Benefits-at-a-Glance for Deductible Options with 20% Coinsurance

Blue Care Network of Michigan

MiBCN.com

Deductible Package 3

Client: JBL

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 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. 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.

Deductible, Copays and Dollar Maximums

Deductible	$1,000 per member; $2,000 per contract per calendar year
Copays • Fixed Dollar Copay	$5 for allergy injections, $30 for office visits, $45 for specialist office visits, $50 for urgent care visits, $150 for emergency room visits and $150 for high tech imaging.
• Coinsurance	20% and 50% for selected services as noted below
Copay/Coinsurance Dollar Maximums	
• Fixed Dollar Copay	None
• Coinsurance – excludes services with 50% coinsurance	$1,500 per member/$3,000 per contract per calendar year
Dollar Maximums	None

Preventive Services

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening	Covered – 100%

Mammography

Mammography Screening	Covered – 100%

Physician Office Services

Office Visits	Covered – $30 copay
Consulting Specialist Care – when referred	Covered – $45 copay

Emergency Medical Care

Hospital Emergency Room (copay waived if admitted)	Covered – $150 copay after deductible
Urgent Care Center	Covered – $50 copay
Ambulance Services – medically necessary	Covered – 80% after deductible, ground and air service

Diagnostic Services

Laboratory and Pathology Tests	Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered – 80% after deductible
High Tech Imaging	Covered - $150 copay after deductible
Radiation Therapy	Covered – 80% after deductible

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – $30 copay
Delivery and Nursery Care	Covered – 100% after deductible for professional charges. See Hospital Care for facility charges

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Hospital Care

Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 80% after deductible, unlimited days
Outpatient Facility visits	$10 copay after deductible
Outpatient Surgery – see member certificate for specific surgical coinsurance	Covered – 80% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered - 80% after deductible, up to 45 days per calendar year
Hospice Care	Covered – 100% after deductible
Home Health Care	Covered – $45 copay after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia.	See Hospital Care for inpatient and outpatient copay
Voluntary Sterilization	Covered – 50% after deductible on all associated cost
Human Organ Transplants	Covered – 80% after deductible; subject to medical criteria

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	**Mental Health Care**: Covered – 80% after deductible **Substance Abuse Care:** Covered – 80% after deductible
Outpatient Mental Health Care	Covered – $30 copay after deductible
Outpatient Substance Abuse Care	Covered – $30 copay after deductible

Other Services

Allergy Testing and Therapy	Covered – 50% after deductible
Allergy Injections	Covered – $5
Chiropractic Spinal Manipulation – when referred	Covered – $45 copay
Outpatient Physical, Speech and Occupational Therapy – subject to significant improvement within 60 days	Covered – $45 copay per visit after deductible. One period of treatment for any combination of therapies within 60 consecutive days per medical 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%
Weight Reduction Procedures	Covered – 50% after deductible

BCN10, 1000D , 20%CR, 1500CM, CO30, 45RP, ER150, UR50, IMG150, WDRPOV, MHSAP

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Covered Services

Formulary Drug – Generic	Covered – $15 copay
Formulary Drug – Brand Name	Covered – $50 copay
Formulary Brand Name when Generic is available	Covered – Difference in cost between brand name drug and generic drug plus $50
Non-Formulary Drugs	Covered – 50% with $70 minimum copay and $100 maximum copay
Sexual Dysfunction Drugs	Covered – 50%
Contraceptives	Covered – Applicable generic, brand or non-formulary copay will apply
Retail – 90 day supply	Covered – $30 copay generic, $100 copay brand, and 50% copay non-formulary with a minimum of $140 and maximum of $200. Sexual Dysfunction drugs 50%.
Mail Order Prescription Drugs	Covered – $30 copay generic, $100 copay brand, and 50% copay non-formulary with a minimum of $140 and maximum of $200 up to a 90 day supply. Sexual Dysfunction drugs 50%.

Definitions

BCN Formulary	A list of all prescription drugs which have been approved for use by BCN and which shall be dispensed through participating pharmacies to members.
Brand Name Drugs	Prescription drugs which are manufactured and marketed under a registered trade name or trademark.
Covered Drugs	Prescription drugs (Generic, Brand Name, Compounded Medication, or Health Habit) which are prescribed by a BCN affiliated provider and obtained through a participating pharmacy. Certain covered drugs are a benefit only if a BCN affiliated provider certifies to BCN and BCN agrees that the covered drug in question is medically necessary. Those drugs are not payable without preauthorization by BCN.
Generic Drugs	Prescription drugs which have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark.
Mail Order Prescription Drugs	Up to a 90-day supply of covered drugs
Participating Pharmacy	A network of licensed pharmacies selected by or authorized by BCN

