



**GROUP PLAN
OPTIONS**

(50+ enrolled)

Effective
October 1, 2011



**Blue Care
Network**
of Michigan

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



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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 PlusSM 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.

Build-a-Plan gives you more

Build-a-Plan gives you more copay options that meet your group's unique needs. When you choose one of Blue Care Network of Michigan's standard, deductible or Blue Elect Plus Self-Referral OptionSM HMO plans you have more freedom to choose different copays, deductibles and coinsurance.

Healthy *Blue* LivingSM, Healthy *Blue* Living RewardsSM, Tiered Copay and BCN Basic options are also available as packaged plans.

Products for groups of 50+ contracts

BCN5, BCN10 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

Members have the freedom to seek care either in BCN's vast network or outside it. 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. Blue Elect Plus offers the value of managed care plus flexibility. Members can self-refer to any doctor.

Deductible plans

Employers can customize their plans by selecting deductibles that are appropriate for their groups. We offer several options with and without coinsurance. The Tiered Copay Option allows groups to purchase a deductible plan without the deductible applying to various health care services, including specialist, emergency and home care. Groups can add a Healthy Blue HMO HRA*.

Healthy *Blue* Living

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

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 HRASM

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.



*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 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.

Groups 51 to 99

- Minimum of five contracts must enroll with BCN.
- Seventy-five percent of eligible employees must enroll in a health plan.

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

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	BCN5	Build-a-plan
		BCN10, MHSAP
Physician office services		
Routine office visits	\$20 copay per visit	\$20 or \$30 copay per visit
Consulting specialist care (when referred)	\$40 copay per visit	\$20 or \$30 ^{††} copay
Preventive services		
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
Diagnostic and therapeutic procedures		
Laboratory tests	Covered in full ¹	Covered in full ¹
Diagnostic x-rays	Covered in full ¹	Covered in full ¹
High tech imaging	Covered in full ¹	\$0, \$150, or \$250 copay
Radiation therapy	Covered in full ¹	Covered in full ¹
Maternity services provided by a physician		
Prenatal and postnatal care	\$20 copay per visit	\$20 or \$30 copay per visit
Delivery in hospital and well-baby care in hospital	Covered in full	Covered in full
Inpatient hospital care		
Number of days of care	Unlimited	Unlimited
In-hospital general nursing care, surgery (including all related surgical services, anesthesia, lab, x-rays and drugs)	\$250 copay per admission ⁴	25% coinsurance ³
Emergency medical care		
Hospital emergency room (copay waived if admitted)	\$150	\$100 or \$150
Urgent care center	\$50 copay	\$35 or \$50 copay
Ground and air ambulance services (when medically necessary)	Covered in full	\$25 copay
Mental health care		
Outpatient visits	\$20 copay per visit	\$20 or \$30 copay per visit
Inpatient psychiatric hospital services (Services covered when authorized by BCN)	Covered in full	25% coinsurance ³
Alcoholism & substance abuse services		
Outpatient treatment	\$20 copay per visit	\$20 or \$30 copay per visit
Intermediate/residential treatment (Services covered when authorized by BCN)	Covered in full	25% coinsurance ³
Detoxification (Services covered when authorized by BCN)	Covered in full	25% coinsurance ³
Skilled nursing care		
Skilled nursing facility care	45 days per calendar year, covered in full	45 days per calendar year, covered in full
Other services		
Prothetics, orthotics, corrective appliances and durable medical equipment (when medically necessary)	50% coinsurance	50% coinsurance
Infertility counseling/treatment (excluding In-vitro fertilization)	50% coinsurance on all associated costs	50% coinsurance on all associated costs
Allergy testing, evaluation and serum; injections	50% coinsurance, \$5 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	Limited to 60 consecutive days per episode; \$20 or \$30 ^{††} copay per visit

¹ Office visit copay may apply per member, per visit

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

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

^{††} \$30 referral physician copay rider option available

Build-a-plan

Deductible w/coinsurance BCN10, 1500CM Deductible Options: 500DED, 1000D, 1500D, 2000D, 3000D, 4000D, 5000D, 7500D	Deductible w/o coinsurance BCN10, WHC10 Deductible Options: 1000D, 1500D, 2000D, 3000D, 4000D, 5000D, 7500D
\$20 or \$30 copay per visit	\$20 or \$30 copay per visit
\$20 or \$30 ^{††} copay after deductible	\$20 or \$30 ^{††} copay 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 ¹	Covered in full ¹
20% or 30% coinsurance after deductible ²	Covered in full ¹ after deductible
20% or 30% coinsurance after deductible ²	\$0, \$150, or \$250 copay after deductible
20% or 30% coinsurance after deductible ²	Covered in full ¹ after deductible
\$20 or \$30 copay per visit	\$20 or \$30 copay per visit
Covered in full after deductible	Covered in full after deductible
Unlimited	Unlimited
20% or 30% coinsurance after deductible ²	Covered in full after deductible
\$100, or \$150 copay after deductible	\$100, or \$150 copay after deductible
\$35 or \$50 copay	\$35 or \$50 copay
20% or 30% coinsurance after deductible ²	\$25 copay after deductible
\$20 or \$30 copay per visit after deductible	\$20 or \$30 copay per visit after deductible
20% or 30% coinsurance after deductible ²	Covered in full after deductible
\$20 or \$30 copay per visit after deductible	\$20 or \$30 copay per visit after deductible
20% or 30% coinsurance after deductible ²	Covered in full after deductible
20% or 30% coinsurance after deductible ²	Covered in full after deductible
45 days per calendar year; 20% or 30% coinsurance after deductible ²	45 days per calendar year; Covered in full after deductible
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, \$5 injections	50% coinsurance after deductible, \$5 injections
Limited to 60 consecutive days per episode; \$20 or \$30 ^{††} copay per visit after deductible	Limited to 60 consecutive days per episode, \$20 or \$30 ^{††} per visit copay after deductible

¹ Office visit copay may apply per member, per visit

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

^{††} \$30 referral physician copay rider option available

Note: Plan year option available only to HRA plans

Blue Care Network Benefits-at-a-glance	Build-a-plan	
	Blue Elect Plus Option 1	
	BEP, IN15C0, IN30RP	
	Deductible Options: \$500/\$1,000 In-Network, \$1,000/\$2,000 Out-of-Network; \$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 ⁸
Physician office services		
Routine office visits	\$15 copay per visit	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
Consulting specialist care	\$30 copay per visit	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
Preventive services		
Periodic physical exam	Covered in full	Not covered
Newborn, well-child assessments and examinations	Covered in full	Not covered
Immunizations	Covered in full	Not covered
Mammography screening	Covered in full	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
Pap smears (lab services)	Covered in full	Not covered
Prostate specific antigen screening (lab services)	Covered in full	Not covered
Diagnostic and therapeutic procedures		
Laboratory tests	Covered in full ¹	Covered in full ¹
Diagnostic x-rays	10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
High tech imaging	\$150 copay	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
Radiation therapy	10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
Maternity services provided by a physician		
Prenatal and postnatal care	\$15 copay per visit	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
Delivery in hospital and well-baby care in hospital	10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
Inpatient hospital care		
Number of days of care	Unlimited	Unlimited
In-hospital general nursing care, surgery (including all related surgical services, anesthesia, lab, x-rays and drugs)	10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
Emergency medical care		
Hospital emergency room (copay waived if admitted)		\$150 copay
Urgent care center		\$50 copay
Ground and air ambulance services (when medically necessary)		\$50 copay
Mental health care		
Outpatient visits	\$15 copay per visit	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
Inpatient psychiatric hospital services (Services covered when authorized by BCN)	10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
Alcoholism & substance abuse services		
Outpatient treatment	\$15 copay per visit	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
Intermediate/residential treatment (Services covered when authorized by BCN)	10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
Detoxification (Services covered when authorized by BCN)	10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
Skilled nursing care		
Skilled nursing facility care	45 days per calendar year, 10% ² , 20% ² or 30% ⁹ coinsurance after deductible (In-network and out-of-network days count toward limit)	45 days per calendar year, 30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible (In-network and out-of-network days count toward limit)
Other services		
Prosthetics, orthotics, corrective appliances and durable medical equipment (when medically necessary)	Covered in full	Not covered
Infertility counseling/treatment (excluding In-vitro fertilization)	50% coinsurance after deductible on all associated costs	Not covered
Allergy testing, evaluation and serum; injections	Covered in full including injections	50% coinsurance after deductible including injections
Outpatient rehabilitation services (subject to significant improvement within 60 days)	Limited to 60 consecutive days per episode, \$30 copay (Limit is combined for in-network and out-of-network services)	Limited to 60 consecutive days per episode, 0% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible (Limit is combined for in-network and out-of-network services)

¹ Office visit copay may apply per member, per visit

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

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

⁸ 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.

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

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

Build-a-plan		Build-a-plan	
Blue Elect Plus Option 2		Blue Elect Plus Option 3	
BEP, IN20C0, IN35RP		BEP, IN30C0, IN45RP, UR60	
Deductible Options: \$500/\$1,000 In-Network, \$1,000/\$2,000 Out-of-Network; \$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: \$500/\$1,000 In-Network, \$1,000/\$2,000 Out-of-Network; \$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 ⁸	In network	Out of network ⁸
\$20 copay per visit	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible	\$30 copay per visit	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
\$35 copay per visit	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible	\$45 copay per visit	30% ⁷ , 40% ⁷ or 50% ¹¹ 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	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible	Covered in full	30% ⁷ , 40% ⁷ or 50% ¹¹ 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 ¹	Covered in full ¹	Covered in full ¹	Covered in full ¹
10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible	10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
\$150 copay	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible	\$150 copay	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible	10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
\$20 copay per visit	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible	\$30 copay per visit	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible	10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
Unlimited	Unlimited	Unlimited	Unlimited
10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible	10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
	\$150 copay		\$150 copay
	\$50 copay		\$60 copay
	\$50 copay		\$50 copay
\$20 copay per visit	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible	\$30 copay per visit	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible	10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
\$20 copay per visit	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible	\$30 copay per visit	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible	10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible	10% ² , 20% ² or 30% ⁹ coinsurance after deductible	30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible
45 days per calendar year, 10% ² , 20% ² or 30% ⁹ coinsurance after deductible (In-network and out-of-network days count toward limit)	45 days per calendar year, 30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible (In-network and out-of-network days count toward limit)	45 days per calendar year, 10% ² , 20% ² or 30% ⁹ coinsurance after deductible (In-network and out-of-network days count toward limit)	45 days per calendar year, 30% ⁷ , 40% ⁷ or 50% ¹¹ 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, 30% ⁷ , 40% ⁷ or 50% ¹¹ 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, 30% ⁷ , 40% ⁷ or 50% ¹¹ coinsurance after deductible (Limit is combined for in-network and out-of-network services)

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

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

⁸ 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.

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

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



Blue Care Network

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 and therapeutic procedures

Laboratory tests

Diagnostic x-rays

High tech imaging

Radiation therapy

Maternity services provided by a physician

Prenatal and postnatal visits

Delivery in hospital and well-baby care in hospital

Inpatient hospital care

Number of days of care

In-hospital physician care, 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)

BCN Basic		Tiered Copay	
BCN Basic Option 1 BAS25, 35RPOV, UR35, ER100	BCN Basic Option 2 BAS35, 50RPOV, 30%BAS, 3KCMB, UR60, ER150	Tiered Copay Option 1 BCN10, 100V15, 30RP, ER100, UR45, IMG150, WDEDFC Deductible Options: 1,000/\$2,000; \$2,000/\$4,000; \$3,000/\$6,000; \$4,000/\$8,000 Coinsurance Options: \$0 or 20%	Tiered Copay Option 2 BCN10, C030, 45RP, ER100, UR60, IMG150, WDEDFC Deductible Options: \$1,000/\$2,000; \$2,000/\$4,000; \$3,000/\$6,000; \$4,000/\$8,000 Coinsurance Options: \$0 or 20%
\$25 copay per visit	\$35 copay per visit	\$15 copay per visit	\$30 copay per visit
\$35 copay per visit	\$50 copay per visit	\$30 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	Covered in full
Covered in full	Covered in full	Covered in full	Covered in full
20% coinsurance ²	30% coinsurance ⁷	Covered in full ¹	Covered in full ¹
20% coinsurance ²	30% coinsurance ⁷	Covered in full or 20% coinsurance ² after deductible	Covered in full or 20% coinsurance ² after deductible
20% coinsurance ²	30% coinsurance ⁷	\$150 copay	\$150 copay
20% coinsurance ²	30% coinsurance ⁷	Covered in full or 20% coinsurance ² after deductible	Covered in full or 20% coinsurance ² after deductible
\$25 copay per visit	\$35 copay per visit	\$15 copay per visit	\$30 copay per visit
20% coinsurance ²	30% coinsurance ⁷	Covered in full after deductible	Covered in full after deductible
Unlimited	Unlimited	Unlimited	Unlimited
20% coinsurance ²	30% coinsurance ⁷	Covered in full or 20% coinsurance ² after deductible	Covered in full or 20% coinsurance ² after deductible
\$100 copay	\$150 copay	\$100 copay	\$100 copay
\$35 copay	\$60 copay	\$45 copay	\$60 copay
\$50 copay ²	\$50 copay ⁷	\$25 copay or 20% coinsurance ² after deductible	\$25 copay or 20% coinsurance ² after deductible
\$25 copay per visit	\$35 copay per visit	\$15 copay per visit	\$30 copay per visit
20% coinsurance ²	30% coinsurance ⁷	Covered in full or 20% coinsurance ² after deductible	Covered in full or 20% coinsurance ² after deductible
\$25 copay per visit	\$35 copay per visit	\$15 copay per visit	\$30 copay per visit
20% coinsurance ²	30% coinsurance ⁷	Covered in full or 20% coinsurance ² after deductible	Covered in full or 20% coinsurance ² after deductible
20% coinsurance ²	30% coinsurance ⁷	Covered in full or 20% coinsurance ² after deductible	Covered in full or 20% coinsurance ² after deductible
20 days per calendar year, 20% coinsurance ²	20 days per calendar year, 30% coinsurance ⁷	45 days per calendar year; covered in full or 20% coinsurance ² after deductible	45 days per calendar year; covered in full or 20% coinsurance ² after deductible
50% coinsurance	50% coinsurance	Covered in full (HRA plans only) or 50% coinsurance	Covered in full (HRA plans only) or 50% coinsurance
50% coinsurance on all associated costs	50% coinsurance on all associated costs	50% coinsurance after deductible on all associated costs	50% coinsurance after deductible on all associated costs
50% coinsurance, \$5 injections ²	50% coinsurance, \$5 injections ⁷	50% coinsurance after deductible, \$5 injections	50% coinsurance after deductible, \$5 injections
30 visits within a 60-day period per episode, 50% coinsurance ²	30 visits within a 60-day period per episode, 50% coinsurance ⁷	Limited to 60 consecutive days per episode; \$30 copay per visit	Limited to 60 consecutive days per episode; \$45 copay per visit

¹ Office visit copay may apply per member, per visit

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

³ Applies to the annual coinsurance inpatient mental health maximum of \$1,000 per member, \$2,000 per family

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

		Healthy Blue Living 2 (HBL2)	
Blue Care Network Healthy Blue Living Benefits-at-a-glance		Enhanced benefits BCN10, C020, ER75, UR35, MHSAP	Standard benefits BCN10, C020, ER75, UR35, 30%CR, 1000D, 1500CM, MHSAP Deductible: \$1,000/member; \$2,000/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>			
Physician office services			
Routine office visits		\$20 copay per visit	\$20 copay per visit
Consulting specialist care (when referred)		\$20 copay per visit	\$20 copay per visit after deductible
Preventive services			
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
Diagnostic and therapeutic procedures			
Laboratory tests		Covered in full ¹	Covered in full ¹
Diagnostic x-rays		Covered in full ¹	30% coinsurance after deductible ²
High tech imaging		Covered in full ¹	30% coinsurance after deductible ²
Radiation therapy		Covered in full ¹	30% coinsurance after deductible ²
Maternity services provided by a physician			
Prenatal and postnatal visits		\$20 copay per visit	\$20 copay per visit
Delivery in hospital and well-baby care in hospital		Covered in full	Covered in full after deductible
Inpatient hospital care			
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)		25% coinsurance ³	30% coinsurance after deductible ²
Emergency medical care			
Hospital emergency room (copay waived if admitted)		\$75 copay	\$75 copay after deductible
Urgent care center		\$35 copay	\$35 copay
Ground and air ambulance services (when medically necessary)		\$25 copay	30% coinsurance after deductible ²
Mental health care			
Outpatient visits		\$20 copay per visit	\$20 copay per visit after deductible
Inpatient psychiatric hospital services (Services covered when authorized by BCN)		25% coinsurance ³	30% coinsurance after deductible ²
Alcoholism & substance abuse services			
Outpatient treatment		\$20 copay per visit	\$20 copay per visit after deductible
Intermediate/residential treatment (Services covered when authorized by BCN)		25% coinsurance ³	30% coinsurance after deductible ²
Detoxification (Services covered when authorized by BCN)		25% coinsurance ³	30% coinsurance after deductible ²
Skilled nursing care			
Skilled nursing facility care		45 days per calendar year, covered in full	45 days per calendar year, 30% coinsurance after deductible ²
Other services			
Prothetics, orthotics, corrective appliances and durable medical equipment (when medically necessary)		50% coinsurance	50% coinsurance
Infertility counseling/treatment (excluding In-vitro fertilization)		50% coinsurance on all associated costs	50% coinsurance after deductible on all associated costs
Allergy testing, evaluation and serum; injections		50% coinsurance, \$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	Limited to 60 consecutive days per episode, \$20 copay per visit after deductible

¹ Office visit copay may apply per member, per visit

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

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

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

Healthy Blue Living 3 (HBL3)		Healthy Blue Living 5 (HBL5)	
Enhanced benefits BCN10, C020, ER75, UR35, 500DED, 20%CR, 1500CM, MHSAP Deductible: \$500/member; \$1,000/family	Standard benefits BCN10, C020, ER100, UR50, 30%CR, 2000D, 1500CM, MHSAP Deductible: \$2,000/member; \$4,000/family	Enhanced benefits BCN10, C020, ER75, UR35, 20%CR, 250DED, 1000CM, MHSAP Deductible: \$250 /member; \$500/family	Standard benefits BCN10, C020, ER100, UR35, 30%CR, 1500D, 1500CM, MHSAP Deductible: \$1,500 /member; \$3,000/family
\$20 copay per visit	\$20 copay per visit	\$20 copay per visit	\$20 copay per visit
\$20 copay per visit after deductible	\$20 copay per visit after deductible	\$20 copay per visit after deductible	\$20 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 ¹	Covered in full ¹	Covered in full ¹	Covered in full ¹
20% coinsurance after deductible ²	30% coinsurance after deductible ²	20% coinsurance after deductible ³	30% coinsurance after deductible ²
20% coinsurance after deductible ²	30% coinsurance after deductible ²	20% coinsurance after deductible ³	30% coinsurance after deductible ²
20% coinsurance after deductible ²	30% coinsurance after deductible ²	20% coinsurance after deductible ³	30% coinsurance after deductible ²
\$20 copay per visit	\$20 copay per visit	\$20 copay per visit	\$20 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 ²	30% coinsurance after deductible ²	20% coinsurance after deductible ³	30% coinsurance after deductible ²
\$75 copay after deductible	\$100 copay after deductible	\$75 copay after deductible	\$100 copay after deductible
\$35 copay	\$50 copay	\$35 copay	\$35 copay
20% coinsurance after deductible ²	30% coinsurance after deductible ²	20% coinsurance after deductible ³	30% coinsurance after deductible ²
\$20 copay per visit after deductible	\$20 copay per visit after deductible	\$20 copay per visit after deductible	\$20 copay per visit after deductible
20% coinsurance after deductible ²	30% coinsurance after deductible ²	20% coinsurance after deductible ³	30% coinsurance after deductible ²
\$20 copay per visit after deductible	\$20 copay per visit after deductible	\$20 copay per visit after deductible	\$20 copay per visit after deductible
20% coinsurance after deductible ²	30% coinsurance after deductible ²	20% coinsurance after deductible ³	30% coinsurance after deductible ²
20% coinsurance after deductible ²	30% coinsurance after deductible ²	20% coinsurance after deductible ³	30% coinsurance after deductible ²
45 days per calendar year, 20% coinsurance after deductible ²	45 days per calendar year, 30% coinsurance after deductible ²	45 days per calendar year, 20% coinsurance after deductible ³	45 days per calendar year, 30% coinsurance after deductible ²
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, \$20 copay per visit after deductible	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	Limited to 60 consecutive days per episode, \$20 copay per visit after deductible

¹ Office visit copay may apply per member, per visit

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

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

⁴ Applies to the annual coinsurance inpatient mental health maximum of \$1,000 per member, \$2,000 per family

Blue Care Network Healthy <i>Blue</i> Living Benefits-at-a-glance	Healthy <i>Blue</i> Living 6 (HBL6)	
	Enhanced benefits BCN10, C025, ER100, UR35, 20%CR, 750DED, 2000CM, MHSAP Deductible: \$750 /member; \$1,500/family	Standard benefits BCN10, C030, ER150, UR50, 30%CR, 2000D, 3000CM, MHSAP Deductible: \$2,000 /member; \$4,000/family
Physician office services		
Routine office visits	\$25 copay per visit	\$30 copay per visit
Consulting specialist care (when referred)	\$25 copay per visit after deductible	\$30 copay per visit after deductible
Preventive services		
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
Diagnostic and therapeutic procedures		
Laboratory tests	Covered in full ¹	Covered in full ¹
Diagnostic x-rays	20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷
High tech imaging	20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷
Radiation therapy	20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷
Maternity services provided by a physician		
Prenatal and postnatal visits	\$25 copay per visit	\$30 copay per visit
Delivery in hospital and well-baby care in hospital	Covered in full after deductible	Covered in full after deductible
Inpatient hospital care		
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 ⁶	30% coinsurance after deductible ⁷
Emergency medical care		
Hospital emergency room (copay waived if admitted)	\$100 copay after deductible	\$150 copay after deductible
Urgent care center	\$35 copay	\$50 copay
Ground and air ambulance services (when medically necessary)	20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷
Mental health care		
Outpatient visits	\$25 copay per visit after deductible	\$30 copay per visit after deductible
Inpatient psychiatric hospital services (Services covered when authorized by BCN)	20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷
Alcoholism & substance abuse services		
Outpatient treatment	\$25 copay per visit after deductible	\$30 copay per visit after deductible
Intermediate/residential treatment (Services covered when authorized by BCN)	20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷
Detoxification (Services covered when authorized by BCN)	20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷
Skilled nursing care		
Skilled nursing facility care	45 days per calendar year, 20% coinsurance after deductible ⁶	45 days per calendar year, 30% coinsurance after deductible ⁷
Other services		
Prothetics, 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, \$25 copay per visit after deductible	Limited to 60 consecutive days per episode, \$30 copay per visit after deductible

¹ Office visit copay may apply per member, per visit

² Applies to the annual coinsurance inpatient mental health maximum of \$1,000 per member, \$2,000 per family

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

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

Healthy Blue Living 7 (HBL7)		Healthy Blue Living 8 (HBL8)	
Enhanced benefits	Standard benefits	Enhanced benefits	Standard benefits
BCN10, C025, 35RP, ER100, UR35, 20%CR 1000D, 2000CM, MHSAP	BCN10, C030, 40RP, ER150, UR50, 30%CR 3000D, 3000CM, MHSAP	BCN10, C030, 40RP, ER150, UR50, 20%CR 2000D, 2000CM, MHSAP	BCN10, C035, 45RP, ER250, UR60, 30%CR, 4000D, 3000CM, MHSAP
Deductible: \$1,000/member; \$2,000/family	Deductible: \$3,000/member; \$6,000/family	Deductible: \$2,000/member; \$4,000/family	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 ¹	Covered in full ¹	Covered in full ¹	Covered in full ¹
20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷	20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷
20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷	20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷
20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷	20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷
\$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 ⁶	30% coinsurance after deductible ⁷	20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷
\$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 ⁶	30% coinsurance after deductible ⁷	20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷
\$25 copay per visit after deductible	\$30 copay per visit after deductible	\$30 copay per visit after deductible	\$35 copay per visit after deductible
20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷	20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷
\$25 copay per visit after deductible	\$30 copay per visit after deductible	\$30 copay per visit after deductible	\$35 copay per visit after deductible
20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷	20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷
20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷	20% coinsurance after deductible ⁶	30% coinsurance after deductible ⁷
45 days per calendar year, 20% coinsurance after deductible ⁶	45 days per calendar year, 30% coinsurance after deductible ⁷	45 days per calendar year, 20% coinsurance after deductible ⁶	45 days per calendar year, 30% coinsurance after deductible ⁷
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

¹ Office visit copay may apply per member, per visit

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

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

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

Healthy Blue Living Rewards (HBLR1)

Blue Care Network Healthy Blue Living Rewards Benefits-at-a-glance	Enhanced BCN10, ER75, UR35, WHC10, IOMHP	Intermediate BCN10, 100V15, UR35, ER75, 10%CR, 1000CM, 250DED, MHSAP Deductible: \$250/member; \$500/family	Standard BCN10, C020, UR50, ER100, 20%CR, 1500CM, 500DED, MHSAP Deductible: \$500/member; \$1,000/family
<i>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.</i>			
Physician office services			
Routine office visits	\$10 copay per visit	\$15 copay per visit	\$20 copay per visit
Consulting specialist care (when referred)	\$10 copay per visit	\$15 copay per visit after deductible	\$20 copay per visit after deductible
Preventive services			
Periodic physical exam	Covered in full	Covered in full	Covered in full
Newborn, well-child assessments and examinations	Covered in full	Covered in full	Covered in full
Immunizations	Covered in full	Covered in full	Covered in full
Mammography screening	Covered in full	Covered in full	Covered in full
Pap smears (lab services)	Covered in full	Covered in full	Covered in full
Prostate specific antigen screening (lab services)	Covered in full	Covered in full	Covered in full
Diagnostic services			
Laboratory tests	Covered in full ¹	Covered in full ¹	Covered in full ¹
Diagnostic tests and x-rays	Covered in full ¹	10% coinsurance after deductible ³	20% coinsurance after deductible ²
High tech imaging	Covered in full ¹	10% coinsurance after deductible ³	20% coinsurance after deductible ²
Radiation therapy	Covered in full ¹	10% coinsurance after deductible ³	20% coinsurance after deductible ²
Maternity services provided by a physician			
Prenatal and postnatal care	\$10 copay per visit	\$15 copay per visit	\$20 copay per visit
Delivery in hospital and well-baby care in hospital	Covered in full	Covered in full after deductible	Covered in full after deductible
Inpatient hospital care			
Number of days of care	Unlimited	Unlimited	Unlimited
In-hospital general nursing care, surgery (including all related surgical services, anesthesia, lab, x-rays and drugs)	Covered in full	10% coinsurance after deductible ³	20% coinsurance after deductible ²
Emergency medical care			
Hospital emergency room (copay waived if admitted)	\$75 copay	\$75 copay after deductible	\$100 copay after deductible
Urgent care center	\$35 copay	\$35 copay	\$50 copay
Ground and air ambulance services (when medically necessary)	\$25 copay	10% coinsurance after deductible ³	20% coinsurance after deductible ²
Mental health care			
Outpatient visits	\$10 copay per visit	\$15 copay per visit after deductible	\$20 copay per visit after deductible
Inpatient psychiatric hospital services (Services covered when authorized by BCN)	Covered in full	10% coinsurance after deductible ³	20% coinsurance after deductible ²
Alcoholism & substance abuse services			
Outpatient treatment	\$10 copay per visit	\$15 copay per visit after deductible	\$20 copay per visit after deductible
Intermediate/residential treatment (Services covered when authorized by BCN)	Covered in full	10% coinsurance after deductible ³	20% coinsurance after deductible ²
Detoxification (Services covered when authorized by BCN)	Covered in full	10% coinsurance after deductible ³	20% coinsurance after deductible ²
Skilled nursing care			
Skilled nursing facility care	45 days per calendar year, covered in full	45 days per calendar year, 10% coinsurance after deductible ³	45 days per calendar year, 20% coinsurance after deductible ²
Other services			
Prothetics, orthotics, corrective appliances and durable medical equipment (when medically necessary)	50% coinsurance	50% coinsurance	50% coinsurance
Infertility counseling/treatment (excluding In-vitro fertilization)	50% coinsurance on all associated costs	50% coinsurance after deductible on all associated costs	50% coinsurance after deductible on all associated costs
Allergy testing, evaluation and serum; injections	50% coinsurance, \$5 injection	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, \$10 copay per visit	Limited to 60 consecutive days per episode, \$15 copay per visit after deductible	Limited to 60 consecutive days per episode, \$20 copay per visit after deductible

¹ Office visit copay may apply per member, per visit

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

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

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

¹ Office visit copay may apply per member, per visit

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

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

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

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

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



Prescription options

Prescription options for BCN5 package, Build-a-plan, Blue Elect Plus, BCN Basic packages and Tiered copay packages
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 for Healthy *Blue* Living plans (pages 10, 11 and 12)
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 options for Healthy *Blue* Living plans 7&8 only (page 13)
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 (pages 14 and 15)
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



(50+ 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**

