

Blue Care Network Benefits-at-a-Glance Deductible Package DED 2

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 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

Health Maintenance Exam	Covered – \$15 copay
Annual Gynecological Exam	Covered – \$15 copay
Pap Smear Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit
Well-Baby and Child Care	Covered – \$15 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 – Office visit copay may apply per member, per visit
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Physician Office Services

Office Visits	Covered – \$15 copay
Consulting Specialist Care – when referred for other than preventive services	Covered – \$15 copay after deductible

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted, inpatient hospital benefits apply	Covered – \$75 copay after deductible
Urgent Care Center	Covered – \$35 copay
Ambulance Services – medically necessary	Covered – 80% after deductible, ground and air service, with a 20% copay up to \$1,500 per member, \$3,000 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% copay up to \$1,500 per member, \$3,000 per family per calendar year
Radiation Therapy	Covered – 80% after deductible, with a 20% copay up to \$1,500 per member, \$3,000 per family per calendar year

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – \$15 copay
Delivery and Nursery Care	Covered – 80% after deductible, with a 20% copay up to \$1,500 per member, \$3,000 per family per calendar year

Hospital Care

Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 80% after deductible, with a 20% copay up to \$1,500 per member, \$3,000 per family per calendar year; unlimited days
Outpatient Surgery – see member certificate for specific surgical copay	Covered – 80% after deductible, with a 20% copay up to \$1,500 per member, \$3,000 per family per calendar year

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 80% after deductible, up to 45 days per calendar year; 20% copay up to \$1,500 per member, \$3,000 per family per calendar year
Hospice Care	Covered – 80% after deductible, with a 20% copay up to \$1,500 per member, \$3,000 per family per calendar year
Home Health Care	Covered – \$15 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% copay up to \$1,500 per member, \$3,000 per family per calendar year
Voluntary Sterilization	Covered – 50% after deductible on all associated costs
Human Organ Transplants	Covered – 80% after deductible, with a 20% copay up to \$1,500 per member, \$3,000 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>Mental Health Care: Covered – 75%, with a 25% copay, up to \$1,000 per member, \$2,000 per family per calendar year, up to 30 days per calendar year</p> <p>Substance Abuse Care: 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%, up to 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
Allergy Injections	Covered – \$5 copay
Chiropractic Spinal Manipulation – when referred	Covered – \$15 copay after deductible
Outpatient Physical, Speech and Occupational Therapy – subject to significant improvement within 60 days	Covered – \$15 copay after deductible, limited to 60 consecutive days per episode
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%

Deductible, Copays and Dollar Maximums

Deductible	\$500 per member / \$1,000 per family per calendar year
Copays	
• Fixed Dollar Copay	\$15 for office visits, \$35 for urgent care visits, \$75 for emergency room visits and \$5 for allergy injections
• Percent Copay	20%, 25% and 50% for select services as noted above
Copay Dollar Maximums	
• Fixed Dollar Copay	None
• Percent Dollar Copay – Medical Services; excludes services with a 50% copay	\$1,500 per member, \$3,000 per family per calendar year
• Percent Dollar Copay – Inpatient Mental Health Care	\$1,000 per member, \$2,000 per family per calendar year
Dollar Maximums	Applies only to Substance Abuse dollar limitation, adjusted annually by the state

The **Deductible** is applicable to all covered services except (1) **preventive services** provided by the member's PCP; (2) **preventive services** obtained as a result of referral from the PCP; (3) routine maternity care; and (4) services paid by a provider or vendor under the delegation of a claim payment arrangement