



Blue Care Network Non Group (Group Conversion & Individual)

(BCN10, 10OV15, ER50)

Preventive Services

Health Maintenance Exam (Preventive Care)	Covered – \$15 copay
Annual Gynecological Exam (Preventive Care)	Covered – \$15 copay
Pap Smear Screening – laboratory services only	Covered in full when authorized by BCN Physician. Office visit copay may apply.
Well-Baby and Child Care	Covered – \$15 copay
Immunizations	Covered – office visit copay may apply per member, per visit
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered in full when authorized by BCN Physician. Office visit copay may apply.

Mammography

Mammography Screening	Covered in full when authorized by a BCN Physician. Office visit copay may apply.
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Physician Office Services

Office Visits	Covered – \$15 copay
Consulting Specialist Care – when referred	Covered – \$15 copay

Emergency Medical Care

Hospital Emergency Room – approved diagnosis (copay waived if admitted)	Covered – \$50 copay
Physician’s Office	Covered – \$15 copay
Urgent Care Center	Covered – \$10 copay
Ambulance Services – medically necessary	Covered – \$25, ground and air services

Diagnostic Services

Laboratory and Pathology Tests	Covered in full when authorized by a BCN Physician.
Diagnostic Tests and X-rays	Covered in full when authorized by a BCN Physician.
Radiation Therapy	Covered in full when authorized by a BCN Physician.

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – \$15 copay
Delivery and Nursery Care	Covered – 25% of each hospital admission up to a maximum of \$1000 per individual or \$2000 per contract

Hospital Care

Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 25% of each hospital admission up to a maximum of \$1000 per individual or \$2000 per contract
Outpatient Surgery	Covered – 25% of each hospital admission up to a maximum of \$1000 per individual or \$2000 per contract. Other services \$15 per visit.

Alternatives to Hospital Care

Skilled Nursing Care	Covered – limited to 45 days per calendar year
Hospice Care	Covered - \$15 each day a visit occurs
Home Health Care	Covered – \$15 copay when medically necessary

Surgical Services

Surgery – includes all related surgical services and anesthesia See Certificate for specific surgery copay	Covered – 25% of each hospital admission up to a maximum of \$1000 per individual or \$2000 per contract
Voluntary Sterilization	Covered – 50% on all charges including facility charges, professional charges, and ancillary service charges
Human Organ Transplants	Covered – 25% of each hospital admission up to a maximum of \$1000 per individual or \$2000 per contract

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	Mental Health Care: Not Covered Substance Abuse Care: Covered – 50% of all fees associated with facility, professional and related services. One program in any 12-month period.
Outpatient Mental Health Care	Covered – 50%, of the fees for each visit up to 20 visits per calendar year
Outpatient Substance Abuse Care	Covered – 50% of all fees associated with facility, professional and related services

Other Services

Allergy Testing and Therapy	Covered – 50% for testing, serum and related office visits \$5 copay for allergy injections
Chiropractic Spinal Manipulation (when referred)	Covered – \$15 copay
Outpatient Physical, Speech and Occupational Therapy	Covered – \$15 copay, limited to one period of treatment for any combination of therapies within 60 consecutive days is covered per medical episode
Durable Medical Equipment	Covered – 50% of the fee for the equipment
Prosthetic and Orthotic Appliances	Covered – 50% of the fee for the equipment
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% on all associated with infertility diagnostic work-up and treatment
Prescription Drugs	Not covered

Deductible, Copays and Dollar Maximums

Deductible	None
Copays	
• Fixed Dollar Copay	\$5 for allergy injections, \$15 office visits for professional services and outpatient facility services, \$50 ER in hospital, \$10 urgent care visits and \$15 for emergency treatment in physician's office, Inpatient and Outpatient Surgery 25%,
• Percent Copay	50% for select services as noted above
Copay Dollar Maximums	(\$1000 ind, \$2000 contract)
• Fixed Dollar Copay	
• Percent Copay	25% or 50% for select services
Dollar Maximums	(\$1000 ind, \$2000 contract)

* There is no coverage under this Certificate for six months from the effective date of coverage for any pre-existing condition. See Certificate for detailed information.

This is intended as an easy-to-read summary. It is not a contract. An official description of benefits is contained in the Blue Care Network Non Group certificate. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan. Services must be provided or arranged by member's primary care physician or health plan.