



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

# Michigan Dental Association Health Care Selection Guide Comprehensive Major Medical (CMM) 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

### Copayments

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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 for name brand drugs or \$120 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 applications, 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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### Inpatient Hospitalization

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Covers your Medical Part A deductible and coinsurance required from the 61st through the 90th day of a hospital admission. It also extends the number of your inpatients days to 365.

### Lifetime Reserve Days

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Covers the daily coinsurance required by Medicare Part A.

### Skilled Nursing Care

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

### Physician Care

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

### Outpatient Medical Health Care

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

**Customer Service:** Blue Cross Blue Shield of Michigan For more information, contact MDA Insurance and Financial Group Office in Lansing  
Customer Service Toll-free Number

**1-800-432-9881**

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

## Comprehensive Major Medical (CMM) Coverage

Plans CMM 250, CMM 500, CMM 1500, CMM 2500

### Preventive Care Services

Payment for preventive services is limited to a combined maximum of \$500 per calendar year per family member (excluding immunizations). There is no deductible or copay for these services.

Health maintenance exam - includes select lab and diagnostic procedures	Covered -100%, one per calendar year*
Annual gynecological exam	Covered -100%, one per calendar year*
Pap smear screening - laboratory and pathology services	Covered -100%, one per calendar year*
Well-baby and child care: - 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 -100%*
Immunizations	Covered -100%, up through age 16*
Fecal occult blood screening	Covered -100%, one per calendar year*
Flexible sigmoidoscopy exam	Covered -100%, one per calendar year*
PSA screening	Covered -100% one per calendar year*

### Mammography

Mammography screening	Covered -100%, one per calendar year, no age restriction*
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### Physicians Office Services

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

### Emergency Medical Care

Hospital emergency room	Covered -80% after deductible
Ambulance Services - must be medically necessary	Covered -80% after deductible

### Diagnostic and Therapeutic Services

Laboratory, pathology and diagnostic tests	Covered -80% after deductible
X-rays and radiation therapy	Covered -80% after deductible

### Maternity Care

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

### Hospital Care

Semi-private room, general nursing, hospital services, inpatient physician care	Covered -80% after deductible, unlimited days
Chemotherapy	Covered -80% after deductible

### Alternatives to Hospital Care

Hospice care- approved programs	Covered -100% limited to dollar maximum which is adjusted periodically
Home health care - approved programs	Covered -80% after deductible, unlimited days

### Surgical Services

Surgery - includes all related surgical services	Covered -80% after deductible, includes surgery at BCBSM - approved ambulatory facilities
Voluntary sterilization	Covered -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, CMM 2500,**

**Human Organ Transplants**

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

**Mental Health Care and Substance Abuse Treatment - Subject to dollar maximums (see "Dollar maximums")**

Inpatient mental health care and substance abuse treatment	Covered - 50% after deductible
Outpatient mental health care	Covered - 50% after deductible
Outpatient substance abuse treatment - in approved facilities	Covered - 50% after deductible, up to state - dollar amount which is adjusted annually

**Other Covered Services**

Contraceptive devices	Covered -100% after deductible
Allergy testing and therapy	Covered - 80% after deductible
Chiropractic spinal manipulation	Covered - 80% after deductible, up to 38 medically necessary visits per calendar year
Outpatient physical, speech and occupational therapy	Covered - 80% after deductible, unlimited visits
Durable medical equipment	Covered - 80% after deductible
Prosthetic and orthotic appliances	Covered - 80% after deductible
Private duty nursing	Covered - 80% 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> - ( per 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, \$3000 per family
	<b>Option 4 (MDA/CMM 2500)</b>	\$2,500 per member, \$5,000 per family
<b>Copays</b>	20% of approved amount for general services and 50% of approved for mental health care and substance abuse treatment	
<b>Copays dollar maximums</b> , ( each calendar year) - excludes copays for mental health care, substance abuse treatment and private duty nursing	<b>Option 1:</b>	\$1,500 per member, \$3,000 per family
	<b>Option 2 &amp; 3:</b>	\$2,000 per member, \$4,000 per family
	<b>Option 4:</b>	\$2,500 per member, \$5,000 per family
<b>Dollar maximums</b>	\$5 million lifetime per member: - \$25,000 <b>lifetime</b> for inpatient mental health care and substance abuse treatment - \$2000 <b>annual</b> , \$5000 <b>lifetime</b> for outpatient mental health care ( subject to overall \$25,000 maximum) Additional \$1 million lifetime maximum per covered specified organ transplant type	

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

**Note:** All Pre-existing conditions, including sterilization, and removal of tonsils and adenoids in children up to the age of 19, are subject to a 365-day waiting period. For Option 3 & 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.