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<p>Deductible</p>	<p>\$250 per member, \$500 per family</p>
<p>Copays</p> <ul style="list-style-type: none"> • Fixed (does not contribute to out-of-pocket maximum) • Percent 	<p>\$50 per Emergency Room Visit \$50 per Urgent Care Facility Visit (freestanding)</p> <p>0% copay on select benefits Ambulance Hospice Care Home Health Care Mammography Screening Preventive Services Private Duty Nursing Skilled Nursing Specified Human Organ Transplant</p> <p>10% copay on select benefits Cardiac Rehab Chemotherapy Delivery and Nursery Care Diagnostic Tests and X-rays Hospital Care – Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies Inpatient Consultations Inpatient Mental Health Care Inpatient Substance Abuse Care Laboratory and Pathology Tests Outpatient Diabetes Education Pre-Natal and Post-Natal Care Professional Visits for Newborn Surgical Services Therapeutic Radiation</p> <p>35% copay on select benefits Acupuncture Allergy Testing and Therapy Chiropractic Spinal Manipulation Durable Medical Equipment & Medical Supplies Massage Therapy by a Massage Therapist, Clinic, Independent Physical Therapist, M.D. or D.O. Office Visits, Outpatient and Home Medical Visits, and Office Consultations Outpatient Mental Health Care Outpatient Substance Abuse Treatment Physical Therapy, Occupational Therapy, Speech Therapy Photo Light Equipment Prescription Contraceptive Devices Prosthetic and Orthotic Appliances Shoe Inserts & Lifts</p>
<p>Copay Dollar Maximums</p> <ul style="list-style-type: none"> • Fixed copays • Percent copays 	<p>None \$1,000 per member, \$2,000 per family</p>
<p>Dollar Maximums</p>	<p>\$1 million lifetime per covered specified human organ transplant type and a separate \$3 million lifetime per member for all other covered services and as noted for individual services</p>



Preventive Services

Health Maintenance Exam Annual Gynecological Exam	Covered – 100%, One of EACH per year calendar year
Pap Smear Screening – Laboratory services only	Covered – 100%, one per calendar year
Well-baby and child care	Covered – 100% <ul style="list-style-type: none"> • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15
Childhood immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics	Covered – 100%
Fecal Occult Blood Screening	Covered – 100%, one per calendar year
Flexible Sigmoidoscopy Exam	Covered – 100%, one per calendar year
Prostate Specific Antigen (PSA) Screening	Covered – 100%, one per calendar year
Chemical Profile	Covered – 100%, one per calendar year
Urinalysis	Covered – 100%, one per calendar year
Chemistry	Covered – 100%, one per calendar year
Complete Blood Count	Covered – 100%, one per calendar year
Chest X-Ray	Covered – 100%, one per calendar year
EKG	Covered – 100%, one per calendar year
Digital Rectal Exam	Covered – 100%, one per calendar year
Air Contrast Barium Enema	Covered – 100%, one per calendar year
Proctoscopic Exam	Covered – 100%, one per calendar year

Mammography

Mammography Screening	Covered – 100% One per calendar year, no age restrictions
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Physician Office Services

Office Visits	Covered – 65%
Outpatient and Home Medical Care Visits	Covered – 65%
Office Consultations	Covered – 65%

Emergency Medical Care

Hospital Emergency Room – Approved diagnosis	Covered - \$50 copay Copay waived if admitted or for an accidental injury
Urgent Care Center (freestanding facility) If services rendered at a hospital based urgent care clinic then hospital component subject to \$50 copay. There may be an additional fee for the physician services which will be subject to deductible and copay (if applicable).	Covered - \$50 copay
Ambulance Services – Medically necessary	Covered – 100%



Diagnostic Services

Laboratory and Pathology Tests	Covered – 90% after deductible
Diagnostic Tests and X-rays	Covered – 90% after deductible
Therapeutic Radiology	Covered – 90% after deductible

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – 90%
Delivery and Nursery Care	Covered – 90% after deductible Includes delivery provided by a certified nurse midwife

Hospital Care

Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies Note: Non-emergency services must be rendered in a participating hospital.	Covered – 90% after deductible Unlimited days
Inpatient Consultations	Covered – 90% after deductible
Chemotherapy	Covered – 90% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100% Up to 60 days per confinement
Hospice Care	Covered – 100% Limited to the dollar maximum which is reviewed and adjusted periodically
Home Health Care - medically necessary	Covered – 100% Unlimited visits

Surgical Services

Surgery, including all related surgical services, anesthesia and surgical assistance	Covered – 90% after deductible
Voluntary Sterilization	Covered – 90% after deductible

Human Organ Transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504) (Liver, Heart, Lung, Pancreas and Heart-Lung)	Covered – 100% Up to \$1 million maximum per transplant type \$5,000 maximum for travel, meals, and lodging (combined) and \$30 maximum per day for meals
Bone marrow – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504); specific criteria applies	Covered – 90% after deductible
Kidney, Cornea and Skin	Covered – 90% after deductible



Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	Covered – 90% (approved facility) 120 days lifetime maximum per member
Outpatient Mental Health Care • Facility and Clinic • Physician's Office	Covered – 65%
Outpatient Substance Abuse Treatment - in approved facilities	Covered – 65%
	<p>Combined 40 visits per members, per calendar year</p> <p>Mental Health Services can be rendered by an M.D., D.O., Ph.D, Outpatient Psychiatric Center (OPC) or If rendered by an independent MSW, CSW, ACSW, MSSW, LLP, or MMH, or Catholic Social Services (located at 616 Shelden Ave., Suite 211, Houghton MI) covered 75% and reimbursed directly to the subscriber</p> <p>Substance Abuse services must be rendered by an approved Substance Abuse Facility</p>

Other Services

Allergy Testing and Therapy	Covered – 65%
Chiropractic Spinal Manipulation	Covered – 65% Up to 24 visits per calendar year
Outpatient Physical, Speech and Occupational Therapy	Covered – 65% Up to 60 visits per calendar year
Durable Medical Equipment and Medical Supplies	Covered – 65%
Prosthetic and Orthotic Appliances	Covered – 65%
Private Duty Nursing	Covered – 100%
Acupuncture	Covered – 65%
	<p>20 visits total, per member, per calendar year Services must be rendered by an M.D. or D.O. Must be an approved diagnosis</p>
Shoe Inserts when shoe is not attached to a brace	Covered - 65% of approved amount One pair of either shoe inserts or lifts per calendar year
Lab procedures performed in a physician's office that are not normally payable in a physician's office setting	Covered – 90% after deductible
Professional visits for a newborn in nursery	Covered – 90% after deductible
Outpatient Diabetes Education and Training	Covered - 90% after deductible Subject to a lifetime maximum of \$1,000 per member
Phototherapy Light Equipment with Photometer (50v bulbs)	Covered - 65% of charges Subject to lifetime maximum of \$400 Replacement bulbs not covered
Cardiac Rehabilitation Phases II & III of treatment	Covered – 90% after deductible



Other Services

<p>Massage Therapy</p> <ul style="list-style-type: none"> • M.D., D.O. • Massage Therapist, Massage Clinic, or Independent Physical Therapist 	<p>Covered – 65%</p> <p>Covered – 65%</p> <hr/> <p>20 visits total, per member, per calendar year</p> <p>Doctors prescription required</p> <p>Approved amount capped at \$40 less copay with reimbursement made to subscriber when services rendered by Massage Therapist or Massage Clinic</p> <p>Must be performed in the office setting</p>
<p>Prescription Contraceptive Devices</p>	<p>Covered – 65%</p>

Prescription Drug Coverage

Benefits-at-a-Glance

Effective 1/1/08



Blue Preferred RxSM Prescription Drug Coverage Benefits-at-a-Glance

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Note: Effective October 1, 2006, the mail order pharmacy for specialty drugs changed to Option Care. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions for rheumatoid arthritis. These drugs require special handling, administration or monitoring.

Option Care will handle mail order prescriptions only for specialty drugs. Continue to send other mail order prescription medications to Medco. A list of specialty drugs is available on our Web site at bcbsm.com. If you have any questions, please call Option Care customer service at 866-515-1355.

<p>Covered Services:</p> <ul style="list-style-type: none"> • Federal-legend drugs • State-controlled drugs • Prescription drug contraceptive medicines • 34 day supply or 100 units of medication • Needles and syringes covered 100% only when provided at the time an Insulin prescription is filled. <ul style="list-style-type: none"> • Up to a 90 day supply of almost any medication 	<p>Retail Prescription Drug Program Preferred Rx Pharmacy (in Michigan):</p> <ul style="list-style-type: none"> • Generic Drugs: 10% copay per prescription Subject to a minimum copay of \$5 and a maximum of \$15 • Brand Drugs: 25% copay per prescription Subject to a minimum copay of \$10 and a maximum of \$30 <p>(Outside Michigan) MedImpact Prescriptions Pharmacy Network</p> <p>Non-Preferred or Non-MedImpact Pharmacy: 75% of approved amount less the appropriate 10% or 25% copay.</p> <p>Mail Order Prescription Drug Program MOPD is subject to the same copay percentages, minimum and maximum requirements as identified above under the Retail RX plan. However, the copay applies three times for a 90 day prescription.</p> <ul style="list-style-type: none"> • Generic Drugs: 10% copay per prescription Subject to a minimum copay of \$15 and a maximum of \$45 • Brand Drugs: 25% copay per prescription Subject to a minimum copay of \$30 and a maximum of \$90
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