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

Michigan Dental Association
Health Care Selection Guide
Flexible Blue[SM]
Medical Coverage
Benefits effective January 1, 2010
Some benefits modified effective July 1, 2010

Flexible Blue Prescription Drug Coverage*

Your Flexible Blue prescription drug benefits, including mail order drugs, are subject to the same deductibles and lifetime dollar maximums 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

- 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)

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 the difference between the maximum allowable cost for the generic drug and the BCBSM approved amount for the 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 (***plus*** an additional 20% of BCBSM approved amount for drugs received out-of-network)
- $60 for each brand name drug (***plus*** an additional 20% of BCBSM approved amount for drugs received out-of-network)

Note: *The 20 percent 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 30-day supply
- $20 for each generic drug **or** $120 for each brand name drug, for a 31 to 90-day supply

Payment of Benefits

Network pharmacy	100% of approved amount less the copay for each prescription or refill.
Non-network pharmacy	80% of approved amount less the copay for each prescription or refill.
Mail order prescription provider	Covers up to a 90-day supply of prescribed medication by mail from Medco less copay. **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 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.

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 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.

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

Preventive Care Services

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.

Service	Plan 3 In-Network	Plan 3 Out-of-Network	Plan 4 In-Network	Plan 4 Out-of-Network
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
Mammography screening – one medically necessary **or** one routine mammogram per calendar year **Note:** Additional mammograms are subject to your in-network deductible and copay.	Covered at 100%	50% after deductible	Covered at 100%	80% 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	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	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
Ovarian cancer screening (CA-125) – one per calendar year	Covered at 100%	Not covered	Covered at 100%	Not covered

Physician Office Services

Service	Plan 3 In-Network	Plan 3 Out-of-Network	Plan 4 In-Network	Plan 4 Out-of-Network
Office visits (includes office consultations and urgent care visits)	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Outpatient and home medical care visits	70% after deductible	50% after deductible	100% after deductible	80% after deductible

Emergency Medical Care

Service	Plan 3		Plan 4	
Hospital emergency room	70% after deductible		100% after deductible	
Ambulance services – must be medically necessary	70% after deductible		100% after deductible	

Diagnostic Services

Service	Plan 3 In-Network	Plan 3 Out-of-Network	Plan 4 In-Network	Plan 4 Out-of-Network
Laboratory and pathology services	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Diagnostic tests and x-rays, therapeutic radiology	70% after deductible	50% after deductible	100% after deductible	80% after deductible

Maternity Services Provided by a Physician or Certified Nurse Midwife

Service	Plan 3 In-Network	Plan 3 Out-of-Network	Plan 4 In-Network	Plan 4 Out-of-Network
Prenatal and 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

Service	Plan 3 In-Network	Plan 3 Out-of-Network	Plan 4 In-Network	Plan 4 Out-of-Network
Semiprivate room, inpatient physician care, general nursing care, hospital services and 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

Service	Plan 3		Plan 4	
Skilled nursing care – up to 90 days per calendar year	70% after deductible		100% 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	70% after deductible		100% after deductible	
Home health care and home infusion therapy – must be medically necessary	70% after deductible		100% after deductible	

Surgical Services

Service	Plan 3 In-Network	Plan 3 Out-of-Network	Plan 4 In-Network	Plan 4 Out-of-Network
Surgery – includes related surgical services and medically necessary facility services by a BCBSM **participating** ambulatory surgery facility	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
Voluntary sterilization	70% after deductible	50% after deductible	100% after deductible	80% after deductible

	Flexible Blue℠ Plan 3		Flexible Blue℠ Plan 4	
	In-Network	**Out-of-Network**	**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	70% after deductible, in designated facilities **only**		100% after deductible, in designated facilities **only**	
Bone marrow transplants – when coordinated through BCBSM Human Organ Transplant Program (1-800-242-3504)	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Kidney, cornea and 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 and substance abuse treatment – unlimited days	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Outpatient mental health care	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Outpatient substance abuse treatment – in approved facilities **only**	70% after deductible		100% 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 and contraceptive injections	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Allergy testing and therapy	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Chiropractic manipulation treatment and osteopathic manipulation treatment – **combined** 24-visit maximum per calendar year	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Outpatient physical, speech and occupational therapy (provided for rehabilitation) – **combined** 60-visit maximum per calendar year	70% after deductible	50% after deductible	100% after deductible	80% after deductible
Durable medical equipment	70% after deductible		100% after deductible	
Prosthetic and orthotic appliances	70% after deductible		100% after deductible	
Private duty nursing services	70% after deductible		100% after deductible	

Deductibles, Copays and Dollar Maximums

Note: Services without a PPO network and emergency services are covered at the in-network level. **If 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 the BCBSM approved amount and the provider's charge.

	Plan 3 In-Network	Plan 3 Out-of-Network	Plan 4 In-Network	Plan 4 Out-of-Network
Deductibles – each calendar year **Note:** The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract. Your deductible **combines** the deductible 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) – no 4th quarter carry-over	$4,000 for a one-person contract **or** $8,000 for a family contract (2 or more members) – no 4th quarter carry-over	$3,050 for a one-person contract **or** $6,150 for a family contract (2 or more members) – no 4th quarter carry-over	$5,950 for a one-person contract **or** $11,900 for a family contract (2 or more members) – no 4th quarter carry-over
Flexible Blue medical copays – see first page for Flexible Blue prescription drug copays **Note:** Copays apply once the deductible has been met.	30% of approved amount	50% of approved amount	No copays	20% of approved amount
Copay dollar maximums – each calendar year **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)	$4,000 for a one-person contract **or** $8,000 for a family contract (2 or more members)	**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)	$2,000 for a one-person contract **or** $4,000 for a family contract (2 or more members)
Lifetime dollar maximums	**Combined** $5 million lifetime maximum for Flexible Blue medical coverage **and** Flexible Blue prescription drug coverage and a **separate** $1 million lifetime maximum per covered specified human organ transplant type per member		**Combined** $5 million lifetime maximum for Flexible Blue medical coverage **and** Flexible Blue prescription drug coverage and a **separate** $1 million lifetime maximum per covered specified human organ transplant type per member	

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.*