

# Blue Care Network OneBlue<sup>SM</sup> Individual – Benefits-at-a-Glance

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

## Preventive Services

*Pre-existing Conditions Clause	Yes, See Certificate language
Health Maintenance Exam	Covered – \$30 copay
Annual Gynecological Exam	Covered – \$30 copay
Pap Smear Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit
Well-Baby and Child Care	Covered – \$30 copay
Immunizations – pediatric and adult	Covered – Office visit copay may apply per member, per visit
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit

## Mammography

Mammography Screening	Covered – 100%
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## Physician Office Services

Office Visits	Covered – \$30 copay
Consulting Specialist Care – when referred	Covered – \$30 copay after deductible

## Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered – \$100 copay after deductible
Urgent Care Center	Covered – \$35 copay
Ambulance Services – ground and air service when medically necessary	Covered – 80% after deductible, with a 20% coinsurance up to \$5,000 per member, \$10,000 per family per calendar year

## Diagnostic Services

Laboratory and Pathology Tests	Covered - Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered - 80% after deductible, with a 20% coinsurance up to \$5,000 per member, \$10,000 per family, per calendar year
Radiation Therapy	Covered - 80% after deductible, with a 20% coinsurance up to \$5,000 per member, \$10,000 per family, per calendar year

## Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – \$30 copay
Delivery and Nursery Care	Covered – 100% after deductible

## Hospital Care

Semi-Private Room, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible, with a 20% coinsurance up to \$5,000 per member, \$10,000 per family, per calendar year. Unlimited days.
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## Alternatives to Hospital Care

Skilled Nursing Care	Covered - 80% after deductible, with a 20% coinsurance up to \$5,000 per member, \$10,000 per family, 45 days per calendar year
Hospice Care	Covered - 100% after deductible
Home Health Care	Covered – \$30 copay after deductible

### Surgical Services

Surgery – includes all related surgical services and anesthesia – see member certificate for specific surgical copays	Covered - 80% after deductible, with a 20% coinsurance up to \$5,000 per member, \$10,000 per family, per calendar year
Voluntary Sterilization	Covered – 50% after deductible
Human Organ Transplants	Covered - 80% after deductible, with a 20% coinsurance up to \$5,000 per member, \$10,000 per family, per calendar year. Subject to medical criteria

### Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	<p><b>Mental Health Care:</b> Covered – 75%, with a 25% coinsurance up to \$1,000 per member, \$2,000 per family; 30 days per calendar year</p> <p><b>Substance Abuse Care:</b> Covered – 50%, one program of treatment per year, up to state mandated dollar limitation, which is adjusted annually by the state.</p>
Outpatient Mental Health Care	Covered – 50%, 20 visits per calendar year
Outpatient Substance Abuse Care	<p>Covered – 50%, one program of treatment per year, up to state mandated dollar limitation, which is adjusted annually by the state.</p> <p>NOTE: A program of treatment may include outpatient or intermediate services or both.</p>

### Other Services

Allergy Testing and Therapy	Covered – 50% after deductible, \$5 copay for allergy injections
Chiropractic Spinal Manipulation – when referred	Covered – \$30 copay after deductible
Outpatient Physical, Speech and Occupational Therapy	Covered – \$30 copay, limited to 60 consecutive days per episode
Infertility Counseling and Treatment (excludes In-vitro Fertilization)	Covered – 50% after deductible
Durable Medical Equipment	Covered – 50%
Temporomandibular Joint Syndrome (TMJ) Treatment	Covered – 50% after deductible
Prosthetic and Orthotic Appliances	Covered – 50%
Prescription Drugs – includes mail order prescription drugs	\$5 Generic/\$50 Brand with contraceptives, mail order \$10 Generic/\$100 Brand up to 90 day supply; \$2500 benefit max

### Deductible, Copays and Dollar Maximums

<b>Deductible</b>	\$500 per member/\$1,000 per family
<b>Copays</b>	
• Fixed Dollar Copay	\$5 for allergy injections, \$30 office visits, \$35 copay for urgent care visits, \$100 after deductible for emergency room visits,
• Percent Copay	20%, 25% or 50% for services listed above
<b>Copay Dollar Maximums</b>	
• Fixed Dollar Copay	None
• Percent Dollar Copay – Medical Services; excludes services with a 50% copay	\$5,000 individual/ \$10,000 per family per calendar year
• Percent Dollar Copay – Inpatient Mental Health Care	\$1,000 individual/\$2,000 per family
<b>Dollar Maximums</b>	See substance abuse services defined above

BCN10, 30OVIN, 500DIN, 20COIN, 5KMIN, IP10IN, E100IN, UR35IN, 55MCIN, PERCIN