



**Blue Care  
of Michigan, Inc.**

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 of Michigan certificates and riders. Payment amounts are based on the Blue Care of Michigan 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.

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.

(Age/sex rated) pre-existing guidelines apply

### Deductible, Copays and Dollar Maximums

<b>Deductible</b>	None
<b>Copays</b>	\$5 for allergy injections, \$10 for office visits, \$20 for urgent care visits, \$25 for health and gynecological exam and \$35 for emergency room visits
• Fixed dollar copay	
• Percent copay (coinsurance)	10%, 25% or 50% for select services as noted below
<b>Copay Dollar Maximums</b>	
• Fixed dollar copay	None
• Percent dollar copay (coinsurance) – medical services; excludes services with a 50% coinsurance	\$1,000 per individual / \$2,000 per contract for inpatient hospital services and outpatient surgery
<b>Dollar Maximums</b>	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 in full.
Annual gynecological exam (preventive care)	Covered in full.
Pap smear screening – laboratory services only	Covered in full.
Well-baby and child care	Covered in full.
Immunizations – pediatric and adult	Covered in full.
Prostate specific antigen (PSA) Screening – laboratory services only	Covered in full.

### Mammography

Mammography screening	Covered in full.
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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. Office visit copay may apply
Diagnostic tests and X-rays	Covered in full. Office visit copay may apply.
Radiation therapy	Covered in full. Office visit copay may apply.



**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 in full for professional services; see hospital care below for facility charges.

**Hospital Care**

Inpatient physician care, general nursing care, hospital services and supplies	Covered – 75% with 25% coinsurance per hospital admission up to a maximum of \$1,000 per individual or \$2,000 per contract; unlimited days
Outpatient surgery	Covered – 75% with 25% coinsurance per hospital admission up to a maximum of \$1,000 per individual or \$2,000 per contract

**Alternatives to Hospital Care**

Skilled nursing care	Covered – 90% with a 10% coinsurance; 14 day maximum per calendar year. Does not apply to the hospital coinsurance maximum
Hospice care	Covered in full
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	Covered – 75% with 25% coinsurance per hospital admission up to a maximum of \$1,000 per individual or \$2,000 per contract
Voluntary sterilization	<b>Not Covered</b>
Human organ transplants (subject to medical criteria)	Covered – 75% with 25% coinsurance per hospital admission up to a maximum of \$1,000 per individual or \$2,000 per contract, professional and ancillary

**Mental Health Care and Substance Abuse Treatment**

Inpatient mental health care and substance abuse care	<b>Mental Health Care:</b> Covered – 75% with 25% coinsurance when authorized. Limited to 14 days per calendar year. Does not apply to hospital coinsurance maximum. <b>Substance Abuse Care:</b> Covered – 50% Does not apply to hospital coinsurance maximum.
Outpatient mental health care	Covered – 50% limited to 20 visits per member per calendar year. Does not apply to hospital coinsurance maximum.
Outpatient substance abuse care	Covered – 50% Does not apply to hospital coinsurance maximum.

**Other Services**

Allergy testing, therapy and office visits	Covered – 50% for evaluation and testing only
Allergy injections	Covered – \$5 copay - Serum is <b>not</b> 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 (including in-vitro fertilization)	<b>Not Covered</b>
Durable medical equipment	<b>Not Covered</b>
Prosthetic and orthotic appliances	Covered in full when such prosthetic appliances are medically necessary and surgically attached or implanted during authorized surgery
Weight Reduction	Covered – 50%