

**Flexible Blue
Prescription Drug Coverage**

Flexible BlueSM Medical Coverage
Benefits effective January 1, 2008

Your Flexible Blue prescription drug benefits, including mail drugs, are subject to the same deductible and lifetime dollar maximum required under your Flexible Blue medical coverage.

Benefits are **not** payable until you have met the Flexible Blue annual deductible. After you have satisfied the deductible you are required to pay fixed dollar copays which are limited to the annual out-of-pocket copay dollar maximum.

What's Covered

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

Note: *If you obtain a brand name drug (including mail order drugs) when a generic equivalent drug is available, you may be required to pay difference between maximum allowable cost for generic and BCBSM-approved amount for brand name drug (even if the prescription is marked "DAW") PLUS your copay. **Exception:** if your physician requests and receives authorization for a brand name drug from the BCBSM Pharmacy Services Department and writes "Dispense as written" or "DAW" on the prescription order, you pay only your copay.*

Flexible Blue Prescription Drug Copays

- \$10 for each generic drug or *plus* additional 20% of BCBSM approved amount for drugs received out-of-network.
- \$60 for each brand name drug *plus* additional 20% BCBSM approved amount for drugs received out-of-network.

Note: *The 20% out-of-network copay will not be applied toward your Flexible Blue annual deductible, annual out-of-pocket copay dollar maximum, or lifetime dollar maximum.*

Mail Order Prescription Drug Copays

- \$10 for each generic drug or \$60 for each brand name drug for up to a 34 day supply.
- \$20 for each generic drug or \$120 for each brand name drug for a 35 to 90 day supply.

Payment of Benefits

Network pharmacies	100% of approved amount less the copay for each prescription or refill.
Non-network pharmacies	80% of approved amount less the copay for each prescription or refill.
Mail order prescription drugs	Covers up to a 90-day supply of prescribed medication by mail from Medco (not covered out-of-network), less copay.

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.*

BCBSM Supplemental (to Medicare) for Retirees

Supplemental coverage is not available to members enrolled in the flexible Blue 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 in Lansing
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.

Flexible Blue SM Plan 3		Flexible Blue SM Plan 4	
In-Network	Out-of-Network	In-Network	Out-of-Network

Preventive Care Services – Payment for preventive care services is limited to a **combined** maximum of \$500 per member per calendar year. There is no deductible or copay.

Health maintenance exam (includes chest X-ray, EKG, cholesterol screening and other 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 as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics	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)	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Outpatient & home medical care visits	70% after deductible	50% after deductible	100% after deductible	80% after deductible

Emergency Medical Care

Hospital emergency room	70% after deductible	100% after deductible
Ambulance services - medically necessary	70% after deductible	100% after deductible

Diagnostic Services

Laboratory & pathology services	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Diagnostic tests & X-rays, therapeutic radiology	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Colonoscopy – one per calendar year	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Mammography screening – one per calendar year, no age restrictions	70% after deductible	50% after deductible	100% after deductible	80% after deductible

Maternity Services Provided by a Physician or Certified Nurse Midwife

Prenatal & postnatal care	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Delivery and nursery care	70% after deductible	50% after deductible	100% after deductible	80% after deductible

Hospital Care

Semiprivate room, inpatient physician care, general nursing care, hospital services & supplies – unlimited days Note: Nonemergency services must be rendered in a participating hospital.	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Inpatient consultations	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Chemotherapy	70% after deductible	50% after deductible	100% after deductible	80% after deductible

Alternatives to Hospital Care

Skilled nursing care – limited to 90 days per calendar year	70% after deductible	100% after deductible
Hospice care – limited to lifetime dollar maximum which is adjusted annually	70% after deductible	100% after deductible
Home health care – unlimited visits	70% after deductible	100% after deductible

Surgical Services

Surgery (includes related surgical services)	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Voluntary sterilization	70% after deductible	50% after deductible	100% after deductible	80% after deductible

Human Organ Transplants	Flexible Blue SM Plan 3		Flexible Blue SM Plan 4	
	In-Network	Out-of-Network	In-Network	Out-of-Network
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 – 70% after deductible, in designated facilities only		Covered – 100% after deductible, in designated facilities only	
Bone marrow transplants – when coordinated through BCBSM Human Organ Transplant Program (1-800-242-3504); specific criteria applies	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Kidney, cornea & skin transplants	70% after deductible	50% after deductible	100% after deductible	80% after deductible

Mental Health Care and Substance Abuse Treatment

Inpatient mental health care & inpatient substance abuse treatment– up to a combined maximum of 60 days per calendar year / 120 days lifetime	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Outpatient mental health care – up to a combined maximum of 120 visits per calendar year	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Outpatient substance abuse treatment (in approved facilities only) – up to annual state-dollar amount (that combines outpatient and residential substance abuse)	70% after deductible	50% after deductible	100% after deductible	80% after deductible

Other Covered Services

Outpatient diabetes management program (ODMP)	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Physician-prescribed contraceptive devices & contraceptive injections	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Allergy testing & therapy	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Chiropractic spinal manipulation & osteopathic manipulative therapy – up to 24 visits per calendar year	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Outpatient physical, speech & occupational therapy (provided for rehabilitation) – up to a combined maximum of 60 visits per calendar year	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Durable medical equipment	70% after deductible	70% after deductible	100% after deductible	100% after deductible
Prosthetic and orthotic appliances	70% after deductible	70% after deductible	100% after deductible	100% after deductible
Private duty nursing services	70% after deductible	70% after deductible	100% after deductible	100% after deductible

Deductible, Copays and Dollar Maximums

Note: a PPO provider refers you to a non-network provider, all covered services obtained from that non-network provider will be subject to applicable out-of-network cost-sharing.

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.

Deductible Note: Your deductible combines the deductible amounts paid under your Flexible Blue medical coverage and your Flexible Blue prescription drug coverage. Deductibles in Plan 4 are based on amounts defined annually by the federal government for Flexible Blue-related health plans. Please call your customer service center for an annual update.	\$2,000 for a one-person contract or \$4,000 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)	\$4,000 for a one-person contract or \$8,000 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)	\$2,900 for a one-person contract or \$5,800 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)	\$5,600 for a one-person contract or \$11,200 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)
Copays Note: Copays apply once the deductible has been met. Services from a provider for which there is no PPO network and emergency services are covered at the in-network level, subject to applicable in-network deductible and copay amounts.	30% of approved amount	50% of approved amount	Flexible Blue medical copays: No copays Flexible Blue prescription drug copays: See inside back panel	Flexible Blue medical copays: 20% of approved amount Flexible Blue prescription drug copays: See inside back panel
Copay dollar maximums Note: Your copay dollar maximum combines the copay amounts paid under your Flexible Blue medical coverage and your Flexible Blue prescription drug coverage.	\$2,000 for a one-person contract or \$4,000 for a family contract (2 or more members) each calendar year	\$4,000 for a one-person contract or \$8,000 for a family contract (2 or more members) each calendar year	Flexible Blue prescription drug copay dollar maximum: \$1,000 for a one-person contract or \$2,000 for a family contract (2 or more members) each calendar year	\$2,000 for a one-person contract or \$4,000 for a family contract (2 or more members) each calendar year
Dollar Maximums (per member)	Combined \$5 million lifetime per member for Flexible Blue medical coverage and Flexible Blue prescription drug coverage and a separate \$1 million lifetime per member per covered specified organ transplant type		Combined \$5 million lifetime per member for Flexible Blue medical coverage and Flexible Blue prescription drug coverage and a separate \$1 million lifetime per member per covered specified organ transplant type	