

## Prescription Drug Coverage \*

### What's Covered

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

### Copays

- \$15 for generic drugs
- \$50 for brand name drugs
- 50% for brand name non-formulary drugs – \$70 minimum/\$100 maximum
- 50% for elective drugs

### Payment of Benefits

<b>Network pharmacy</b>	100% of approved amount less the copay for each prescription or refill.
<b>Non-network pharmacy</b>	75% of approved amount less the copay for each prescription or refill.
<b>Mail order prescription provider</b>	Covers up to a 90-day supply of covered medication by mail from Medco or at participating 90-day retail network pharmacies, less a <b>\$30 copay for generic drugs, \$100 copay for brand name drugs or \$140 minimum to \$200 maximum for brand name non-formulary drugs. There is no coverage out of network.</b>

*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 includes 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

## BCBSM Supplemental (to Medicare) for Retirees

### Inpatient Hospitalization

Covers your Medicare Part A deductible and coinsurance required from the 61<sup>st</sup> through the 90<sup>th</sup> day of a hospital admission. It also extends the number of your inpatient days to 365.

### Lifetime Reserve Days

Covers the daily coinsurance required by Medicare Part A for days 91 through 150.

### Skilled Nursing Care

Covers the daily coinsurance required by Medicare Part A for days 21 through 100.

### Physician Care

Covers the yearly deductible and 20 percent medical coinsurance required by Medicare Part B except for home care, office visits and injections.

### Outpatient Medical Health Care

Covers the medical and psychiatric coinsurance required by Medicare Part B.

### 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**



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.

**Comprehensive Major Medical (CMM) Coverage**  
**Plans CMM 250, CMM 500, CMM 1500 and CMM 2500**

**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 select lab and diagnostic procedures	Covered at 100%, one per calendar year**
Gynecological exam	Covered at 100%, one per calendar year**
Pap smear screening – laboratory and pathology services	Covered at 100%, one per calendar year**
Mammography screening	Covered at 100% when provided by a <b>participating</b> provider (80% after deductible when provided by a non-participating provider), one medically necessary <b>or</b> one routine mammogram per calendar year <b>Note:</b> Additional mammograms are subject to your deductible and copay.
Well-baby and child care: <ul style="list-style-type: none"> <li>• 6 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 6 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> <li>• Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</li> </ul>	Covered at 100%*
Adult and childhood immunizations as recommended by the Advisory Committee on Immunization Practices or other sources as recognized by BCBSM	Covered at 100%*
Fecal occult blood screening	Covered at 100%, one per calendar year**
Flexible sigmoidoscopy exam	Covered at 100%, one per calendar year**
PSA screening	Covered at 100%, one per calendar year**
Ovarian cancer screening (CA-125)	Covered at 100%, one per calendar year**

**Physician Office Services**

Office visits (non-routine)	80% after deductible
Outpatient and home medical care visits	80% after deductible

**Emergency Medical Care**

Hospital emergency room	80% after deductible
Ambulance services – must be medically necessary	80% after deductible

**Diagnostic Services**

Laboratory and pathology services	80% after deductible
Diagnostic tests and x-rays, therapeutic radiology	80% after deductible

**Maternity Services**

Prenatal and postnatal care	80% after deductible
Delivery and nursery care	80% after deductible

**Hospital Care**

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies – unlimited days <b>Note:</b> Nonemergency services must be rendered in a <b>participating</b> hospital.	80% after deductible, unlimited days
Chemotherapy	80% after deductible

**Alternatives to Hospital Care**

Hospice care – approved programs	Covered at 100%, up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a <b>participating</b> hospice program <b>only</b> ; limited to dollar maximum that is reviewed and adjusted periodically
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 <b>participating</b> ambulatory surgery facility	80% after deductible
Colonoscopy	80% after deductible
Voluntary sterilization	80% after deductible, subject to 365-day waiting period

**\*\* To be covered, these services must be performed by a BCBSM participating provider.**

**Comprehensive Major Medical (CMM) Coverage**  
**Plans CMM 250, CMM 500, CMM 1500 and CMM 2500**

**Human Organ Transplants**

Specified human organ transplants of: liver, heart, lung, pancreas and heart-lung	Covered at 100%, subject to 365-day waiting period, in designated facilities <b>only</b>
Bone marrow transplants – subject to program guidelines	80% after deductible, in designated cancer centers
Kidney, cornea and skin transplants	80% after deductible

**Mental Health Care and Substance Abuse Treatment**

Inpatient mental health care and substance abuse treatment	80% after deductible, unlimited days
Outpatient mental health care	80% after deductible
Outpatient substance abuse treatment – in approved facilities <b>only</b>	80% after deductible

**Other Covered Services**

Outpatient diabetes management program (ODMP)	80% after deductible
Allergy testing and therapy	80% after deductible
Chiropractic spinal manipulation	80% after deductible, up to 38 medically necessary visits per calendar year
Outpatient physical, speech and occupational therapy	80% after deductible, unlimited visits
Durable medical equipment	80% after deductible
Prosthetic and orthotic appliances	80% after deductible
Private duty nursing services	80% after deductible

**Deductibles, Copays and Dollar Maximums**

**Note:** 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.

<b>Deductibles</b> – each calendar year	<b>Option 1 (MDA/CMM 250) +</b>	\$250 per member, \$500 per family
	<b>Option 2 (MDA/CMM 500) +</b>	\$500 per member, \$1,000 per family
	<b>Option 3 (MDA/CMM 1500)</b>	\$1,500 per member, \$3,000 per family
	<b>Option 4 (MDA/CMM 2500)</b>	\$2,500 per member, \$5,000 per family
<b>Copays</b> <b>Note:</b> Copays apply once the deductible has been met.		20% of approved amount
<b>Copay dollar maximums</b> – each calendar year – applies to copays for all covered services, including mental health and substance abuse services – but <b>does not</b> apply to private duty nursing percent copays	<b>Option 1</b>	\$1,500 per member, \$3,000 per family
	<b>Option 2</b>	\$2,000 per member, \$4,000 per family
	<b>Option 3</b>	\$2,000 per member, \$4,000 per family
	<b>Option 4</b>	\$2,500 per member, \$5,000 per family
<b>Lifetime dollar maximums</b>		\$1 million lifetime maximum per covered specified human organ transplant type and a <b>separate</b> \$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. For Options 3 and 4, the deductible and copay amounts are waived for the first \$300 of covered services, per member, for treatment of bodily injuries incurred as a result of an accident.

+ If you are currently enrolled in Option 1 or Option 2, you may remain in the plan; however, these plans are not available for new enrollment.