



## An individual HMO 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, 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 BAAG is only an educational tool and should not be relied upon as legal or compliance advice.

### Benefit Highlights

<b>Pre-existing conditions clause</b>	For individuals 19 years of age and older: <ul style="list-style-type: none"> <li>This product is subject to medical underwriting.</li> <li>All benefits, except preventive care, are subject to a 180-day waiting period for pre-existing conditions.</li> </ul>
<b>Annual deductible</b>	\$500 per individual, \$1,000 per family per calendar year.
<b>Copays/Coinsurance</b>	
<ul style="list-style-type: none"> <li><b>Fixed dollar copay</b></li> </ul>	\$5 for allergy injections, \$30 office visits, \$35 for urgent care visits, \$100 for emergency room visits.
<ul style="list-style-type: none"> <li><b>Coinsurance</b></li> </ul>	20%, 25% or 50% for specific services defined below
<b>Annual maximums</b>	
<ul style="list-style-type: none"> <li><b>Fixed dollar copay</b></li> </ul>	None
<ul style="list-style-type: none"> <li><b>Coinsurance for medical services; excludes services with a 50% coinsurance</b></li> </ul>	\$5,000 per individual, \$10,000 per family per calendar year.
<ul style="list-style-type: none"> <li><b>Coinsurance for inpatient mental health care</b></li> </ul>	\$1,000 per individual, \$2,000 per family per calendar year.
<b>Annual out-of-pocket maximum.</b> <b>The annual out-of-pocket maximum limits the amount members are responsible for paying each year. Once the annual out-of-pocket maximum is met, most services are payable at 100% of the BCN-approved amount.</b>	\$5,500 per individual, \$11,000 per family for medical services. \$1,000 per individual, \$2,000 per family for inpatient mental health services. Excludes services with 50% coinsurance and flat dollar copay.
<b>Lifetime maximum</b>	None
<b>Fourth-quarter carryover</b>	Any amount you pay toward your deductible during the last three months of the calendar year will be applied to your deductible for the following calendar year. We will not apply amounts paid under other contracts toward your deductible.

### Preventive Services

<b>Preventive medical and immunizations</b>	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 BCBSM and BCN that are in compliance with the provisions of the Patient Protection and Affordable Care Act.
<b>Mammography screening</b>	Covered – 100% with no deductible

### Physician Office Services

<b>Office visits</b>	Covered – \$30 copay; specialty care covered after deductible
<b>Consulting specialist care</b>	Covered – \$30 copay after deductible; must be referred

### Emergency Medical Care

<b>Medical emergencies and accidental injuries</b>	Covered – \$100 copay after deductible; copay waived if admitted; inpatient benefit will apply
<b>Urgent care</b>	Covered – \$35 copay
<b>Ambulance service: medically necessary, emergency ground transport and air ambulance</b>	Covered – 80% after deductible

<b>Diagnostic Services</b>	
Ultrasounds, laboratory tests, pathology, EKGs, diagnostic radiology and x-rays	Covered – 80% after deductible. Pre-natal ultrasound, lab and pathology and screening EKGs covered 100%; deductible does not apply
Colonoscopy(diagnostic)	Covered – 80% after deductible
CT Scans and MRIs	Covered – 80% after deductible
Radiation therapy	Covered – 80% after deductible
<b>Maternity Services Provided by a Physician</b>	
Pre and postnatal care	Covered – \$30 copay per visit
Delivery and newborn care	Covered – 100% after deductible for services provided by a physician Facility charges covered 80% after deductible.
<b>Inpatient Hospital Care</b>	
Semi-private room, general nursing care, hospital services and supplies	Covered – 80% after deductible; unlimited days
<b>Surgical Services</b>	
Surgery includes all related surgical services and anesthesia. See member certificate for specific surgical coinsurance.	Covered – 80% after deductible
Voluntary sterilization	Covered – 50% after deductible
Human organ transplants	Covered – 80% after deductible; subject to medical criteria
<b>Alternatives to Hospital Care</b>	
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
<b>Other Medical Benefits</b>	
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% with no deductible
Temporomandibular Joint Syndrome Treatment	Covered – 50% after deductible
Prosthetics: mandated only	Covered – 50% with no deductible
<b>Mental Health Care and Substance Abuse Treatment</b>	
Inpatient mental health care and substance abuse care	<b>Mental Health Care:</b> Covered – 75% with no deductible up to \$1,000 per member; \$2,000 per family per calendar year; 30 days per calendar year <b>Substance Abuse Care:</b> Covered – 50% with no deductible. One program of treatment per 12 month period.
Outpatient mental health care	Covered – 50%, 20 visits per calendar year
Outpatient substance abuse care	Covered – 50%, one program of treatment per 12 month period. <b>NOTE:</b> A program of treatment may include outpatient or immediate services or both.
<b>Prescription Drugs</b>	
Includes mail-order prescription drugs	\$5 generic and \$50 brand retail copay with contraceptives and mail order for a 30 day supply 83-90 day retail supply – \$10 generic and \$100 brand copay 31 - 90 mail order supply – \$10 generic and \$100 brand copay.