per visit
Intermediate/residential treatment (Services covered when authorized by BCN)	Nonparity: One program of treatment per year with a 50% coinsurance
	Parity: Covered in full
Detoxification (Services covered when authorized by BCN)	Nonparity: 50% coinsurance
	Parity: Covered in full
<b>Skilled nursing care</b>	
Skilled nursing facility care	45 days per calendar year, covered in full
<b>Other services</b>	
Prothetics, orthotics, corrective appliances and durable medical equipment (when medically necessary)	50% coinsurance
Infertility counseling/treatment (excluding In-vitro fertilization)	50% coinsurance on all associated costs
Allergy testing, evaluation and serum; injections	50% coinsurance, \$5 injections
Outpatient rehabilitation services (subject to significant improvement within 60 days)	Limited to 60 consecutive days per episode; \$40 copay per visit

<sup>1</sup> Office visit copay may apply per member, per visit

<sup>4</sup> Copay applies to the annual maximum of \$750 per member, \$1,000 per family

## BCN Basic

BCN Basic Option 1 BAS25, 35RPOV, UR35, ER100	BCN Basic Option 2 BAS35, 50RPOV, 30%BAS, 3KCMB, UR60, ER150
\$25 copay per visit	\$35 copay per visit
\$35 copay per visit	\$50 copay per visit
Covered in full	Covered in full
Covered in full	Covered in full
Covered in full	Covered in full
Covered in full	Covered in full
Covered in full	Covered in full
Covered in full	Covered in full
20% coinsurance <sup>2</sup>	30% coinsurance <sup>7</sup>
20% coinsurance <sup>2</sup>	30% coinsurance <sup>7</sup>
20% coinsurance <sup>2</sup>	30% coinsurance <sup>7</sup>
20% coinsurance <sup>2</sup>	30% coinsurance <sup>7</sup>
\$25 copay per visit	\$35 copay per visit
20% coinsurance <sup>2</sup>	30% coinsurance <sup>7</sup>
Unlimited	Unlimited
20% coinsurance <sup>2</sup>	30% coinsurance <sup>7</sup>
\$100 copay	\$150 copay
\$35 copay	\$60 copay
\$50 copay <sup>2</sup>	\$50 copay <sup>7</sup>
Nonparity: 20 visits per calendar year, 50% coinsurance	Nonparity: 20 visits per calendar year, 50% coinsurance
Parity: \$25 copay per visit	Parity: \$35 copay per visit
Nonparity: 14 days per calendar year with 50% coinsurance up to mental health coinsurance maximum of \$1,500 per member, \$3,000 per family per calendar year	Nonparity: 14 days per calendar year with 50% coinsurance up to mental health coinsurance maximum of \$3,000 per member, \$6,000 per family per calendar year
Parity: 20% coinsurance <sup>2</sup>	Parity: 30% coinsurance <sup>7</sup>
Nonparity: One program of treatment per year with a 50% coinsurance	Nonparity: One program of treatment per year with a 50% coinsurance
Parity: \$25 copay per visit	Parity: \$35 copay per visit
Nonparity: One program of treatment per year with a 50% coinsurance	Nonparity: One program of treatment per year with a 50% coinsurance
Parity: 20% coinsurance <sup>2</sup>	Parity: 30% coinsurance <sup>7</sup>
Nonparity: 50% coinsurance	Nonparity: 50% coinsurance
Parity: 20% coinsurance <sup>2</sup>	Parity: 30% coinsurance <sup>7</sup>
20 days per calendar year, 20% coinsurance <sup>2</sup>	20 days per calendar year, 30% coinsurance <sup>7</sup>
50% coinsurance	50% coinsurance
50% coinsurance on all associated costs	50% coinsurance on all associated costs
50% coinsurance, \$5 injections <sup>2</sup>	50% coinsurance, \$5 injections <sup>7</sup>
30 visits within a 60-day period per episode, 50% coinsurance <sup>2</sup>	30 visits within a 60-day period per episode, 50% coinsurance <sup>7</sup>

<sup>2</sup> Applies to the annual coinsurance maximum of \$1,500 per member, \$3,000 per family

<sup>7</sup> Applies to the annual coinsurance maximum of \$3,000 per member, \$6,000 per family

		Healthy Blue Living 3 (HBL3)	
Blue Care Network Healthy Blue Living Benefits-at-a-glance		Enhanced benefits BCN10, C020, ER75, UR35, 500DED, 20%CR, 1500CM Deductible: \$500/member; \$1,000/family	Standard benefits BCN10, C020, ER100, UR50, 30%CR, 2000D, 1500CM Deductible: \$2,000/member; \$4,000/family
<i>HBL members (subscribers and covered spouse) must complete program requirements within the first 90 days of enrollment or re-enrollment. To qualify for or maintain enhanced benefits, members 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. Members who use tobacco must enroll in BCN's tobacco cessation program, within 120 days of enrollment or re-enrollment. Members with a BMI of 30 or more must choose one of two BCN-sponsored weight management programs (Weight Watchers® or the Walkingspree pedometer-based walking program) within 120 days of enrollment or re-enrollment.</i>			
<b>Physician office services</b>			
Routine office visits		\$20 copay per visit	\$20 copay per visit
Consulting specialist care (when referred)		\$20 copay per visit after deductible	\$20 copay per visit after deductible
<b>Preventive services</b>			
Periodic physical exam		Covered in full	Covered in full
Newborn, well-child assessments and examinations		Covered in full	Covered in full
Immunizations		Covered in full	Covered in full
Mammography screening		Covered in full	Covered in full
Pap smears (lab services)		Covered in full	Covered in full
Prostate specific antigen screening (lab services)		Covered in full	Covered in full
<b>Diagnostic and therapeutic procedures</b>			
Laboratory tests		Covered in full <sup>1</sup>	Covered in full <sup>1</sup>
Diagnostic x-rays		20% coinsurance after deductible <sup>2</sup>	30% coinsurance after deductible <sup>2</sup>
High tech imaging		20% coinsurance after deductible <sup>2</sup>	30% coinsurance after deductible <sup>2</sup>
Radiation therapy		20% coinsurance after deductible <sup>2</sup>	30% coinsurance after deductible <sup>2</sup>
<b>Maternity services provided by a physician</b>			
Prenatal and postnatal visits		\$20 copay per visit	\$20 copay per visit
Delivery in hospital and well-baby care in hospital		Covered in full after deductible	Covered in full after deductible
<b>Inpatient hospital care</b>			
Number of days of care		Unlimited	Unlimited
In-hospital physician care, general nursing care, surgery (including all related surgical services, anesthesia, lab, x-rays and drugs)		20% coinsurance after deductible <sup>2</sup>	30% coinsurance after deductible <sup>2</sup>
<b>Emergency medical care</b>			
Hospital emergency room (copay waived if admitted)		\$75 copay after deductible	\$100 copay after deductible
Urgent care center		\$35 copay	\$50 copay
Ground and air ambulance services (when medically necessary)		20% coinsurance after deductible <sup>2</sup>	30% coinsurance after deductible <sup>2</sup>
<b>Mental health care</b>			
Outpatient visits		Nonparity: 20 visits per year, 50% coinsurance	Nonparity: 20 visits per year, 50% coinsurance
		Parity: \$20 copay per visit after deductible	Parity: \$20 copay per visit after deductible
Inpatient psychiatric hospital services (Services covered when authorized by BCN)		Nonparity: 30 days per calendar year, 25% coinsurance <sup>5</sup>	Nonparity: 30 days per calendar year, 25% coinsurance <sup>5</sup>
		Parity: 20% coinsurance after deductible <sup>2</sup>	Parity: 30% coinsurance after deductible <sup>2</sup>
<b>Alcoholism &amp; substance abuse services</b>			
Outpatient treatment		Nonparity: One program of treatment per year with 50% coinsurance	Nonparity: One program of treatment per year with 50% coinsurance
		Parity: \$20 copay per visit after deductible	Parity: \$20 copay per visit after deductible
Intermediate/residential treatment (Services covered when authorized by BCN)		Nonparity: One program of treatment per year with a 50% coinsurance	Nonparity: One program of treatment per year with a 50% coinsurance
		Parity: 20% coinsurance after deductible <sup>2</sup>	Parity: 30% coinsurance after deductible <sup>2</sup>
Detoxification (Services covered when authorized by BCN)		Nonparity: 50% coinsurance	Nonparity: 50% coinsurance
		Parity: 20% coinsurance after deductible <sup>2</sup>	Parity: 30% coinsurance after deductible <sup>2</sup>
<b>Skilled nursing care</b>			
Skilled nursing facility care		45 days per calendar year, 20% coinsurance after deductible <sup>2</sup>	45 days per calendar year, 30% coinsurance after deductible <sup>2</sup>
<b>Other services</b>			
Prosthetics, orthotics, corrective appliances and durable medical equipment (when medically necessary)		50% coinsurance	50% coinsurance
Infertility counseling/treatment (excluding In-vitro fertilization)		50% coinsurance after deductible on all associated costs	50% coinsurance after deductible on all associated costs
Allergy testing, evaluation and serum; injections		50% coinsurance after deductible, \$5 injection	50% coinsurance after deductible, \$5 injection
Outpatient rehabilitation services (subject to significant improvement within 60 days)		Limited to 60 consecutive days per episode, \$20 copay per visit after deductible	Limited to 60 consecutive days per episode, \$20 copay per visit after deductible

<sup>1</sup> Office visit copay may apply per member, per visit

<sup>2</sup> Applies to the annual coinsurance maximum of \$1,500 per member, \$3,000 per family

<sup>5</sup> Applies to the annual coinsurance inpatient mental health maximum of \$1,000 per member, \$2,000 per family

Healthy Blue Living 7 (HBL7)		Healthy Blue Living 8 (HBL8)	
Enhanced benefits BCN10, C025, 35RP, ER100, UR35, 20%CR 1000D, 2000CM, Deductible: \$1,000/member; \$2,000/family	Standard benefits BCN10, C030, 40RP, ER150, UR50, 30%CR 3000D, 3000CM Deductible: \$3,000/member; \$6,000/family	Enhanced benefits BCN10, C030, 40RP, ER150, UR50, 20%CR 2000D, 2000CM Deductible: \$2,000/member; \$4,000/family	Standard benefits BCN10, C035, 45RP, ER250, UR60, 30%CR, 4000D, 3000CM Deductible: \$4,000/member; \$8,000/family
\$25 copay per visit	\$30 copay per visit	\$30 copay per visit	\$35 copay per visit
\$35 copay per visit after deductible	\$40 copay per visit after deductible	\$40 copay per visit after deductible	\$45 copay per visit after deductible
Covered in full	Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full	Covered in full
Covered in full <sup>1</sup>	Covered in full <sup>1</sup>	Covered in full <sup>1</sup>	Covered in full <sup>1</sup>
20% coinsurance after deductible <sup>6</sup>	30% coinsurance after deductible <sup>7</sup>	20% coinsurance after deductible <sup>6</sup>	30% coinsurance after deductible <sup>7</sup>
20% coinsurance after deductible <sup>6</sup>	30% coinsurance after deductible <sup>7</sup>	20% coinsurance after deductible <sup>6</sup>	30% coinsurance after deductible <sup>7</sup>
20% coinsurance after deductible <sup>6</sup>	30% coinsurance after deductible <sup>7</sup>	20% coinsurance after deductible <sup>6</sup>	30% coinsurance after deductible <sup>7</sup>
\$25 copay per visit	\$30 copay per visit	\$30 copay per visit	\$30 copay per visit
Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible
Unlimited	Unlimited	Unlimited	Unlimited
20% coinsurance after deductible <sup>6</sup>	30% coinsurance after deductible <sup>7</sup>	20% coinsurance after deductible <sup>6</sup>	30% coinsurance after deductible <sup>7</sup>
\$100 copay after deductible	\$150 copay after deductible	\$150 copay after deductible	\$250 copay after deductible
\$35 copay	\$50 copay	\$50 copay	\$60 copay
20% coinsurance after deductible <sup>6</sup>	30% coinsurance after deductible <sup>7</sup>	20% coinsurance after deductible <sup>6</sup>	30% coinsurance after deductible <sup>7</sup>
Nonparity: 20 visits per year, 50% coinsurance	Nonparity: 20 visits per year, 50% coinsurance	Nonparity: 20 visits per year, 50% coinsurance	Nonparity: 20 visits per year, 50% coinsurance
Parity: \$25 copay per visit after deductible	Parity: \$30 copay per visit after deductible	Parity: \$30 copay per visit after deductible	Parity: \$35 copay per visit after deductible
Nonparity: 30 days per calendar year, 25% coinsurance <sup>5</sup>	Nonparity: 30 days per calendar year, 25% coinsurance <sup>5</sup>	Nonparity: 30 days per calendar year, 25% coinsurance <sup>5</sup>	Nonparity: 30 days per calendar year, 25% coinsurance <sup>5</sup>
Parity: 20% coinsurance after deductible <sup>6</sup>	Parity: 30% coinsurance after deductible <sup>7</sup>	Parity: 20% coinsurance after deductible <sup>6</sup>	Parity: 30% coinsurance after deductible <sup>7</sup>
Nonparity: One program of treatment per year with a 50% coinsurance	Nonparity: One program of treatment per year with a 50% coinsurance	Nonparity: One program of treatment per year with a 50% coinsurance	Nonparity: One program of treatment per year with a 50% coinsurance
Parity: \$25 copay per visit after deductible	Parity: \$30 copay per visit after deductible	Parity: \$30 copay per visit after deductible	Parity: \$35 copay per visit after deductible
Nonparity: One program of treatment per year with a 50% coinsurance	Nonparity: One program of treatment per year with a 50% coinsurance	Nonparity: One program of treatment per year with a 50% coinsurance	Nonparity: One program of treatment per year with a 50% coinsurance
Parity: 20% coinsurance after deductible <sup>6</sup>	Parity: 30% coinsurance after deductible <sup>7</sup>	Parity: 20% coinsurance after deductible <sup>6</sup>	Parity: 30% coinsurance after deductible <sup>7</sup>
Nonparity: 50% coinsurance	Nonparity: 50% coinsurance	Nonparity: 50% coinsurance	Nonparity: 50% coinsurance
Parity: 20% coinsurance after deductible <sup>6</sup>	Parity: 30% coinsurance after deductible <sup>7</sup>	Parity: 20% coinsurance after deductible <sup>6</sup>	Parity: 30% coinsurance after deductible <sup>7</sup>
45 days per calendar year, 20% coinsurance after deductible <sup>6</sup>	45 days per calendar year, 30% coinsurance after deductible <sup>7</sup>	45 days per calendar year, 20% coinsurance after deductible <sup>6</sup>	45 days per calendar year, 30% coinsurance after deductible <sup>7</sup>
50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
50% coinsurance after deductible on all associated costs	50% coinsurance after deductible on all associated costs	50% coinsurance after deductible on all associated costs	50% coinsurance after deductible on all associated costs
50% coinsurance after deductible, \$5 injection	50% coinsurance after deductible, \$5 injection	50% coinsurance after deductible, \$5 injection	50% coinsurance after deductible, \$5 injection
Limited to 60 consecutive days per episode, \$35 copay per visit after deductible	Limited to 60 consecutive days per episode, \$40 copay per visit after deductible	Limited to 60 consecutive days per episode, \$40 copay per visit after deductible	Limited to 60 consecutive days per episode, \$45 copay per visit after deductible

<sup>1</sup> Office visit copay may apply per member, per visit

<sup>6</sup> Applies to the annual coinsurance maximum of \$2,000 per member, \$4,000 per family

<sup>7</sup> Applies to the annual coinsurance maximum of \$3,000 per member, \$6,000 per family



HBLR members (subscribers and covered spouse) must complete the program requirements, which include a Health Assessment and Qualification Form, within the first 90 days of enrollment or re-enrollment. To qualify for or maintain enhanced or intermediate benefits, members need to follow their primary care physician's recommendations for a healthy lifestyle. Tobacco users must enroll in BCN's tobacco cessation program within 120 days of enrollment or re-enrollment. Members with a body mass index of 30 or more must choose one of two BCN-sponsored weight management programs (Weight Watchers® or the Walkingspree pedometer-based walking program) within 120 days of enrollment or re-enrollment.

## Blue Care Network

Healthy *Blue* Living Rewards  
Benefits-at-a-glance

### Physician office services

Routine office visits

Consulting specialist care (when referred)

### Preventive services

Periodic physical exam

Newborn, well-child assessments and examinations

Immunizations

Mammography screening

Pap smears (lab services)

Prostate specific antigen screening (lab services)

### Diagnostic services

Laboratory tests

Diagnostic tests and x-rays

High tech imaging

Radiation therapy

### Maternity services provided by a physician

Prenatal and postnatal care

Delivery in hospital and well-baby care in hospital

### Inpatient hospital care

Number of days of care

In-hospital general nursing care, surgery (Including all related surgical services, anesthesia, lab, x-rays and drugs)

### Emergency medical care

Hospital emergency room (copay waived if admitted)

Urgent care center

Ground and air ambulance services (when medically necessary)

### Mental health care

Outpatient visits

Inpatient psychiatric hospital services  
(Services covered when authorized by BCN)

### Alcoholism & substance abuse services

Outpatient treatment

Intermediate/residential treatment  
(Services covered when authorized by BCN)

Detoxification  
(Services covered when authorized by BCN)

### Skilled nursing care

Skilled nursing facility care

### Other services

Prothetics, orthotics, corrective appliances and durable medical equipment (when medically necessary)

Infertility counseling/treatment (excluding In-vitro fertilization)

Allergy testing, evaluation and serum; injections

Outpatient rehabilitation services  
(subject to significant improvement within 60 days)

Healthy Blue Living Rewards 2 (HBLR2)			Healthy Blue Living Rewards 3 (HBLR3)		
Enhanced	Intermediate	Standard	Enhanced	Intermediate	Standard
BCN10, C020, UR35, ER75, 10%CR, 500CM, 250DED, MHSAP	BCN10, C025, UR50, ER100, 20%CR, 1000CM, 500DED, MHSAP	BCN10, C030, UR60, ER150, 30%CR, 1500CM, 1000D, MHSAP	BCN10, C025, 35RP, UR35, ER100, 20%CR, 1500CM, 1500D, MHSAP	BCN10, C030, 40RP, UR50, ER150, 20%CR, 2000CM, 2000D, MHSAP	BCN10, C035, 45RP, UR60, ER200, 20%CR, 3000CM, 3000D, MHSAP
Deductible: \$250/member; \$500/family	Deductible: \$500/member; \$1,000/family	Deductible: \$1,000/member; \$2,000/family	Deductible: \$1,500/member; \$3,000/family	Deductible: \$2,000/member; \$4,000/family	Deductible: \$3,000/member; \$6,000/family
\$20 copay per visit	\$25 copay per visit	\$30 copay per visit	\$25 copay per visit	\$30 copay per visit	\$35 copay per visit
\$20 copay per visit after deductible	\$25 copay per visit after deductible	\$30 copay per visit after deductible	\$35 copay per visit after deductible	\$40 copay per visit after deductible	\$45 copay per visit after deductible
Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Covered in full <sup>1</sup>	Covered in full <sup>1</sup>	Covered in full <sup>1</sup>	Covered in full <sup>1</sup>	Covered in full <sup>1</sup>	Covered in full <sup>1</sup>
10% coinsurance after deductible <sup>10</sup>	20% coinsurance after deductible <sup>3</sup>	30% coinsurance after deductible <sup>2</sup>	20% coinsurance after deductible <sup>2</sup>	20% coinsurance after deductible <sup>6</sup>	20% coinsurance after deductible <sup>7</sup>
10% coinsurance after deductible <sup>10</sup>	20% coinsurance after deductible <sup>3</sup>	30% coinsurance after deductible <sup>2</sup>	20% coinsurance after deductible <sup>2</sup>	20% coinsurance after deductible <sup>6</sup>	20% coinsurance after deductible <sup>7</sup>
10% coinsurance after deductible <sup>10</sup>	20% coinsurance after deductible <sup>3</sup>	30% coinsurance after deductible <sup>2</sup>	20% coinsurance after deductible <sup>2</sup>	20% coinsurance after deductible <sup>6</sup>	20% coinsurance after deductible <sup>7</sup>
\$20 copay per visit	\$25 copay per visit	\$30 copay per visit	\$25 copay per visit	\$30 copay per visit	\$35 copay per visit
Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible	Covered in full after deductible
Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
10% coinsurance after deductible <sup>10</sup>	20% coinsurance after deductible <sup>3</sup>	30% coinsurance after deductible <sup>2</sup>	20% coinsurance after deductible <sup>2</sup>	20% coinsurance after deductible <sup>6</sup>	20% coinsurance after deductible <sup>7</sup>
\$75 copay per visit after deductible	\$100 copay per visit after deductible	\$150 copay per visit after deductible	\$100 copay per visit after deductible	\$150 copay per visit after deductible	\$200 copay per visit after deductible
\$35 copay	\$50 copay	\$60 copay	\$35 copay	\$50 copay	\$60 copay
10% coinsurance after deductible <sup>10</sup>	20% coinsurance after deductible <sup>3</sup>	30% coinsurance after deductible <sup>2</sup>	20% coinsurance after deductible <sup>2</sup>	20% coinsurance after deductible <sup>6</sup>	20% coinsurance after deductible <sup>7</sup>
\$20 copay per visit after deductible	\$25 copay per visit after deductible	\$30 copay per visit after deductible	\$25 copay per visit after deductible	\$30 copay per visit after deductible	\$35 copay per visit after deductible
10% coinsurance after deductible <sup>10</sup>	20% coinsurance after deductible <sup>3</sup>	30% coinsurance after deductible <sup>2</sup>	20% coinsurance after deductible <sup>2</sup>	20% coinsurance after deductible <sup>6</sup>	20% coinsurance after deductible <sup>7</sup>
\$20 copay per visit after deductible	\$25 copay per visit after deductible	\$30 copay per visit after deductible	\$25 copay per visit after deductible	\$30 copay per visit after deductible	\$35 copay per visit after deductible
10% coinsurance after deductible <sup>10</sup>	20% coinsurance after deductible <sup>3</sup>	30% coinsurance after deductible <sup>2</sup>	20% coinsurance after deductible <sup>2</sup>	20% coinsurance after deductible <sup>6</sup>	20% coinsurance after deductible <sup>7</sup>
10% coinsurance after deductible <sup>10</sup>	20% coinsurance after deductible <sup>3</sup>	30% coinsurance after deductible <sup>2</sup>	20% coinsurance after deductible <sup>2</sup>	20% coinsurance after deductible <sup>6</sup>	20% coinsurance after deductible <sup>7</sup>
45 days per calendar year, 10% coinsurance after deductible <sup>10</sup>	45 days per calendar year, 20% coinsurance after deductible <sup>3</sup>	45 days per calendar year, 30% coinsurance after deductible <sup>2</sup>	45 days per calendar year, 20% coinsurance after deductible <sup>2</sup>	45 days per calendar year, 20% coinsurance after deductible <sup>6</sup>	45 days per calendar year, 20% coinsurance after deductible <sup>7</sup>
50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
50% coinsurance after deductible on all associated costs	50% coinsurance after deductible on all associated costs	50% coinsurance after deductible on all associated costs	50% coinsurance after deductible on all associated costs	50% coinsurance after deductible on all associated costs	50% coinsurance after deductible on all associated costs
50% coinsurance after deductible, \$5 injection	50% coinsurance after deductible, \$5 injection	50% coinsurance after deductible, \$5 injection	50% coinsurance after deductible, \$5 injection	50% coinsurance after deductible, \$5 injection	50% coinsurance after deductible, \$5 injection
Limited to 60 consecutive days per episode, \$20 copay per visit after deductible	Limited to 60 consecutive days per episode, \$25 copay per visit after deductible	Limited to 60 consecutive days per episode, \$30 copay per visit after deductible	Limited to 60 consecutive days per episode, \$35 copay per visit after deductible	Limited to 60 consecutive days per episode, \$40 copay per visit after deductible	Limited to 60 consecutive days per episode, \$45 copay per visit after deductible

<sup>1</sup> Office visit copay may apply per member, per visit

<sup>2</sup> Applies to the annual coinsurance maximum of \$1,500 per member, \$3,000 per family

<sup>3</sup> Applies to the annual coinsurance maximum of \$1,000 per member, \$2,000 per family

<sup>6</sup> Applies to the annual coinsurance maximum of \$2,000 per member, \$4,000 per family

<sup>7</sup> Applies to the annual coinsurance maximum of \$3,000 per member, \$6,000 per family

<sup>10</sup> Applies to the annual coinsurance maximum of \$500 per member, \$1,000 per family



## Prescription options

### Prescription options for BCN5, deductible packages, Blue Elect Plus and BCN Basic package Prescription drug copay choices include contraceptives and two times the applicable copay for mail order up to a 90-day supply

- 50% per prescription, (minimum copay \$5, maximum copay \$100)
- \$10 copay for generic, \$40 copay for brand-name†
- \$10 copay for generic, \$20 copay for brand-name and \$40 copay for nonformulary
- \$15 copay for generic and \$50 copay for brand name†
- \$15 copay for generic, \$50 copay for brand-name, 50% for nonformulary (minimum copay \$70, maximum copay \$100)
- \$20 copay for generic, \$60 copay for brand-name, 50% for nonformulary (minimum copay \$80, maximum copay \$100)
- \$10 copay for generic, \$40 copay for brand-name, \$80 copay for nonformulary, 20% coinsurance (\$100 maximum copay per prescription) for Specialty Formulary, 20% coinsurance (\$200 maximum copay per prescription) for Specialty Nonformulary. The combined Specialty Formulary and Specialty Nonformulary prescription drugs coinsurance maximum is \$2,400 per member, per calendar year.
- \$15 copay for generic, \$50 copay for brand-name, \$80 copay for nonformulary, 20% coinsurance (\$150 maximum copay per prescription) for Specialty Formulary, 20% coinsurance (\$300 maximum copay per prescription) for Specialty Nonformulary. The combined Specialty Formulary and Specialty Nonformulary prescription drugs coinsurance maximum is \$3,600 per member, per calendar year.
- \$20 copay for generic, \$60 copay for brand-name, \$80 copay for nonformulary, 20% coinsurance (\$200 maximum copay per prescription) for Specialty Formulary, 20% coinsurance (\$400 maximum copay per prescription) for Specialty Nonformulary. The combined Specialty Formulary and Specialty Nonformulary prescription drugs coinsurance maximum is \$4,800 per member, per calendar year.

### Prescription options only for Healthy *Blue* Living plan 3 (page 10) Prescription drug copay choices include contraceptives and two times the applicable copay for mail order up to a 90-day supply

- \$5/\$30 Enhanced†, \$15/\$50 Standard†
- \$5/\$30 Enhanced†, 50% (\$5/\$100) Standard
- \$10/\$20 Enhanced†, \$15/\$50 Standard†
- \$10/\$20 Enhanced†, 50% (\$5/\$100) Standard
- \$10/\$40 Enhanced†, \$15/\$50 Standard†
- \$10/\$40 Enhanced†, 50% (\$5/\$100) Standard

### Prescription option only for Healthy *Blue* Living plans 7&8 (page 11) Prescription drug copay choices include contraceptives and two times the applicable copay for mail order up to a 90-day supply

- \$10/\$40 Enhanced†, 50% (\$5/\$100) Standard

### Prescription options for Healthy *Blue* Living Rewards plans (page 13) Prescription drug copay choices include contraceptives and two times the applicable copay for mail order up to a 90-day supply

- \$5/\$30 Enhanced†, \$5/\$40 Intermediate†, \$10/\$40 Standard†
- \$5/\$30 Enhanced†, \$5/\$40 Intermediate†, \$15/\$50 Standard†
- \$5/\$30 Enhanced†, \$5/\$50 Intermediate†, 50% Standard
- \$10/\$20 Enhanced†, \$10/\$40 Intermediate†, \$15/\$50 Standard†
- \$10/\$40 Enhanced†, \$15/\$50 Intermediate†, \$20/\$60 Standard†

### Prescription options for Savings Plus Approved Drug List

- \$0 copay for generic, \$40 copay for brand-name, 75% coinsurance for nonformulary
- \$4 copay for generic, \$20 copay for brand-name, 75% coinsurance for nonformulary
- \$4 copay for generic, \$40 copay for brand-name, 75% coinsurance for nonformulary
- \$4 copay for generic, \$60 copay for brand-name, 75% coinsurance for nonformulary

**Notes**










**Blue Care  
Network  
of Michigan**

A nonprofit corporation and independent licensee  
of the Blue Cross and Blue Shield Association

  
(2-49 enrolled)

 BCN is available  
in these counties

 BCN is only  
available in portions  
of these counties

 BCN is not available  
in these counties

**BCN  
SERVICE  
AREA**

