



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

# Michigan Dental Association Health Care Selection Guide

Community Blue<sup>SM</sup> PPO  
Medical Coverage



Benefits effective January 1, 2006

## Prescription Drug Coverage

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### What's Covered

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- Federal legend drugs
- Disposable needles and syringes dispensed with insulin, or chemotherapeutic drugs
- State controlled drugs
- Oral contraceptive medication

### Copays

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- \$15 for generic drugs
- \$60 for brand name non-formulary drugs
- \$30 for brand name drugs
- 50 percent copay for elective drugs

### Payment of Benefits

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- Network pharmacies** 100% of approved amount less the copay for each prescription or refill.
- Non-network pharmacies** 75% of approved amount less the copay for each prescription or refill.
- Mail order prescription drugs** Covers up to a 90-day supply of covered medication by mail from Medco, less a **\$30 copay for generic drugs, \$60 copay for name brand drugs or \$120 copay for non-formulary drugs.**

*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 MedImpact network.*

### What's not covered

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- 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 appliances even if prescribed by a physician
- More than a 34 day supply, except for specified maintenance drugs that are covered for 100-unit doses
- Refills dispensed after one year from the date of the original order
- Drugs for cosmetic purposes

## BCBSM Supplemental (to Medicare) for Retirees

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Supplemental coverage is not available to members enrolled in the Community Blue PPO Plan.

**Customer Service:** Blue Cross Blue Shield of Michigan  
Customer Service Toll-free Number

**1-800-432-9881**

For more information, contact the  
MDA Insurance and Financial Group Office

**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. It is not a contract. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificate 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 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.

Community Blue <sup>SM</sup> PPO Plan 3		Community Blue <sup>SM</sup> PPO Plan 12	
In-Network	Out-of-Network	In-Network	Out-of-Network

**Preventive Care Services** – Payment for preventive services, excluding immunizations, is limited to a combined maximum of \$500 per member per calendar year.

Health maintenance exam (includes chest X-ray, EKG and select lab procedures) – one per calendar year	Covered at 100%	Not covered	Covered at 100%	Not covered
Gynecological exam – one per calendar year	Covered at 100%	Not covered	Covered at 100%	Not covered
Pap smear screening – one per calendar year	Covered at 100%	Not covered	Covered at 100%	Not covered
Well-baby and child care visits - 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	Covered at 100%	Not covered	Covered at 100%	Not covered
Immunizations – up through age 16	Covered at 100%	Not covered	Covered at 100%	Not covered
Fecal occult blood screening – one per calendar year	Covered at 100%	Not covered	Covered at 100%	Not covered
Flexible sigmoidoscopy exam – one per calendar year	Covered at 100%	Not covered	Covered at 100%	Not covered
PSA screening – one per calendar year	Covered at 100%	Not covered	Covered at 100%	Not covered

### Physicians Office Services

Office visits (includes office consultations and urgent care visits)	\$10 copay	60% after deductible*	\$30 copay	60% after deductible*
Outpatient & home medical care visits	80% after deductible	60% after deductible*	80% after deductible	60% after deductible*

### Emergency Medical Care

\* must be medically necessary

\* must be medically necessary

Hospital emergency room	\$50 copay for facility charges (waived if admitted or for an accidental injury)	\$50 copay for facility charges (waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	80% after deductible	80% after deductible

### Diagnostic Services

Laboratory & pathology services	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Diagnostic tests & X-rays, therapeutic radiology	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Mammography screening – one per calendar year, no age restrictions	80% after deductible	60% after deductible	80% after deductible	60% after deductible

### Maternity Services Provided by a Physician or Certified Nurse Midwife

Prenatal & postnatal care	Covered -100%	60% after deductible	Covered -100%	60% after deductible
Delivery and nursery care	80% after deductible	60% after deductible	80% after deductible	60% after deductible

### Hospital Care

Semiprivate room, inpatient physician care, general nursing care, hospital services & supplies – unlimited days <b>Note:</b> Nonemergency services must be rendered in a <b>participating</b> hospital.	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Inpatient consultations	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Chemotherapy	80% after deductible	60% after deductible	80% after deductible	60% after deductible

### Alternatives to Hospital Care

Skilled nursing care – up to 120 days per calendar year	80% after deductible	80% after deductible
Hospice care – limited to dollar maximum which is adjusted periodically	Covered at 100%	Covered at 100%
Home health care – unlimited visits	80% after deductible	80% after deductible

### Surgical Services

Surgery (includes related surgical services)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Voluntary sterilization	80% after deductible	60% after deductible	80% after deductible	60% after deductible

Community Blue <sup>SM</sup> PPO Plan 3		Community Blue <sup>SM</sup> PPO Plan 12	
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### Human Organ Transplants

Specified organ transplants in designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (1-800-242-3504) – up to \$1 million lifetime maximum per transplant type	Covered at 100% in designated facilities <b>only</b>		Covered at 100% in designated facilities <b>only</b>	
Bone marrow transplants – when coordinated through BCBSM Human Organ Transplant Program (1-800-242-3504); specific criteria applies	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Kidney, cornea & skin transplants	80% after deductible	60% after deductible	80% after deductible	60% after deductible

### Mental Health Care and Substance Abuse Treatment

Inpatient mental health care		50% after deductible		50% after deductible	
Inpatient substance abuse treatment		50% after deductible		50% after deductible	
Outpatient mental health care	Facility & clinic	50% after deductible		50% after deductible	
	Physician's office	50% of approved amount	50% after deductible	50% of approved amount	50% after deductible
Outpatient substance abuse treatment – in approved facilities, up to the state-dollar amount which is adjusted annually		50% after deductible		50% after deductible	

### Other Covered Services

Outpatient diabetes management program (ODMP)		80% after deductible	60% after deductible	80% after deductible	60% after deductible
Allergy testing & therapy		Covered at 100%	60% after deductible	Covered at 100%	60% after deductible
Chiropractic spinal manipulation – up to 24 visits per calendar year		Covered at 100%	60% after deductible	Covered at 100%	60% after deductible
Outpatient physical, speech & occupational therapy – a <b>combined</b> 60-visit maximum per calendar year for physical therapy in the outpatient department of a hospital as well as in the physician's office	Facility & clinic	80% after deductible		80% after deductible	
	Physician's office – <b>excludes speech and occupational therapy</b>	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Durable medical equipment		80% after deductible	60% after deductible	80% after deductible	60% after deductible
Prosthetic and orthotic appliances		80% after deductible	60% after deductible	80% after deductible	60% after deductible
Private duty nursing services		50% after deductible		50% after deductible	

### Deductible, Copays and Dollar Maximums

**Note:** If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

<b>Deductible</b> Note: In-network deductible is waived if service is performed in a PPO physician's office. Out-of-network deductible amounts also apply toward the in-network deductible.		\$250 per member, \$500 per family per calendar year	\$500 per member, \$1,000 per family per calendar year	\$1,000 per member, \$2,000 per family per calendar year	\$2,000 per member, \$4,000 per family per calendar year
<b>Copays</b> Note: Services from a provider for which there is no PPO network are covered at the in-network level, subject to in-network deductible and copay amounts	Fixed dollar copays	\$10 for office visits, \$50 for emergency room visits	\$50 for emergency room visits	\$30 for office visits, \$50 for emergency room visits	\$50 for emergency room visits
	Percent copays	20% for general services, <b>waived if service is performed in a PPO physician's office</b> , and 50% for mental health, substance abuse and private duty nursing	40% for general services and 50% for mental health, substance abuse and private duty nursing	20% for general services, <b>waived if service is performed in a PPO physician's office</b> , and 50% for mental health, substance abuse and private duty nursing	40% for general services and 50% for mental health, substance abuse and private duty nursing
<b>Copay dollar maximums</b> Note: Out-of-network copays also apply toward the in-network maximum. Out-of-network copays also apply toward the in-network copay dollar maximum.	Fixed dollar copays	None		None	
	Percent copays	\$1,000 per member, \$2,000 per family per calendar year	\$3,000 per member, \$6,000 per family per calendar year	\$2,500 per member, \$5,000 per family per calendar year	\$3,000 per member, \$6,000 per family per calendar year
<b>Dollar Maximums</b>		\$5 million lifetime per member: \$15,000 <b>annual</b> , \$30,000 <b>lifetime</b> for inpatient mental health care and substance abuse treatment \$2,000 <b>annual</b> , \$5,000 <b>lifetime</b> for outpatient mental health care (subject to overall \$15,000/\$30,000 maximum) Additional \$1 million lifetime maximum per covered specified organ transplant type		\$5 million lifetime per member: \$15,000 <b>annual</b> , \$30,000 <b>lifetime</b> for inpatient mental health care and substance abuse treatment \$2,000 <b>annual</b> , \$5,000 <b>lifetime</b> for outpatient mental health care (subject to overall \$15,000/\$30,000 maximum) Additional \$1 million lifetime maximum per covered specified organ transplant type	