

High Deductible Health Plan



**Blue Care
Network**
of Michigan

MIBCN.com

\$2,000 High Deductible Health Plan with 0 Coinsurance and \$10/\$40/\$80 Prescription Drug Coverage

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, Coinsurance and Out of Pocket Maximum

Deductible Note: deductible is combined for both medical and prescription drug coverage. The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract	\$2,000 per member, \$4,000 per contract per calendar year
Fixed Dollar Copay Note: Copay amounts apply once the deductible has been met	\$10 for Tier 1 Formulary Preferred drugs, \$40 for Tier 2 Formulary Option drugs and \$80 for Tier 3 Non-Formulary
Coinsurance Note: Coinsurance amounts apply once the deductible has been met	50% for select services as noted below
Out of Pocket Maximum – total amount paid toward medical and pharmacy services including deductible, copays and coinsurance.	\$4,000 per member, \$8,000 per contract per calendar year
Lifetime 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 – laboratory services only	Covered – 100%

Mammography

Mammography Screening	Covered – 100%
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Physician Office Services

Office Visits	Covered – 100% after deductible. Deductible does not apply to preventive services and routine maternity care
Consulting Specialist Care – when referred	Covered – 100% after deductible. Deductible does not apply to preventive services

Emergency Medical Care

Hospital Emergency Room	Covered – 100% after deductible
Urgent Care Center	Covered – 100% after deductible
Ambulance Services – medically necessary	Covered – 100% after deductible

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100% after deductible
Diagnostic Tests and X-rays	Covered – 100% after deductible
Radiation Therapy	Covered – 100% after deductible

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – 100% (Deductible does not apply)
Delivery and Nursery Care	Covered – 100% after deductible

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 100% after deductible
Outpatient Surgery – see member certificate for specific surgical coinsurance	Covered – 100% after deductible

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Alternatives to Hospital Care	
Skilled Nursing Care	Covered – 100% after deductible up to 45 days per calendar year
Hospice Care	Covered – 100% after deductible
Home Health Care	Covered – 100% after deductible
Surgical Services	
Surgery – includes all related surgical services and anesthesia.	Covered – 100% after deductible
Voluntary Sterilization	Covered – Male - 50% after deductible Covered – Female - 100% (Deductible does not apply)
Human Organ Transplants	Covered – 100% after deductible
Reduction Mammoplasty (subject to medical criteria)	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible
Weight Reduction (subject to medical criteria)	Covered – 50% after deductible
Mental Health Care and Substance Abuse Treatment	
Inpatient Mental Health Care and Substance Abuse Care	Covered – 100% after deductible
Outpatient Mental Health Care	Covered – 100% after deductible
Outpatient Substance Abuse Care	Covered – 100% after deductible
Other Services	
Allergy Testing and Therapy	Covered – 100% after deductible
Allergy Injections	Covered – 100% after deductible
Chiropractic Spinal Manipulation – when referred	Covered – 100% after deductible
Outpatient Physical, Speech and Occupational Therapy – subject to significant improvement within 60 days	Covered – 100% after deductible. Limited to 60 consecutive days per episode for a combination of therapies.
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible
Durable Medical Equipment	Covered – 50% after deductible
Prosthetic and Orthotic Appliances	Covered – 50% after deductible
Prescription Drugs	
Tier 1 – Formulary Preferred	Covered – \$10 copay after deductible
Tier 2 – Formulary Option	Covered - \$40 copay after deductible
Formulary brand when Generic is available	Covered – Difference in cost between brand name drug and generic drug plus \$40 after deductible
Tier 3 - Non-Formulary Drugs	Covered – \$80 copay after deductible
Sexual Dysfunction Drugs	Covered – 50% after deductible
Contraceptives	Covered – Tier 1 covered in full (deductible does not apply) Applicable tiers 2 and 3 copays will apply after deductible
90 Day Retail: 31-83 day supply	Not covered
90 Day Retail: 84-90 day supply	Covered – Two times the tiered copayments defined above after deductible
Mail order: 30 day supply	Covered – applicable tiered copayment will apply
Mail order: 31-90 day supply	Covered – Two times the tiered copayments defined above after deductible

HDHP, 2000HD, 4KOMHD, P1048D, MOPD20