Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Client: MARTIN LUTHER KING JR

Benefits-at-a-Glance for Healthy *Blue* Living HMO Gold $1500℠

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.

Healthy *Blue* Living℠ members (subscribers and covered spouse) must complete program requirements within the first 90 days of enrollment or re-enrollment. To qualify for or maintain enhanced benefits, members need to complete a health risk appraisal and qualification form during the first 90 days and follow their primary care physician's recommendations for a healthy lifestyle. Members who use tobacco must enroll in BCN's smoking cessation program, Quit the Nic, within 120 days of enrollment or re-enrollment. Members with a BMI of 30 or above must choose one of two BCN-sponsored weight management programs (Weight Watchers or Walking Spree Pedometer) within 120 days of enrollment or re-enrollment.

	Enhanced Benefits	**Standard Benefits**
	CLSSSM, D1500, WDRPOV, CI20%, 3500PM, CO20, 30RP, ER150, UR35, IMG150, DSR20%, VACR50, PVSN, P415CS, 90D3X	**CLSSSM, D4000, WDRPOV, CI30%, 6350PM, CO35, 45RP, ER250, UR50, IMG150, DSR30%, VACR50, PVSN, P625CS, 90D3X**
Member's Responsibility: Deductible, Copays, Coinsurance and Dollar Maximums **Note:** The **Deductible** will apply to certain services as defined below.		
Deductible **Note:** Coinsurance and select fixed dollar copays apply once the deductible has been met.	$1,500 per individual/$3,000 per family per calendar year	$4,000 per individual/$8,000 per family per calendar year
Fixed dollar copays	$20 for office visits, $30 for specialist visits, $35 for urgent care visits, $150 for emergency room visits, $150 for high tech imaging and $5 for allergy injections	$35 for office visits, $45 for specialist visits, $50 for urgent care visits, $250 for emergency room visits, $150 for high tech imaging and $5 for allergy injections
Coinsurance	20% and 50% for select services as noted below	30% and 50% for select services as noted below
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays	$3,500 per member/$7,000 per family per calendar year	$6,350 per member/$12,700 per family per calendar year
Preventive Services – as defined by the Affordable Care Act and included in your Certificate of Coverage		
Health Maintenance Exam	Covered – 100%	Covered – 100%
Annual Gynecological Exam	Covered – 100%	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%	Covered – 100%
Well-Baby and Child Care	Covered – 100%	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%	Covered – 100%

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Preventive Services – as defined by the Affordable Care Act and included in your Certificate of Coverage		
Routine Colonoscopy	Covered – 100%	Covered – 100%
Mammography Screening	Covered – 100%	Covered – 100%
Voluntary Female Sterilization	Covered – 100%	Covered – 100%
Breast Pumps (DME guidelines apply. Limited to no more than one per 24 month period)	Covered – 100%	Covered – 100%
Maternity Pre-Natal Care	Covered – 100%	Covered – 100%
Physician Office Services		
PCP Office Visits	Covered – $20 copay	Covered – $35 copay
Consulting Specialist Care – when referred for other than preventive services	Covered – $30 copay	Covered – $45 copay
Emergency Medical Care		
Hospital Emergency Room – copay waived if admitted	Covered – $150 copay after deductible	Covered – $250 copay after deductible
Urgent Care Center	Covered – $35 copay	Covered – $50 copay
Ambulance Services – medically necessary	Covered – 80% after deductible	Covered – 70% after deductible
Diagnostic Services		
Laboratory and Pathology Tests	Covered – 100%	Covered – 100%
Diagnostic Tests and X-rays	Covered – 80% after deductible	Covered – 70% after deductible
High Technology Imaging (MRI, CAT, PET)	Covered – $150 copay after deductible	Covered – $150 copay after deductible
Radiation Therapy	Covered – 80% after deductible	Covered – 70% after deductible

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Maternity Services Provided by a Physician		
Post-Natal Care. See Preventive Services section for Pre-Natal Care	Covered – $20 copay	Covered – $35 copay
Delivery and Nursery Care	Covered – 100% after deductible for professional services; see Hospital Care for facility charges	Covered – 100% after deductible for professional services; see Hospital Care for facility charges
Hospital Care		
General Nursing Care, Hospital Services and Supplies	Covered – 80% after deductible; unlimited days	Covered – 70% after deductible; unlimited days
Outpatient Surgery – See member certificate for select surgical coinsurance	Covered – 80% after deductible	Covered – 70% after deductible
Alternatives to Hospital Care		
Skilled Nursing Care	Covered – 80% after deductible up to 45 days per calendar year	Covered – 70% after deductible up to 45 days per calendar year
Hospice Care	Covered – 100% after deductible when authorized	Covered – 100% after deductible when authorized
Home Health Care	Covered – $30 copay after deductible	Covered – $45 copay after deductible
Surgical Services		
Surgery – includes all related surgical services and anesthesia.	Covered – 80% after deductible	Covered – 70% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – 50% after deductible	Covered – 50% after deductible
Elective Abortion (One procedure per two year period of membership)	Covered – 50% after deductible	Covered – 50% after deductible
Human Organ Transplants (subject to medical criteria)	Covered – 80% after deductible	Covered – 70% after deductible
Reduction mammoplasty (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 50% after deductible	Covered – 50% after deductible

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Mental Health Care and Substance Abuse Treatment		
Inpatient Mental Health Care	Covered – 80% after deductible	Covered – 70% after deductible
Inpatient Substance Abuse Care	Covered – 80% after deductible	Covered – 70% after deductible
Outpatient Mental Health Care	Covered – $20 copay	Covered – $35 copay
Outpatient Substance Abuse Care	Covered – $20 copay	Covered – $35 copay
Autism Spectrum Disorders, Diagnoses and Treatment		
Applied behavioral analyses (ABA) treatment Limited to 25 hours per week for line therapy for children through age 18	Covered – $20 copay	Covered – $35 copay
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18 Physical, speech and occupational therapy for autism spectrum disorder is unlimited.	Covered – $30 copay after deductible	Covered – $45 copay after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit	See your outpatient mental health benefit and medical office visit benefit
Other Services		
Allergy Testing and Therapy	Covered – 50% after deductible	Covered – 50% after deductible
Allergy Injections	Covered – $5 copay	Covered – $5 copay
Chiropractic Spinal Manipulation – when referred	Covered – $30 copay; up to 30 visits per calendar year	Covered – $45 copay; up to 30 visits per calendar year
Rehabilitative Services – subject to meaningful improvement within 90 days • Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year • Outpatient Speech Therapy – limited to 30 visits per calendar year	Covered – $30 copay after deductible	Covered – $45 copay after deductible

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Habilitative Services • Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year Outpatient Speech Therapy – limited to 30 visits per calendar year	Covered – $30 copay after deductible	Covered – $45 copay after deductible
Outpatient Cardiac and Pulmonary Rehabilitation	Covered – $30 copay after deductible; limited to a benefit maximum of 30 visits per calendar year	Covered – $45 copay after deductible; limited to a benefit maximum of 30 visits per calendar year
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible on all associated costs	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%	Covered – 50%
Diabetic Supplies	Covered – 80%	Covered – 70%
Pediatric Vision • Eye Exam – Limited to once per calendar year for members up to the age of 19 • Prescription Glasses – Frames (chosen from a select collection) and lenses are covered once per calendar year for members up to the age of 19	Covered – 100%	Covered – 100%
Prescription Drugs	Covered – • Tier 1A - $4 copay, Tier 1B - $15 copay, Tier 2 - $40 copay, Tier 3 - $80 copay, Tier 4 – 20% coinsurance (Max $200), Tier 5 – 20% coinsurance (Max $300); 30 day supply. • Excludes drugs for the treatment of sexual dysfunction, weight loss, cough & cold • 90 day supply for mail order and retail: Three times applicable copay less $10. • Contraceptives - Tier 1A – 100%, Tier 1B – $15 copay, Tier 2 - $40 copay, Tier 3 - $80 copay • Preventive Drugs covered in full	Covered – • Tier 1A - $6 copay, Tier 1B - $25 copay, Tier 2 - $50 copay, Tier 3 - $80 copay, Tier 4 – 20% coinsurance (Max $200), Tier 5 – 20% coinsurance (Max $300); 30 day supply. • Excludes drugs for the treatment of sexual dysfunction, weight loss, cough & cold • 90 day supply for mail order and retail: Three times applicable copay less $10. • Contraceptives - Tier 1A – 100%, Tier 1B – $25 copay, Tier 2 - $50 copay, Tier 3 - $80 copay • Preventive Drugs covered in full