

Benefits-at-a-Glance for BCN Basic Package Plan



**Blue Care
Network**
of Michigan

MiBCN.com

This is intended as an easy-to-read summary. 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 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.

Deductible, Copays and Dollar Maximums

Deductible	None
Copays	
• Fixed Dollar Copay	\$25 for PCP office visits, \$35 referral physician visit, \$35 for urgent care visits, \$50 for ambulance services, \$100 for emergency room visits and \$5 for allergy injections
• Percent Copay (Coinsurance)	20% and 50% for select services as noted below
Copay Dollar Maximums	
• Fixed Dollar Copay	None
• Percent Dollar Copay (Coinsurance) – Medical Services; excludes services with a 50% copay	\$1,500 per member, \$3,000 per family per calendar year
Dollar Maximums	Applies only to Substance Abuse dollar limitation, adjusted annually by the state

Preventive Services

Health Maintenance Exam	Covered – \$25 copay*
Annual Gynecological Exam if Performed by PCP	Covered – \$25 copay*
Pap Smear Screening – laboratory services only	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family. Office visit copay may apply per member, per visit
Well-Baby and Child Care	Covered – \$25 copay*
Immunizations – pediatric and adult	Covered – \$25 copay *
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family. Office visit copay may apply per member, per visit

Mammography

Mammography Screening	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family. Office visit copay may apply per member, per visit
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Physician Office Services

Office Visits	Covered – \$25 copay*
Consulting Specialist Care – when referred for other than preventive services	Covered – \$35 copay*

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted, inpatient hospital benefits apply	Covered – \$100 copay*
Urgent Care Center	Covered – \$35 copay*
Ambulance Services – medically necessary	Covered – \$50 copay applies to the annual maximum of \$1,500 per member, \$3,000 per family

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Diagnostic Services

Laboratory and Pathology Tests	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family. Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family. Office visit copay may apply per member, per visit
Radiation Therapy	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family. Office visit copay may apply per member, per visit

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – \$25 copay*
Delivery and Nursery Care	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family
Outpatient Surgery – see member certificate for specific surgical copays	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family. Office visit copay may apply per member, per visit

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family
Hospice Care	Covered – 100%
Home Health Care	Covered – 80%, limited to a 60-day period per calendar year; 20% copay applies to the annual maximum of \$1,500 per member, \$3,000 per family

Surgical Services

Surgery – includes all related surgical services and anesthesia. See member certificate for specific surgical copays.	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family
Voluntary Sterilization	Covered – 50%* on all associated costs
Human Organ Transplants	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	Mental Health Care: Covered – 50%*, up to 14 days per calendar year Substance Abuse Care: Covered – 50%*, up to state mandated dollar limitation which is adjusted annually by the state
Outpatient Mental Health Care	Covered – 50%*, up to 20 visits per calendar year
Outpatient Substance Abuse Care	Covered – 50%*, up to state mandated dollar limitation which is adjusted annually by the state

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Other Services

Allergy Testing and Therapy	Covered – 50% for evaluation
Allergy Injections	Covered – \$5 copay
Chiropractic Spinal Manipulation – when referred	Covered – \$35 copay*
Outpatient Physical, Speech and Occupational Therapy – subject to significant improvement within 60 days	Covered – 50%, up to 30 visits for a 60-day period; 50% copay applies to the annual maximum of \$1,500 per member, \$3,000 per family
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% on all associated costs*
Durable Medical Equipment	Covered – 50%*
Prosthetic and Orthotic Appliances	Covered – 50%*

*Copay does not apply to Annual Copayment Maximum

BCN-BASIC, BAS25, 35RPOV, UR35, ER100, FCR

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