

# Benefits-at-a-Glance for Nongroup and Group Conversion



**Blue Care  
Network**  
of Michigan

**MiBCN.com**

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

The information in this document is based on BCN's current interpretation of the Patient Protection and Affordable Care Act (PPACA). 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 BAAG 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.

## Deductible, Copays and Dollar Maximums

<b>Deductible</b>	None
<b>Copays</b>	\$15 for office visits, \$25 for ambulance services, \$10 for urgent care visits, \$50 for emergency room visits and \$5 for allergy injections
• Fixed Dollar Copay	
• Coinsurance	25% and 50% for select services as noted below
<b>Copay Dollar Maximums</b>	
• Fixed Dollar Copay	None
• Coinsurance – Inpatient hospital services and outpatient surgery.	\$1,000 per member, \$2,000 per family per calendar year
• Coinsurance – Inpatient Mental Health Care	\$1,000 per member, \$2,000 per family per calendar year

## Preventive Services

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%

## Mammography

Mammography Screening	Covered – 100%
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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 – copay waived if admitted, inpatient hospital benefits apply	Covered – \$50 copay
Urgent Care Center	Covered – \$10 copay
Ambulance Services – medically necessary	Covered – \$25 copay, ground and air service

## Diagnostic Services

Laboratory and Pathology Tests	Covered – Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered – Office visit copay may apply per member, per visit
Radiation Therapy	Covered – Office visit copay may apply per member, per visit

## Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – \$15 copay
Delivery and Nursery Care	Covered – 100% for professional services. See Hospital Care below for facility charges.

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## Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 75%, with a 25% coinsurance, up to \$1,000 per member, \$2,000 per family per calendar year; unlimited days
Outpatient Surgery	Covered – 75%, with a 25% coinsurance, up to \$1,000 per member, \$2,000 per family per calendar year

## Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100%, up to 45 days per calendar year
Hospice Care	Covered – 100%
Home Health Care	Covered – \$15 copay when medically necessary

## Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 75%, with a 25% coinsurance, up to \$1,000 per member, \$2,000 per family per calendar year
Voluntary Sterilization	Covered – 50% on all associated costs
Human Organ Transplants	Covered – 75%, with a 25% coinsurance, up to \$1,000 per member, \$2,000 per family per calendar year; subject to medical criteria

## Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	<b>Mental Health Care:</b> Not Covered <b>Substance Abuse Care:</b> Covered – 50%, one program of treatment per year
Outpatient Mental Health Care	Covered – 50%, up to 20 visits per calendar year
Outpatient Substance Abuse Care	Covered – 50%, one program of treatment per year <b>Note:</b> A program of treatment may include outpatient or intermediate services or both.

## Other Services

Allergy Testing and Therapy	Covered – 50% for testing, serum and related office visits
Allergy Injections	Covered – \$5 copay
Chiropractic Spinal Manipulation – when referred	Covered – \$15 copay
Outpatient Physical, Speech and Occupational Therapy – subject to significant improvement within 60 days	Covered – \$15 copay, limited to 60 consecutive days per episode for a combination of therapies
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% on all associated costs
Durable Medical Equipment	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%
Weight Reduction	Covered – 50%

BCN10, 100V15, ER50

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