

Benefits-at-a-Glance for Personal Plus – Non Group



**Blue Care
Network**
of Michigan

MiBCN.com

This is intended as an easy-to-read summary. 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.

(Age/Sex Rated) Pre-Existing Guidelines apply

Deductible, Copays and Dollar Maximums

Deductible	None
Copays	\$5 for allergy injections, \$10 office visits for professional services and outpatient facility services, \$35 ER, \$20 urgent care visits and \$10 for emergency treatment in physician's office, \$25 for health and gynecological exam
• Fixed Dollar Copay	
• Percent Copay (Coinsurance)	25% or 50% for select services as noted below
Copay Dollar Maximums	
• Fixed Dollar Copay	None
• Percent Dollar Copay (Coinsurance) – Medical Services; excludes services with a 50% copay	\$1,000 ind./\$2,000 contract (applies to out of pocket max)
Dollar Maximums	Outpatient and Inpatient Substance Abuse limited to a combined maximum aggregate dollar limitation per member per calendar year

Preventive Services

Health Maintenance Exam (Preventive Care)	Covered – \$25 or 50% whichever is less, per exam or assessment
Annual Gynecological Exam (Preventive Care)	Covered – \$25 or 50% whichever is less, per exam or assessment
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 – \$10 copay
Immunizations – pediatric and adult	Covered – \$10 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 – \$10 copay
Consulting Specialist Care – when referred	Covered – \$10 copay

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered – \$35 copay
Urgent Care Center	Covered – \$20 copay
Ambulance Services – medically necessary	Covered – 50%, ground and air service

Diagnostic Services

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

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Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – \$10 copay
Delivery and Nursery Care (includes well baby care in hospital)	Covered – 25% of each hospital admission up to a maximum of \$1000 per individual or \$2000 per contract

Hospital Care

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 \$10 per visit.

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 10% of total charges up to 14 day maximum
Hospice Care	Not Covered
Home Health Care	Covered – \$10 copay limited to 30 consecutive day period per calendar year

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	Not Covered
Human Organ Transplants	Covered – 25% of all charges including facility, professional and ancillary

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	Mental Health Care: Covered –when authorized by a BCN provider in an approved facility. Limited to 14 days per year Substance Abuse Care: Covered – 50% copayment of all costs associated with the authorized care and limited to dollar limitation by state insurance commissioner
Outpatient Mental Health Care	Covered – 50% of charges per visit, limited to 20 visits per member per calendar year
Outpatient Substance Abuse Care	Covered – 50% copayment per visit limited to maximum dollar limitation

Other Services

Allergy Testing and Therapy	Covered – 50% for evaluation and testing only
Allergy Injections	Covered – \$5 copay - Serum is not covered
Chiropractic Spinal Manipulation – when referred	Covered – \$10 copay
Outpatient Physical, Speech and Occupational Therapy – subject to significant improvement within 60 days	Covered – \$10 office visit copay - limited to 30 consecutive day period of treatment per condition per calendar year
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Not Covered
Durable Medical Equipment	Not Covered
Prosthetic and Orthotic Appliances	Covered when such prosthetic appliances are medically necessary and surgically attached or implanted during authorized surgery

BCN5, CO10, ER50, FCR

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* 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.