



Flexible BlueSM Plan 2 Medical Coverage with Flexible BlueSM RX Prescription Drugs Benefits-at-a-Glance

LAKE SHORE PUBLIC SCHOOLS

This is intended as an easy-to-read summary. **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.

In-network

Out-of-network

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 our approved amount and the provider's charge.

Deductibles Note: Your deductible combines the deductible amounts paid under your Flexible Blue medical coverage and your Flexible Blue prescription drug coverage. 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.	\$1,250 for a one-person contract or \$2,500 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)	\$2,500 for a one-person contract or \$5,000 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)
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.		
Copays <ul style="list-style-type: none"> Fixed dollar copays Percent copays 	None None	None 20% of approved amount
Copay dollar maximums <ul style="list-style-type: none"> Fixed dollar copays Percent copays 	Not applicable Not applicable	Not applicable \$1,000 for a one-person contract or \$2,000 for a family contract (2 or more members) each calendar year (excludes 20% out-of-network prescription drug copays) Note: Your copay dollar maximum combines the copay amounts paid under your Flexible Blue medical coverage and your Flexible Blue prescription drug coverage.
Dollar maximums	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 human organ transplant type	

Physician office services

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



In-network

Out-of-network

Preventive care services – *Payment for preventive services is limited to a **combined** maximum of \$500 per member per calendar year

Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Gynecological exam	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Well-baby and child care	Covered – 100% (no deductible or copay)* <ul style="list-style-type: none"> • 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 	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics	Covered – 100% (no deductible or copay)*	Not covered
Fecal occult blood screening	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered

Mammography

Mammography screening	Covered – 100% (no deductible or copay)	Covered – subject to your Flexible Blue medical out-of-network deductible and percent copay
	One per calendar year, no age restriction	

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



In-network

Out-of-network

Emergency medical care

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

Diagnostic services

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

Maternity services provided by a physician

Prenatal and postnatal care	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Includes care provided by a certified nurse midwife		
Delivery and nursery care	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Includes delivery provided by a certified nurse midwife		

Hospital care

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

Alternatives to hospital care

Skilled nursing care	Covered – 100% after in-network deductible, in participating skilled nursing facilities only Limited to 90 days per member per calendar year	
Hospice care	Covered – 100% after in-network deductible, through a participating hospice program only Limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – must be medically necessary	Covered – 100% after in-network deductible, by a participating home health care agency only	
Home infusion therapy – must be medically necessary	Covered – 100% after in-network deductible, by participating providers only	

Surgical services

Surgery – includes presurgical consultations, related surgical services and medically necessary facility services by a participating ambulatory surgery facility	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Colonoscopy	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
One per member per calendar year		
Voluntary sterilization	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible



In-network

Out-of-network

Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100% after in-network deductible, in designated facilities only , limited to \$1 million lifetime maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Specified oncology clinical trials	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Kidney, cornea and skin	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible

Mental health care and substance abuse treatment

Inpatient mental health care and inpatient substance abuse treatment	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
	Limited to a combined maximum of 60 days per calendar year with 120 days lifetime per member	
Outpatient mental health care	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible, in participating facilities only
	Limited to a combined maximum of 120 visits per member per calendar year	
Outpatient substance abuse treatment – in approved facilities only	Covered – 100% after in-network deductible	Covered – 100% after in-network deductible, in approved facilities only
	Limited to annual state-dollar amount (that combines outpatient and residential substance abuse)	

Other covered services

Outpatient Diabetes Management Program (ODMP)	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Allergy testing and therapy	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Osteopathic manipulative therapy	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Chiropractic spinal manipulation	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Outpatient physical, speech and occupational therapy services – provided for rehabilitation	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
	Note: Outpatient physical therapy is not covered at nonparticipating facilities. Limited to a combined maximum of 60 visits per member per calendar year	
Durable medical equipment	Covered – 100% after in-network deductible	Covered – 100% after in-network deductible
Prosthetic and orthotic appliances	Covered – 100% after in-network deductible	Covered – 100% after in-network deductible
Private duty nursing services	Covered – 100% after in-network deductible	Covered – 100% after in-network deductible



Prescription drug coverage

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

Benefits are **not** payable until after you have met the Flexible Blue annual deductible.

Note: Effective October 1, 2006, the mail order pharmacy for **specialty drugs** changed to Option Care, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Option Care 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 Blue members.) A list of specialty drugs is available on our Web site at bcbsm.com. Log in under "I am a Member." If you have any questions, please call Option Care customer service at 866-515-1355.

<p>Flexible BlueSM Rx Prescription Drug Plan:</p> <ul style="list-style-type: none"> • "Rx only" drugs • Prescribed over-the-counter drugs – when covered by BCBSM • State-controlled drugs • Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs <p>Note: Needles and syringes have no copay.</p> <ul style="list-style-type: none"> • Mail order (home delivery) prescription drugs – up to a 90-day supply of prescribed medication by mail from Medco (no coverage out-of-network) 	<p>Network pharmacy: 100% of approved amount after Flexible Blue medical coverage deductible</p> <p>Note: If 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 your copay, if applicable. This cost difference will not be applied toward your in-network deductible, nor your out-of-pocket or lifetime maximums, if applicable.</p> <p>Non-network pharmacy: 80% of approved amount after Flexible Blue medical coverage deductible (The 20% out-of-network copay will not be applied toward your annual Flexible Blue deductible, out-of-pocket copay maximum or lifetime dollar maximum.)</p>
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Note: A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a MedImpact pharmacy outside Michigan. MedImpact is an independent company providing pharmacy benefit services for Blue members. A **non-network** pharmacy is a pharmacy NOT in the Preferred Rx or MedImpact networks.

Features of your prescription drug plan

<p>Drug interchange and generic copay waiver</p>	<p>Certain drugs may not be covered for a second prescription 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 bcbsm.com.</p> <p>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.</p>
<p>Quantity limits</p>	<p>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 bcbsm.com.</p>



Additional riders

<p>Rider FB – CM1000/2000-P, 2000/4000-NP</p>	<p>Adds an annual copay maximum of \$1,000 for a one-person contract, \$2,000 for a family contract (2 or more members) for in-network services and increases the copay maximum for out-of-network services to \$2,000 for a one-person contract, \$4,000 for a family contract (2 or more members).</p>
<p>Rider FB – OCSM-24</p>	<p>Adds coverage for osteopathic and chiropractic spinal manipulation, up to 24 visits per member per calendar year, subject to applicable cost-sharing</p>
<p>Rider FB – RM100 and Rider FB – PC 500M</p>	<p>Removes copay and deductible for screening mammography services provided by PPO providers. Adds coverage for preventive care benefits provided by PPO providers, up to a combined maximum of \$500 per member per calendar year. Mammography services are not included in the \$500 annual maximum. Note: These riders are available only as a “package” of preventive care services.</p>
<p>Rider FB RX-PD-GB \$10/\$60 Mail Order 2X</p>	<p>Adds specific copays for generic and brand name drugs and doubles the copay for mail order drugs for a 35- to 90-day supply. It removes any applicable percent copay for prescription drugs only. Note: When this rider is selected you must also select the Flexible Blue Rx Program Certificate and Rider FB – CM1000/2000-P, 2000/4000-NP or Rider FB – CM2000/4000-P, 4000/8000-NP.</p>
<p>Rider CI, Rider PCD2 and Rider PD-CM</p>	<p>Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and IUDs, and Rx only oral or injectable contraceptive medications. Note: These riders are only available as a “prescription drug package” with the Flexible Blue Prescription Drug Plan. Riders CI and PCD2 are part of your medical-surgical coverage and Rider PD-CM is part of your prescription drug coverage.</p>
<p>Rider XVA-2</p>	<p>Excludes benefits for any services related to an abortion except for a spontaneous abortion, or to prevent the death of the woman upon whom the abortion is performed. BCBSM does pay for services or supplies to treat complications resulting from an abortion.</p>