

## Benefits-at-a-Glance for \$500 Deductible/20% Coinsurance



Blue Care  
Network  
of Michigan

MIBCN.com

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, Coinsurance and Dollar Maximums

<b>Deductible</b>	\$500 per member/\$1,000 per contract per calendar year (plan year IF HRA)
<b>Copays</b>	\$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.
• Fixed Dollar Copay	
• Coinsurance	20% and 50% for selected services as noted below
<b>Copay/Coinsurance Dollar Maximums</b>	
• Fixed Dollar Copay	None
• Coinsurance – excludes services with 50% coinsurance	\$1,500 per member/\$3,000 per contract per calendar year (plan year IF HRA)
<b>Dollar Maximums</b>	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

## Benefits-at-a-Glance for \$500 Deductible/20% Coinsurance



**Blue Care  
Network  
of Michigan**

[MIBCN.com](http://MIBCN.com)

### Hospital Care

Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 80% after deductible, unlimited days
Outpatient Facility visit	Covered – \$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 (plan year <b>IF HRA</b> )
Hospice Care	Covered – 100% after deductible
Home Health Care	Covered – \$30 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	<b>Mental Health Care:</b> Covered – 80% after deductible <b>Substance Abuse Care:</b> 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% OR 100% (HRA only)
Prosthetic and Orthotic Appliances	Covered – 50% OR 100% (HRA only)
Weight Reduction Procedures	Covered – 50% after deductible

BCN10, 500D, 20%CR, 1500CM, CO30, 45RP, ER150, UR50, IMG150, WDRPOV, MHSAP, (PLAN YR, DME5, P&O5 **IF HRA**)



**Simply Blue<sup>SM</sup> PPO HSA – Prescription Drug Coverage  
with \$20 / \$60  
50% / \$80 minimum / \$100 maximum Formulary (Nonpreferred) Brand Name  
Triple-Tier Copay  
Open Formulary  
Benefits-at-a-Glance**

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. Payment amounts are based on BCBSM's approved amount, less any applicable deductible, copay and/or coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

**Specialty Drugs** – The mail order pharmacy for specialty drugs is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel<sup>®</sup> and Humira<sup>®</sup>) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at [bcbsm.com](http://bcbsm.com). Log in under "I am a Member." If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days) once applicable deductible has been met.

**Member's responsibility (copays)**

Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual coinsurance/copay dollar maximum required under your Simply Blue HSA medical coverage. Benefits are not payable until after you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are required to pay applicable prescription drug fixed dollar copays which are subject to your annual coinsurance/copay dollar maximums.

Note: Copays apply once the deductible has been met.

		90-day retail network pharmacy	* Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
Tier 1 – Generic or prescribed over-the-counter drugs	1 to 30-day period	\$20 copay	\$20 copay	\$20 copay	\$20 copay <i>plus</i> an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$40 copay	No coverage	No coverage
	84 to 90-day period	\$40 copay	\$40 copay	No coverage	No coverage
Tier 2 – Formulary (preferred) brand-name drugs	1 to 30-day period	\$60 copay	\$60 copay	\$60 copay	\$60 copay <i>plus</i> an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$120 copay	No coverage	No coverage
	84 to 90-day period	\$120 copay	\$120 copay	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.

\* BCBSM will not pay for drugs obtained from non-network mail order providers, including Internet providers.

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.



**Member's responsibility (copays), continued**

		90-day retail network pharmacy	* Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
Tier 3 – Nonformulary (nonpreferred) brand-name drugs	1 to 30-day period	\$80 or 50% of the approved amount (whichever is greater), but no more than \$100	\$80 or 50% of the approved amount (whichever is greater), but no more than \$100	\$80 or 50% of the approved amount (whichever is greater), but no more than \$100	\$80 or 50% of the approved amount (whichever is greater), but no more than \$100 <i>plus</i> an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$180 or 50% of the approved amount (whichever is greater), but no more than \$200	No coverage	No coverage
	84 to 90-day period	\$160 or 50% of the approved amount (whichever is greater), but no more than \$200	\$180 or 50% of the approved amount (whichever is greater), but no more than \$200	No coverage	No coverage

**Covered services**

FDA-approved drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay <i>plus</i> an additional 20% prescription drug out-of-network copay **
Prescribed over-the-counter drugs – when covered by BCBSM	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay <i>plus</i> an additional 20% prescription drug out-of-network copay **
State-controlled drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay <i>plus</i> an additional 20% prescription drug out-of-network copay **
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no copay.	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug <i>plus</i> an additional 20% prescription drug out-of-network copay **

\* BCBSM will not pay for drugs obtained from non-network mail order providers, including Internet providers.

\*\* The 20% prescription drug out-of-network copay will not be applied toward your Simply Blue HSA deductible or annual coinsurance/copay dollar maximum.



### Features of your prescription drug plan

<p><b>BCBSM Custom Formulary</b></p>	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the formulary is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> <li>• <b>Tier 1 (generic)</b> – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment.</li> <li>• <b>Tier 2 (preferred brand)</b> – Tier 2 includes brand-name drugs from the Custom Formulary. Preferred brand name drugs are also safe and effective, but require a higher copay.</li> <li>• <b>Tier 3 (nonpreferred brand)</b> – Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay for these drugs.</li> </ul>
<p><b>Prior authorization/step therapy</b></p>	<p>A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. <b>Step Therapy</b>, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at <a href="http://bcbsm.com">bcbsm.com</a>. Log In under <i>I am a Member</i> and click on <i>Prescription Drugs</i>.</p>
<p><b>Mandatory maximum allowable cost drugs</b></p>	<p>If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the difference in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug <i>plus</i> your applicable copay regardless of whether you or your physician requests the brand name drug. <b>Exception:</b> If your physician requests and receives authorization for a nonpreferred brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay.  <b>Note:</b> This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.</p>
<p><b>Drug Interchange and generic copay waiver</b></p>	<p>BCBSM's drug interchange and generic copay waiver programs encourage physicians to prescribe a less-costly generic equivalent.          If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.</p>
<p><b>Quantity limits</b></p>	<p>To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits. A list of these drugs is available at <a href="http://bcbsm.com">bcbsm.com</a>.</p>



**Delta Dental PPO (Point-of-Service)**  
**Benefit Features for**  
**Michigan Chamber Services, Inc. Groups**  
**Client #5515**  
**Plan MC100**

Delta Dental PPO (Point-of-Service) is a national point-of-service preferred provider organization administered by Delta Dental of Michigan. You can go to any licensed dentist, but you could increase your benefits and lower your out-of-pocket costs if you choose a PPO dentist. If you do not go to a PPO dentist, you may also choose a dentist who participates in Delta Dental Premier, our carefully managed fee-for-service program. However, you might have to pay more.

	PPO Dentist	Premier Dentist	Nonparticipating Dentist
Effective: January 1, 2010	Plan Pays	Plan Pays	Plan Pays
<b>CLASS I</b>			
<b>Diagnostic and Preventive Services</b> – Used to diagnose and/or prevent dental abnormalities or disease (includes exams, cleanings, and fluoride treatments).	100%	100%	100%
<b>Emergency Palliative Treatment</b> – Used to temporarily relieve pain.	100%	100%	100%
<b>Radiographs</b> – X-rays.	100%	100%	100%
<b>Sealants</b> – Dental sealants to prevent decay of permanent molars (to age nine on first molars; to age 14 on second molars).	100%	100%	100%
<b>CLASS II</b>			
<b>Oral Surgery</b> – Extractions and dental surgery, including preoperative and postoperative care.	90%	80%	80%
<b>Minor Restorative Services</b> – Used to repair teeth damaged by disease or injury (for example, fillings).	90%	80%	80%
<b>Periodontics</b> – Used to treat diseases of the gums and supporting structures of the teeth.	90%	80%	80%
<b>Endodontics</b> – Used to treat teeth with diseased or damaged nerves (for example, root canals).	90%	80%	80%
<b>CLASS III</b>			
<b>Major Restorative Services</b> – Used when teeth cannot be restored with another filling material (for example, crowns).	60%	50%	50%
<b>Prosthodontics</b> – Used to replace missing natural teeth (for example, bridges, endosteal implants, and dentures).	60%	50%	50%
<b>CLASS IV</b>			
<b>Orthodontics (to age 19)</b> – Used to correct malposed teeth and/or facial bones (for example, braces).	50%	50%	50%
<b>Maximum Payment</b> – \$1,000 per person total per calendar year for Class I, Class II and Class III Benefits. Delta Dental's payment for Class IV Benefits will not exceed a lifetime maximum of \$1,000 per eligible person.			
<b>Deductible</b> – \$50 per person total per calendar year limited to a maximum deductible of \$150 per family per calendar year on Class II and Class III Benefits. The deductible does not apply to Class I or Class IV Benefits.			

**Customer Service toll-free number (800) 524-0149**  
**www.deltadentalmi.com**

This document is intended as a supplement to your Dental Care Certificate and Summary of Dental Plan Benefits. Please refer to your certificate and summary for policy exclusions and limitations.

