



An individual health plan from Blue Care Network of Michigan.

This is an easy-to-read description of some of the most frequently used benefits and provides only a general overview of your benefits. 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.

Benefit Highlights	
Annual deductible	\$500 per individual contract per calendar year. \$1,000 per family contract (two or more members) per calendar year.
Copays	
<ul style="list-style-type: none"> Fixed dollar copay 	\$5 for allergy injections, \$30 office visits, \$35 for urgent care visits, \$100 for emergency room visits.
<ul style="list-style-type: none"> Percent copay 	20%, 25% or 50% for specific services defined below
Annual maximums	
<ul style="list-style-type: none"> Fixed dollar copay 	None
<ul style="list-style-type: none"> Percent dollar copay for medical services; excludes services with a 50% copay 	\$5,000 per individual contract per calendar year. \$10,000 per family contract (two or more members) per calendar year.
<ul style="list-style-type: none"> Percent dollar copay – inpatient mental health care 	\$1,000 per individual contract. \$2,000 per family contract (two or more members).
Lifetime maximum	None
Preventive Services	
Pre-existing conditions clause	All benefits are subject to a 180-day waiting period for pre-existing conditions.
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
Pediatric and adult immunizations	Covered – Office visit copay may apply per member, per visit
Prostate specific antigen screening (laboratory services only)	Covered – Office visit copay may apply per member, per visit
Mammography screening	Covered – 100%
Physician Office Services	
Office visits	Covered – \$30 copay; deductible applies for speciality care
Consulting specialist care	Covered (if referred) – \$30 copay after deductible
Emergency Medical Care	
Hospital emergency room	Covered – \$100 copay after deductible; copay waived if admitted; inpatient copay will apply
Urgent care	Covered – \$35 copay
Ambulance service: medically necessary, emergency ground transport and air ambulance	Covered – 80% after deductible
Diagnostic Services	
Laboratory tests and pathology	Covered – Office visit copay may apply per member, per visit
Diagnostic tests and X-rays	Covered – 80% after deductible
Radiation therapy	Covered – 80% after deductible

Maternity Services Provided by a Physician	
Pre and postnatal care	Covered – \$30 copay
Delivery and nursery care	Covered – 100% after deductible
Inpatient Hospital Care	
Semi-private room, general nursing care, hospital services and supplies	Covered – 80% after deductible; unlimited days
Surgical Services	
Surgery includes all related surgical services and anesthesia. See member certificate for specific surgical copays.	Covered – 80% after deductible
Voluntary sterilization	Covered – 50% after deductible
Human organ transplants	Covered – 80% after deductible; subject to medical criteria
Alternatives to Hospital Care	
Skilled nursing care	Covered – 80% after deductible; 45 days per calendar year
Hospice care	Covered – 100% after deductible
Home health care	Covered – \$30 copay after deductible
Other Medical Benefits	
Allergy testing and therapy	Covered – 50% after deductible, \$5 copay for allergy injections
Chiropractic spinal manipulation	Covered (if referred) – \$30 copay after deductible
Outpatient physical, speech and occupational therapy	Covered – \$30 copay after deductible; limited to 60 consecutive days per episode for a combination of therapies
Infertility counseling and treatment (excludes in-vitro fertilization)	Covered – 50% after deductible
Durable medical equipment	Covered – 50%
Temporomandibular Joint Syndrome Treatment	Covered – 50% after deductible
Prosthetic and orthotic appliances	Covered – 50%
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; 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%, 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 immediate services or both.</p>
Prescription Drugs	
Includes mail-order prescription drugs	<p>\$5 generic and \$50 brand retail copay with contraceptives and mail order</p> <p>\$10 generic and \$100 brand copay up to 90-day supply; \$2,500 benefit maximum</p>