

Otterbase, Inc.
 #00411343-0001-0001 (Kent)
 #00411343-0001-0002 (Wayne)



Benefits-at-a-Glance for Tiered Copay Plan TC4P w/MHP

BCN10, 1000D, 20%CR, 1500CM, CO30, 45RP, ER100, UR60, IMG150, WDEDFC, MHSAP, FCR

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.

Deductible, Copays and Dollar Maximums	
Deductible	\$1,000 per member / \$2,000 per family per calendar year
Copays	
• Fixed Dollar Copay	\$30 for office visits, \$45 for specialist office visits, \$60 for urgent care visits, \$100 for emergency room visits, \$150 for high technology x-rays and \$5 for allergy injections
• Percent Copay	20% and 50% for select services as noted below
Copay Dollar Maximums	
• Fixed Dollar Copay	None
• Percent Dollar Copay - Excludes services with a 50% coinsurance	\$1,500 per member, \$3,000 per family 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 – laboratory services only	Covered – 100%
Mammography	
Mammography Screening	Covered – 100%
Physician Office Services	
Office Visits	Covered – \$30 copay
Consulting Specialist Care – when referred for other than preventive services	Covered – \$45 copay
Emergency Medical Care	
Hospital Emergency Room – copay waived if admitted	Covered – \$100 copay
Urgent Care Center	Covered – \$60 copay
Ambulance Services – medically necessary	Covered - 80% after deductible, with a 20% coinsurance up to \$1,500 per member, \$3,000 per family per calendar year
Diagnostic Services	
Laboratory and Pathology Tests	Covered – Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered - 80% after deductible, with a 20% coinsurance up to \$1,500 per member, \$3,000 per family per calendar year
High Technology X-rays	Covered - \$150 copay
Radiation Therapy	Covered - 80% after deductible, with a 20% coinsurance up to \$1,500 per member, \$3,000 per family per calendar year
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 services. See Hospital Care below for facility charges.

Hospital Care	
General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible, with a 20% coinsurance up to \$1,500 per member, \$3,000 per family per calendar year; unlimited days
Outpatient Surgery – see member certificate for specific surgical copays	Covered - 80% after deductible, with a 20% coinsurance up to \$1,500 per member, \$3,000 per family per calendar year
Alternatives to Hospital Care	
Skilled Nursing Care	Covered - 80% after deductible up to 45 days per calendar year, 20% coinsurance up to \$1,500 per member, \$3,000 per family per calendar year
Hospice Care	Covered – 100% after deductible
Home Health Care	Covered – \$45 copay
Surgical Services	
Surgery – includes all related surgical services and anesthesia. See member certificate for specific surgical copays.	Covered - 80% after deductible, with a 20% coinsurance up to \$1,500 per member, \$3,000 per family per calendar year
Voluntary Sterilization	Covered – 50% after deductible on all associated costs
Human Organ Transplants	Covered - 80% after deductible, with a 20% coinsurance up to \$1,500 per member, \$3,000 per family per calendar year; 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, with a 20% coinsurance up to \$1,500 per member, \$3,000 per family per calendar year when authorized by BCN Substance Abuse Care: Covered - 80% after deductible, with a 20% coinsurance up to \$1,500 per member, \$3,000 per family per calendar year when authorized by BCN
Outpatient Mental Health Care	Covered – \$30 copay
Outpatient Substance Abuse Care	Covered – \$30 copay
Other Services	
Allergy Testing and Therapy	Covered – 50% after deductible
Allergy Injections	Covered – \$5 copay
Chiropractic Spinal Manipulation – when referred	Covered – \$45 copay
Outpatient Physical, Speech and Occupational Therapy – subject to significant improvement within 60 days	Covered – \$45 copay; limited to 60 consecutive days per episode for a combination of therapies
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%

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Benefits-at-a-Glance for \$10/\$20/\$40 Prescription Drug Coverage

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Covered Services	
Formulary Drug – Generic	Covered – \$10 copay
Formulary Drug – Brand Name	Covered – \$20 copay
Formulary Brand Name when Generic is available	Covered – Difference in cost between brand name drug and generic drug plus \$20
Non-Formulary Drugs	Covered – \$40 copay
Sexual Dysfunction Drugs	Covered – 50%
Contraceptives	Covered – Applicable generic, brand or non-formulary copay will apply
Retail – 90 day supply	Covered – \$20 generic copay, \$40 brand copay, and \$80 non-formulary copay. 50% for sexual dysfunction drugs.
Mail Order Prescription Drugs	Covered – \$20 generic copay, \$40 brand copay, and \$80 non-formulary copay up to a 90 day supply. 50% for sexual dysfunction drugs.
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