Blue Cross Blue Shield of Michigan
A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Michigan Dental Association
Health Care Selection Guide
Community Blue[SM] PPO $250 Deductible
Medical Coverage
Benefits effective January 1, 2010
Some benefits modified effective July 1, 2010

MDA Insurance

Prescription Drug Coverage *

What's Covered

- FDA-approved drugs
- State-controlled drugs
- Disposable needles and syringes dispensed with insulin or chemotherapeutic drugs
- FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered)
- Prescribed over the counter (OTC) drugs when covered by BCBSM (does not require a prescription under federal law)

Copays

- $10 for generic drugs
- $40 for brand name drugs
- $80 for brand name non-formulary drugs
- 50%for elective drugs

Payment of Benefits

Network pharmacy	100% of approved amount less the copay for each prescription or refill.
Non-network pharmacy	75% of approved amount less the copay for each prescription or refill.
Mail order prescription provider	Covers up to a 90-day supply of covered medication by mail from Medco, less a **$20 copay for generic drugs, $80 copay for brand name drugs or $160 copay for brand name non-formulary drugs. There is no coverage out of network.**

Note: *A network pharmacy is a Preferred Rx pharmacy in Michigan or a MedImpact pharmacy outside Michigan. A non-network pharmacy is a pharmacy not in the Preferred Rx or MedImpact networks. As of 1/1/10,* ***retail*** *coverage of prescriptions has expanded to include 83 to 90-day supplies, subject to one copay that is double the amount for a 30-day supply. Requires all* ***retail*** *90-day supplies of medication be obtained from a "****90-Day Retail Network****" provider.*

* Prior Authorization/ Step Therapy and Mandatory Allowable Cost (MAC) may be required.

What's Not Covered

- Drugs that cost less than your copay
- Administration of drugs or any drug consumed at the time and place of the prescription order
- Refills not authorized by a physician
- Therapeutic devices or applications, even if prescribed by a physician
- More than a 30-day supply, exceptions may be made for certain maintenance drugs or for certain drugs where package size prevents a 30 day supply from being dispensed
- Refills dispensed after one year from the date of the original order
- Drugs for cosmetic purposes

Customer Service:

Blue Cross Blue Shield of Michigan
Customer Service Toll-free Number
1-800-432-9881

For more information,
contact MDA Insurance
1-800-860-2272

BCS

MDA health programs are underwritten by BCS Life Insurance Company and administered by Blue Cross Blue Shield of Michigan. Some conditions are subject to a 365-day waiting period.

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 Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

Community Blue℠ PPO Coverage
Plan 3

	In-Network	Out-of-Network
Preventive Care Services		
Payment for preventive care services, excluding mammography screening and immunizations, is limited to a **combined** maximum of $1,000.00 per calendar year per family member. There is no deductible or copay for these services.		
Health maintenance exam (includes chest x-ray, EKG, cholesterol testing and other select lab procedures) – one per calendar year	Covered at 100%	Not covered
Gynecological exam – one per calendar year	Covered at 100%	Not covered
Pap smear screening – one per calendar year	Covered at 100%	Not covered
Mammography screening – one medically necessary **or** one routine mammogram per calendar year	Covered at 100% **Note:** Additional mammograms are subject to your deductible and copay.	60% after deductible
Well-baby and child care: • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered at 100%	Not covered
Adult and childhood immunizations as recommended by the Advisory Committee on Immunization Practices or other sources as recognized by BCBSM	Covered at 100%	Not covered
Fecal occult blood screening – one per calendar year	Covered at 100%	Not covered
Flexible sigmoidoscopy exam – one per calendar year	Covered at 100%	Not covered
PSA screening – one per calendar year	Covered at 100%	Not covered
Ovarian cancer screening (CA-125) – one per calendar year	Covered at 100%	Not covered
Physician Office Services		
Office visits (includes office consultations and urgent care visits)	$10 copay per office visit	60% after deductible, must be medically necessary
Outpatient and home medical care visits	80% after deductible	60% after deductible, must be medically necessary
Emergency Medical Care		
Hospital emergency room	$50 copay per visit for facility charges (copay waived if admitted or for an accidental injury)	
Ambulance services – must be medically necessary	80% after deductible	80% after deductible
Diagnostic Services		
Laboratory and pathology services	80% after deductible	60% after deductible
Diagnostic tests and x-rays, therapeutic radiology	80% after deductible	60% after deductible
Maternity Services Provided by a Physician or Certified Nurse Midwife		
Prenatal and postnatal care	Covered at 100%	60% after deductible
Delivery and nursery care	80% after deductible	60% after deductible
Hospital Care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies – unlimited days **Note:** Nonemergency services must be rendered in a **participating** hospital.	80% after deductible	60% after deductible
Inpatient consultations	80% after deductible	60% after deductible
Chemotherapy	80% after deductible	60% after deductible
Alternatives to Hospital Care		
Skilled nursing care – up to 120 days per calendar year	80% after deductible	
Hospice care – up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically	Covered at 100%	
Home health care and home infusion therapy – must be medically necessary	80% after deductible	
Surgical Services		
Surgery – includes related surgical services and medically necessary facility services by a BCBSM **participating** ambulatory surgery facility	80% after deductible	60% after deductible
Colonoscopy	80% after deductible	60% after deductible
Voluntary sterilization	80% after deductible	60% after deductible

Community Blue℠ PPO Coverage
Plan 3

	In-Network	Out-of-Network
Human Organ Transplants		
Specified human organ transplants in designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (1-800-242-3504) – up to $1 million lifetime per transplant type	Covered at 100%, in designated facilities **only**	
Bone marrow transplants – when coordinated through BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after deductible	60% after deductible
Kidney, cornea and skin transplants	80% after deductible	60% after deductible
Mental Health Care and Substance Abuse Treatment		
Inpatient mental health care and substance abuse treatment – unlimited days	80% after deductible	60% after deductible
Outpatient mental health care	80% after deductible	60% after deductible
Outpatient substance abuse treatment – in approved facilities **only**	80% after deductible	
Other Covered Services		
Outpatient diabetes management program (ODMP)	80% after deductible	60% after deductible
Allergy testing and therapy	Covered at 100%	60% after deductible
Chiropractic manipulation treatment and osteopathic manipulation treatment – **combined** 24-visit maximum per calendar year	$10 copay per office visit	60% after deductible
Outpatient physical, speech and occupational therapy – **combined** 60-visit maximum per calendar year	80% after deductible	60% after deductible
Durable medical equipment	80% after deductible	
Prosthetic and orthotic appliances	80% after deductible	
Private duty nursing services	50% after deductible	

Deductibles, Copays and Dollar Maximums

Note: Services from a provider for which there is no PPO network are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between the BCBSM approved amount and the provider's charge.

		In-Network	Out-of-Network
Deductibles – each calendar year **Note:** In-network deductible is waived if service is performed in a PPO physician's office (except mental health care and substance abuse treatment). Out-of-network deductible amounts also apply toward the in-network deductible.		$250 per member, $500 per family	$500 per member, $1,000 per family
Copays **Note:** Copays apply once the deductible has been met.	Fixed dollar copays	• $10 copay for office visits • $50 copay for emergency room visits	$50 copay for emergency room visits
	Percent copays	• 50% for private duty nursing • 20% for mental health care and substance abuse treatment • 20% for most other covered services (copay waived if service is performed in a PPO physician's office)	• 50% for private duty nursing • 40% for mental health care and substance abuse treatment • 40% for most other covered services
Copay dollar maximums – each calendar year – applies to copays for all covered services, including mental health and substance abuse services – but **does not** apply to fixed dollar copays and private duty nursing percent copays		$1,000 per member, $2,000 per family	$3,000 per member, $6,000 per family
Lifetime dollar maximums		$1 million lifetime maximum per covered specified human organ transplant type and a **separate** $5 million lifetime maximum per member for all other covered services	

Note: *All pre-existing conditions, including sterilization and removal of tonsils and adenoids in children up to age 19, are subject to a 365-day waiting period.*