Smart Select℠

An individual health plan from Blue Care Network of Michigan.

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 Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance 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 benefit summary 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.

NOTE: The deductible will apply to certain services as defined below.

Benefit Highlights	
Annual deductible	
(other than maternity)	$1,500 per member / $3,000 per family per calendar year, **or** $2,500 per member / $5,000 per family per calendar year, **or** $5,000 per member / $10,000 per family per calendar year
Maternity deductible	$3,000 per member per calendar year
Copay/Coinsurance	
• Fixed dollar copay	$30 for office visits, $35 for urgent care visits, $200 after deductible for emergency room visits and $5 for allergy injections
• Coinsurance	20% and 50% for select services as noted below
Copay/coinsurance dollar maximums	
• Fixed dollar copay	None
• Coinsurance for medical services; excludes services with a 50% coinsurance	$5,000 individual / $10,000 per family, per calendar year
Dollar maximums	None
Preventive Services	
Preventive medical and immunizations	**Covered –** 100% with no deductible, copay or coinsurance. Includes: health maintenance exam, select laboratory services, gynecologic exam, Pap smear screening, prostate specific antigen screening, well-baby and well-child exams and other adult preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCN that are in compliance with the provisions of the Patient Protection and Affordable Care Act.
Mammography screening	**Covered –** 100%
Physician Office Services	
Office visits	**Covered –** $30 copay
Consulting specialist care – when referred for other than preventive services	**Covered –** $30 copay after deductible

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Emergency Medical Services	
Hospital emergency room – copay waived if admitted	**Covered –** $200 copay after deductible
Urgent care center	**Covered –** $35 copay
Ambulance services – medically necessary	**Covered –** 80% after deductible, ground and air service, 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- and post-natal visits	**Covered –** $30 copay after maternity deductible
Delivery and newborn care	**Covered –** 100% after maternity deductible for professional services. 20% coinsurance after maternity deductible for facility charges up to $5,000 per member, $10,000 per family per calendar year
Hospital Care	
General nursing care, hospital services and supplies	**Covered –** 80% after deductible, with 20% coinsurance up to $5,000 per member, $10,000 per family per calendar year. Unlimited days. **NOTE:** maternity deductible applies to delivery and nursery care
Alternatives to Hospital Care	
Skilled nursing care	**Covered –** 80% after deductible, up to 45 days per calendar year; 20% coinsurance up to $5,000 per member, $10,000 per family 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	Not covered
Pregnancy termination	Not covered
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	**Mental health care:** Not covered **Substance abuse care:** **Covered –** 50% after deductible, limited to one program of treatment per year
Outpatient mental health care	**Covered –** 50% after deductible, up to 20 visits per calendar year
Outpatient substance abuse care	**Covered –** 50% after deductible, limited to one program of treatment per year **Note:** A program of treatment may include outpatient or intermediate services or both.
Other Services	
Allergy testing and therapy	**Covered –** 50% after deductible
Allergy injections	**Covered –** $5 copay
Chiropractic spinal manipulation – when referred	**Covered –** $30 copay after deductible
Outpatient physical, speech and occupational therapy – subject to significant improvement within 60 days	**Covered –** $30 copay after deductible, limited to 60 consecutive days per episode for a combination of therapies
Infertility treatment including infertility drugs	Not covered
Durable medical equipment	Not covered
Diabetic supplies	**Covered –** 50%
Prosthetic and orthotic appliances	Not covered, with the exception of internal prosthetic devices and breast prosthesis resulting from a medically necessary mastectomy
Temporomandibular joint syndrome treatment	**Covered –** 50% after deductible
Prescription drugs – includes mail order prescription drugs and contraceptives	$4 copay generic, $60 copay brand, 75% coinsurance for drugs not on the Savings Plus drug list. Mail order 2X copay up to 90 day supply: $8 copay generic, $120 copay brand, 75% coinsurance for drugs not on the Savings Plus drug list

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