



## Flexible Blue<sup>SM</sup> Plan 2 Medical Coverage with Flexible Blue<sup>SM</sup> RX Prescription Drugs Benefits-at-a-Glance for Western Michigan Health Insurance Pool

The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This BAAG is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

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. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits, please see the applicable BCBSM certificates and riders if your group is underwritten or your summary plan description if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

### In-network

### Out-of-network \*

#### Member's responsibility (deductibles, copays and dollar maximums)

**Note: 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.**

|   | In-network   | Out-of-network *  |
|---|--|---|
| <b>Deductibles</b><br><b>Note:</b> Your deductible <b>combines</b> deductible amounts paid under your Flexible Blue medical coverage <b>and</b> your Flexible Blue prescription drug coverage.<br><b>Note:</b> The full family deductible <b>must</b> be met under a two-person or family contract before benefits are paid for any person on the contract. | \$1,250 for a one-person contract or \$2,500 for a family contract (2 or more members) each calendar year ( <b>no 4<sup>th</sup> quarter carry-over</b> )                          | \$2,500 for a one-person contract or \$5,000 for a family contract (2 or more members) each calendar year ( <b>no 4<sup>th</sup> quarter carry-over</b> ) |
|   | Deductibles 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. |   |
| <b>Fixed dollar copays</b>  | Based on prescription drug copay rider selected  | Based on prescription drug copay rider selected   |
| <b>Percent copays</b><br><b>Note:</b> Copays apply once the deductible has been met.  | None   | 20% of approved amount  |
| <b>Annual copay dollar maximums</b><br><b>Note:</b> Your copay dollar maximum <b>combines</b> copay amounts paid under your Flexible Blue medical coverage <b>and</b> your Flexible Blue prescription drug coverage.  | \$1,000 for a one-person contract or \$2,000 for a family contract (2 or more members) each calendar year – applies to prescription drug copays                                    | \$2,000 for a one-person contract or \$4,000 for a family contract (2 or more members) each calendar year   |
| <b>Lifetime dollar maximum</b>  | None   |   |

#### Preventive care services

|  | In-network  | Out-of-network * |
|--|---|------------------|
| Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures | 100% (no deductible or copay), one per member per calendar year | Not covered      |
| Gynecological exam   | 100% (no deductible or copay), one per member per calendar year | Not covered      |
| Pap smear screening – laboratory and pathology services  | 100% (no deductible or copay), one per member per calendar year | Not covered      |

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

\* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. 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.



**In-network**

**Out-of-network \***

**Preventive care services, *continued***

|   |  |   |
|---|--|---|
| Well-baby and child care visits   | 100% (no deductible or copay)<br>• 6 visits, birth through 12 months<br>• 6 visits, 13 months through 23 months<br>• 6 visits, 24 months through 35 months<br>• 2 visits, 36 months through 47 months<br>• Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit | Not covered   |
| Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act | 100% (no deductible or copay)  | Not covered   |
| Fecal occult blood screening  | 100% (no deductible or copay), one per member per calendar year  | Not covered   |
| Flexible sigmoidoscopy exam   | 100% (no deductible or copay), one per member per calendar year  | Not covered   |
| Prostate specific antigen (PSA) screening   | 100% (no deductible or copay), one per member per calendar year  | Not covered   |
| Routine mammogram and related reading   | 100% (no deductible or copay)<br><b>Note:</b> Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.  | 80% after out-of-network deductible<br><b>Note:</b> Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider. |
|   | One per member per calendar year   |   |
| Colonoscopy – routine or medically necessary  | 100% (no deductible or copay) for routine colonoscopy<br><b>Note:</b> Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and percent copay.   | 80% after out-of-network deductible   |
|   | One routine colonoscopy per member per calendar year   |   |

**Physician office services**

|   |                                  |                                     |
|---|----------------------------------|-------------------------------------|
| Office visits                           | 100% after in-network deductible | 80% after out-of-network deductible |
| Outpatient and home medical care visits | 100% after in-network deductible | 80% after out-of-network deductible |
| Office consultations                    | 100% after in-network deductible | 80% after out-of-network deductible |
| Urgent care visits                      | 100% after in-network deductible | 80% after out-of-network deductible |

**Emergency medical care**

|  |                                  |                                  |
|--|----------------------------------|----------------------------------|
| Hospital emergency room                          | 100% after in-network deductible | 100% after in-network deductible |
| Ambulance services – must be medically necessary | 100% after in-network deductible | 100% after in-network deductible |

**Diagnostic services**

|                                   |                                  |                                     |
|-----------------------------------|----------------------------------|-------------------------------------|
| Laboratory and pathology services | 100% after in-network deductible | 80% after out-of-network deductible |
| Diagnostic tests and x-rays       | 100% after in-network deductible | 80% after out-of-network deductible |
| Therapeutic radiology             | 100% after in-network deductible | 80% after out-of-network deductible |

\* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. 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.



**In-network**

**Out-of-network \***

**Maternity services provided by a physician**

|                             |   |                                     |
|-----------------------------|---|-------------------------------------|
| Prenatal and postnatal care | 100% after in-network deductible<br>Includes covered services provided by a certified nurse midwife | 80% after out-of-network deductible |
| Delivery and nursery care   | 100% after in-network deductible<br>Includes covered services provided by a certified nurse midwife | 80% after out-of-network deductible |

**Hospital care**

|   |                                  |                                     |
|---|----------------------------------|-------------------------------------|
| Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies<br><b>Note:</b> Nonemergency services must be rendered in a <b>participating</b> hospital. | 100% after in-network deductible | 80% after out-of-network deductible |
| Unlimited days  |                                  |                                     |
| Inpatient consultations   | 100% after in-network deductible | 80% after out-of-network deductible |
| Chemotherapy  | 100% after in-network deductible | 80% after out-of-network deductible |

**Alternatives to hospital care**

|   |   |                                  |
|---|---|----------------------------------|
| Skilled nursing care – must be in a <b>participating</b> skilled nursing facility                                     | 100% after in-network deductible<br>Limited to a maximum of 90 days per member per calendar year  | 100% after in-network deductible |
| Hospice care  | 100% after in-network deductible<br>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 (after reaching dollar maximum, member transitions into individual case management) | 100% after in-network deductible |
| Home health care – must be medically necessary and provided by a <b>participating</b> home health care agency         | 100% after in-network deductible  | 100% after in-network deductible |
| Home infusion therapy – must be medically necessary and given by <b>participating</b> home infusion therapy providers | 100% after in-network deductible  | 100% after in-network deductible |

**Surgical services**

|  |                                  |                                     |
|--|----------------------------------|-------------------------------------|
| Surgery – includes related surgical services and medically necessary facility services by a <b>participating</b> ambulatory surgery facility | 100% after in-network deductible | 80% after out-of-network deductible |
| Presurgical consultations  | 100% after in-network deductible | 80% after out-of-network deductible |
| Voluntary sterilization  | 100% after in-network deductible | 80% after out-of-network deductible |

**Human organ transplants**

|   |                                  |   |
|---|----------------------------------|---|
| Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) | 100% after in-network deductible | 100% after in-network deductible – in designated facilities <b>only</b> |
| Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)  | 100% after in-network deductible | 80% after out-of-network deductible                                     |
| Specified oncology clinical trials  | 100% after in-network deductible | 80% after out-of-network deductible                                     |
| Kidney, cornea and skin transplants   | 100% after in-network deductible | 80% after out-of-network deductible                                     |

\* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a “low-access area” by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. 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.



**In-network**

**Out-of-network \***

**Mental health care and substance abuse treatment**

**Note:** If your employer has **51 or more** employees (including seasonal and part-time) and is subject to the MHP law, covered mental health and substance abuse services are subject to the following frequency limits. If you receive your health care benefits through a collectively bargained agreement, please contact your employer and/or union to determine when or if this benefit level applies to your plan.

|   |                                  |  |
|---|----------------------------------|--|
| Inpatient mental health care and inpatient substance abuse treatment      | 100% after in-network deductible | 80% after out-of-network deductible  |
|   | Unlimited days                   |  |
| Outpatient mental health care<br>• Facility and clinic                    | 100% after in-network deductible | 100% after in-network deductible, in participating facilities <b>only</b>    |
| • Physician's office  | 100% after in-network deductible | 80% after out-of-network deductible  |
| Outpatient mental health care   | 100% after in-network deductible | 80% after out-of-network deductible, in participating facilities <b>only</b> |
| Outpatient substance abuse treatment – in approved facilities <b>only</b> | 100% after in-network deductible | 100% after in-network deductible   |

**Other covered services**

|  |   |  |
|--|---|--|
| Outpatient Diabetes Management Program (ODMP)                                      | 100% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay) for diabetes self-management training | 80% after out-of-network deductible  |
| Allergy testing and therapy  | 100% after in-network deductible  | 80% after out-of-network deductible  |
| Chiropractic & Osteopathic spinal manipulation                                     | 100% after in-network deductible  | 80% after out-of-network deductible  |
|  | Up to 24 visits per member per calendar year  |  |
| Outpatient physical, speech and occupational therapy – provided for rehabilitation | 100% after in-network deductible  | 80% after out-of-network deductible<br><b>Note:</b> Services at nonparticipating outpatient physical therapy facilities are not covered. |
|  | Limited to a <b>combined</b> maximum of 60 visits per member per calendar year  |  |
| Durable medical equipment  | 100% after in-network deductible  | 100% after in-network deductible   |
| Prosthetic and orthotic appliances   | 100% after in-network deductible  | 100% after in-network deductible   |
| Private duty nursing   | 100% after in-network deductible  | 100% after in-network deductible   |

\* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. 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.



## Flexible Blue<sup>SM</sup> RX Prescription Drug Plan \$10 / \$40 Fixed Dollar Copay with \$1,000 / \$2,000 Copay Maximum Benefits-at-a-Glance

**Specialty Drugs** – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel<sup>®</sup> and Humira<sup>®</sup>) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at [bcbsm.com](http://bcbsm.com). Log in under “I am a Member.” If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

**Effective July 1, 2010, BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).**

### Network pharmacy \*

### Non-network pharmacy \*

#### Member’s responsibility (deductibles, copays and dollar maximums)

Your Flexible Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual copay maximum required under your Flexible Blue HSA medical coverage. Benefits are **not** payable until after you have met the Flexible Blue HSA annual deductible. After you have satisfied the deductible you are required to pay applicable fixed dollar prescription drug copays which are subject to your annual copay dollar maximums.

**Note:** If your prescription is filled by any type of network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber has not indicated “Dispensed as Written” (DAW) on the prescription, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic **plus** the applicable copay.

|   | Network pharmacy *  | Non-network pharmacy *   |
|---|---|--|
| <b>Deductibles</b> (each calendar year)<br><b>Note:</b> The full family deductible <b>must</b> be met under a two-person or family contract before benefits are paid for any person on the contract.          | Same as Flexible Blue medical coverage (no 4 <sup>th</sup> quarter carry-over)<br><b>Note:</b> Includes deductible amounts paid under your Flexible Blue medical coverage.  | Same as Flexible Blue medical coverage (no 4 <sup>th</sup> quarter carry-over)<br><b>Note:</b> Includes deductible amounts paid under your Flexible Blue medical coverage. |
| Deductibles 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.                            |   |  |
| <b>Fixed dollar copays</b><br><b>Note:</b> Copays apply once the deductible has been met.   |   |  |
| <ul style="list-style-type: none"> <li>Generic or prescribed over-the-counter drugs<br/> <b>Note:</b> Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.</li> </ul> | \$10 copay  | \$10 copay <b>plus</b> an additional 20% of BCBSM approved amount for the drug **  |
| <ul style="list-style-type: none"> <li>Brand name drugs</li> </ul>  | \$40 copay  | \$40 copay <b>plus</b> an additional 20% of BCBSM approved amount for the drug **  |
| <ul style="list-style-type: none"> <li>Mail order (home delivery) prescription drugs</li> </ul>   | <b>Copay for up to a 30 day supply:</b> <ul style="list-style-type: none"> <li>\$10 copay for generic drugs</li> <li>\$40 copay for brand name drugs</li> </ul> <b>Copay for a 31 to 90 day supply:</b> <ul style="list-style-type: none"> <li>\$20 copay for generic drugs</li> <li>\$80 copay for brand name drugs</li> </ul> | No coverage  |

\* A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a Medco pharmacy outside Michigan. Medco is an independent company providing pharmacy benefit services for Blues members. A **non-network** pharmacy is a pharmacy NOT in the Preferred Rx or Medco networks.

\*\* The 20% prescription drug out-of-network copay will **not** be applied toward your annual Flexible Blue deductible or annual copay dollar maximum.



**Network pharmacy**

**Non-network pharmacy**

**Member's responsibility (deductibles, copays and dollar maximums), *continued***

|                                     |   |   |
|-------------------------------------|---|---|
| <b>Annual copay dollar maximums</b> | \$1,000 for a one-person contract or \$2,000 for a family contract (2 or more members) each calendar year<br><b>Note:</b> Includes copay amounts paid under your Flexible Blue medical coverage, if applicable. | \$2,000 for a one-person contract or \$4,000 for a family contract (2 or more members) each calendar year (excludes 20% out-of-network prescription drug copays)<br><b>Note:</b> Includes copay amounts paid under your Flexible Blue medical coverage. |
| <b>Lifetime dollar maximum</b>      | None  |   |

**Covered services**

|  |  |   |
|--|--|---|
| FDA-approved drugs   | Subject to Flexible Blue medical deductible and Flexible Blue prescription drug fixed dollar copay | Subject to Flexible Blue medical deductible and Flexible Blue prescription drug fixed dollar copay <b>plus</b> an additional 20% prescription drug out-of-network copay |
| Prescribed over-the-counter drugs – when covered by BCBSM  | Subject to Flexible Blue medical deductible and Flexible Blue prescription drug fixed dollar copay | Subject to Flexible Blue medical deductible and Flexible Blue prescription drug fixed dollar copay <b>plus</b> an additional 20% prescription drug out-of-network copay |
| State-controlled drugs   | Subject to Flexible Blue medical deductible and Flexible Blue prescription drug fixed dollar copay | Subject to Flexible Blue medical deductible and Flexible Blue prescription drug fixed dollar copay <b>plus</b> an additional 20% prescription drug out-of-network copay |
| Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs<br><b>Note:</b> Needles and syringes have no copay. | Subject to Flexible Blue medical deductible and Flexible Blue prescription drug fixed dollar copay | Subject to Flexible Blue medical deductible and Flexible Blue prescription drug fixed dollar copay <b>plus</b> an additional 20% prescription drug out-of-network copay |
| Mail order (home delivery) prescription drugs – up to a 90-day supply of medication by mail from Medco (BCBSM network mail order provider)                 | Subject to Flexible Blue medical deductible and Flexible Blue prescription drug fixed dollar copay | No coverage   |

**Features of your prescription drug plan**

|  |  |
|--|--|
| <b>Drug interchange and generic copay waiver</b> | Certain drugs may not be covered for future prescriptions if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at <b>bcbsm.com</b> .<br>If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.  |
| <b>Quantity limits</b>                           | Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at <b>bcbsm.com</b> .  |
| <b>Prescription drug preferred therapy</b>       | A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications <b>before</b> prescribing a more expensive brand-name drug. It applies only to prescriptions being filed for the first time of a targeted medication.<br>Before filling your <b>initial</b> prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at <b>bcbsm.com, along with the preferred medications</b> .<br>If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect <b>all</b> targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider. |



### Additional riders

|   |   |
|---|---|
| <b>Rider CI, Rider PCD2 and Rider PD-CM</b> | <p>Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and IUDs, and FDA-approved oral, or self- injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered).</p> <p><b>Note:</b> These riders are only available as part of a “prescription drug package” with the Flexible Blue Prescription Drug Plan.</p> <p>Riders CI and PCD2 are part of your medical-surgical coverage, subject to the same deductible and copay, if any, you pay for medical-surgical services.</p> <p>Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.</p> |
|---|---|