

Benefits-at-a-Glance for Healthy *Blue* Living Package 7 w/MHP Acemco Incorporated 00276853-0001-0003

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. Healthy *Blue* LivingSM members must complete program requirements within first 90 days of enrollment or re-enrollment. To qualify or maintain enhanced benefits, the subscriber and covered spouse 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. If a smoker, must enroll in the smoking cessation program, Quit The Nic, within 120 days of enrollment or re-enrollment. If BMI is = 30, must complete two online coaching questionnaires within 120 days of enrollment or re-enrollment.

	Enhanced Benefits BCN10, CO25, 35RP, ER100, UR35, 20%CR, 1000D, 2000CM, MHSAP	Standard Benefits BCN10, CO30, 40RP, ER150, UR50, 30%CR, 3000D, 3000CM, MHSAP
Deductible, Copays and Dollar Maximums		
Note: The Deductible is applicable to all covered services except (1) preventive services provided by the member's PCP; (2) preventive services obtained as a result of referral from the PCP; (3) routine maternity care; and (4) services paid by a provider or vendor under the delegation of a claim payment arrangement		
Deductible	\$1,000 per member, \$2,000 per contract per calendar year	\$3,000 per member, \$6,000 per contract per calendar year
Copays É Fixed Dollar Copay	\$5 for allergy injections, \$25 for office visits, \$25 for outpatient mental health and substance abuse visits, \$35 for referral physician visits, \$35 for urgent care visits and \$100 for emergency room visits	\$5 for allergy injections, \$30 for PCP office visits, \$30 for outpatient mental health and substance abuse visits, \$40 for referral physician visits, \$50 for urgent care visits and \$150 for emergency room visits
É Percent Copay (Coinsurance)	20% and 50% of approved amount for select services	30% and 50% of approved amount for select services
Copay Dollar Maximums É Fixed Dollar Copay	None	None
É Percent Copay (Coinsurance) – Excludes services with a flat dollar and 50% coinsurance	\$2,000 per member, \$4,000 per contract per calendar year	\$3,000 per member, \$6,000 per contract per calendar year
Dollar Maximums	None	None
Preventive Services		
Health Maintenance Exam	Covered ó 100%	Covered ó 100%
Annual Gynecological Exam	Covered ó 100%	Covered ó 100%
Pap Smear Screening ó laboratory services only	Covered ó 100%	Covered ó 100%
Well-Baby and Child Care	Covered ó 100%	Covered ó 100%
Immunizations ó pediatric and adult	Covered ó 100%	Covered ó 100%
Prostate Specific Antigen (PSA) Screening ó laboratory services only	Covered ó 100%	Covered ó 100%
Mammography		
Mammography Screening	Covered ó 100%	Covered ó 100%
Physician Office Services		
Office Visits	Covered ó \$25 copay	Covered ó \$30 copay
Consulting Specialist Care ó when referred	Covered ó \$35 copay after deductible	Covered ó \$40 copay after deductible

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Emergency Medical Care		
Hospital Emergency Room ó copay waived if admitted, inpatient hospital copays apply	Covered - \$100 copay after deductible	Covered - \$150 copay after deductible
Urgent Care Center	Covered - \$35 copay	Covered - \$50 copay
Ambulance Services ó medically necessary	Covered ó 80% after deductible, ground and air services, with a 20% coinsurance up to \$2,000 per member, \$4,000 per family per calendar year	Covered ó 70% after deductible, ground and air services, with a 30% coinsurance up to \$3,000 per member, \$6,000 per family per calendar year
Diagnostic Services		
Laboratory and Pathology Tests	Covered ó Office visit copay may apply per member, per visit	Covered ó Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered ó 80% after deductible, with a 20% coinsurance up to \$2,000 per member, \$4,000 per family per calendar year	Covered ó 70% after deductible, with a 30% coinsurance up to \$3,000 per member, \$6,000 per family per calendar year
Radiation Therapy	Covered ó 80% after deductible, with a 20% coinsurance up to \$2,000 per member, \$4,000 per family per calendar year	Covered ó 70% after deductible, with a 30% coinsurance up to \$3,000 per member, \$6,000 per family per calendar year
Maternity Services Provided by a Physician		
Pre-Natal and Post-Natal Care	Covered ó \$25 copay	Covered ó \$30 copay
Delivery and Nursery Care	Covered ó 100% after deductible for professional services; see hospital care below for facility charges.	Covered ó 100% after deductible for professional services; see hospital care below for facility charges.
Hospital Care		
General Nursing Care, Hospital Services and Supplies	Covered ó 80% after deductible, with 20% coinsurance up to \$2,000 per member, \$4,000 per family per calendar year; unlimited days	Covered ó 70% after deductible, with a 30% coinsurance up to \$3,000 per member, \$6,000 per family per calendar year; unlimited days
Outpatient Surgery ó see member certificate for specific surgical copay	Covered ó 80% after deductible, with a 20% coinsurance up to \$2,000 per member, \$4,000 per family per calendar year	Covered ó 70% after deductible, with a 30% coinsurance up to \$3,000 per member, \$6,000 per family per calendar year
Alternatives to Hospital Care		
Skilled Nursing Care	Covered ó 80% after deductible, up to 45 days per calendar year; 20% coinsurance up to \$2,000 per member, \$4,000 per family per calendar year	Covered ó 70% after deductible, up to 45 days per calendar year; 30% coinsurance up to \$3,000 per member, \$6,000 per family per calendar year
Hospice Care	Covered ó 100% after deductible	Covered ó 100% after deductible
Home Health Care	Covered ó \$35 copay after deductible	Covered ó \$40 copay after deductible
Surgical Services		
Surgery ó includes all related surgical services and anesthesia ó see member certificate for specific surgical copays	See Hospital Care for inpatient and outpatient copays	See Hospital Care for inpatient and outpatient copays
Voluntary Sterilization	Covered ó 50% after deductible on all associated costs	Covered ó 50% after deductible on all associated costs
Human Organ Transplants	Covered ó 80% after deductible, with a 20% coinsurance up to \$2,000 per member, \$4,000 per family per calendar year; subject to medical criteria	Covered ó 70% after deductible, with a 30% coinsurance up to \$3,000 per member, \$6,000 per family per calendar year; subject to medical criteria

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Mental Health Care and Substance Abuse Treatment		
Inpatient Mental Health Care and Substance Abuse Care	Mental Health Care: Covered 6 80% after deductible, with a 20% coinsurance up to \$2,000 per member, \$4,000 per family per calendar year when authorized by BCN	Mental Health Care: Covered 6 70% after deductible, with a 30% coinsurance, up to \$3,000 per member, \$6,000 per family per calendar year when authorized by BCN
	Substance Abuse Care: Covered 6 80% after deductible, with a 20% coinsurance up to \$2,000 per member, \$4,000 per family per calendar year when authorized by BCN	Substance Abuse Care: Covered 6 70% after deductible, with a 30% coinsurance, up to \$3,000 per member, \$6,000 per family per calendar year when authorized by BCN
Outpatient Mental Health Care	Covered 6 \$25 copay after deductible	Covered 6 \$30 copay after deductible
Outpatient Substance Abuse Care	Covered 6 \$25 copay after deductible	Covered 6 \$30 copay after deductible
Other Services		
Allergy Testing and Therapy	Covered 6 50% after deductible, \$5 copay for allergy injections	Covered 6 50% after deductible, \$5 copay for allergy injections
Chiropractic Spinal Manipulation (when referred)	Covered 6 \$35 copay after deductible	Covered - \$40 copay after deductible
Outpatient Physical, Speech and Occupational Therapy (subject to significant improvement within 60 days)	Covered 6 \$35 copay after deductible, limited to 60 consecutive days per episode for a combination of therapies	Covered 6 \$40 copay after deductible, limited to 60 consecutive days per episode for a combination of therapies
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered 6 50% after deductible on all associated costs	Covered 6 50% after deductible on all associated costs
Durable Medical Equipment	Covered 6 50%	Covered 6 50%
Prosthetic and Orthotic Appliances	Covered 6 50%	Covered 6 50%

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Benefits-at-a-Glance for \$10/\$40 Prescription Drug Coverage

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Covered Services	
Formulary Drug ó Generic	Covered ó \$10 copay
Formulary Drug ó Brand Name	Covered ó \$40 copay
Formulary Brand Name when Generic is available	Covered ó Difference in cost between brand name drug and generic drug plus \$40
Non-Formulary Drugs	Not Covered
Sexual Dysfunction Drugs	Covered ó 50%
Contraceptives	Covered ó Applicable generic or brand copay will apply
Retail ó 90 day supply	Covered ó \$20 copay generic, \$80 copay brand. Sexual Dysfunction drugs 50%.
Mail Order Prescription Drugs	Covered ó \$20 copay generic, \$80 copay brand 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

Benefits-at-a-Glance for 50% Prescription Drug Coverage

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Covered Services	
Formulary Drug ó Generic	Covered ó 50% with \$5 minimum copay and \$100 maximum copay
Formulary Drug ó Brand Name	Covered ó 50% with \$5 minimum copay and \$100 maximum copay
Formulary Brand Name when Generic is available	Covered ó Difference in cost between brand name drug and generic drug plus 50% coinsurance
Non-Formulary Drugs	Covered ó 50% with \$5 minimum copay and \$100 maximum copay
Sexual Dysfunction Drugs	Covered ó 50%
Contraceptives	Covered ó 50% with \$5 minimum copay and \$100 maximum copay
Retail ó 90 day supply	Covered ó 50% with \$10 minimum copay and \$200 maximum copay. Sexual dysfunction drugs 50%.
Mail Order Prescription Drugs	Covered ó 50% with \$10 minimum copay and \$200 maximum copay 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