



Flexible BlueSM Plan 2 Medical Coverage with Preventive Care, Mammography and Prescription Benefits Benefits-at-a-Glance for Windover High School

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.

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 *
Deductibles 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 Note: Copays apply once the deductible has been met.		
<ul style="list-style-type: none"> Fixed dollar copays 	None	None
<ul style="list-style-type: none"> Percent copays 	None	20% of approved amount
Copay dollar maximums	Not applicable	\$1,000 for a one-person contract or \$2,000 for a family contract (2 or more members) each calendar year
Dollar maximums	\$1 million lifetime maximum per covered specified human organ transplant type and a separate \$5 million lifetime maximum per member for all other covered services and as noted above for individual services	

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

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* 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.

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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 • 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 	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunization Practices or other sources as recognized by BCBSM.	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

Screening mammography

Routine mammogram	Covered – 100% (no deductible or copay)	Covered – 80% after out-of-network deductible
One per member per calendar year		

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

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

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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
Routine screening colonoscopy	Covered – 100% (no deductible or copay)	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

Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	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 transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	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 transplants	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
Outpatient mental health care	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible, in participating facilities only
Outpatient substance abuse treatment – in approved facilities only	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible, in approved facilities only

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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 and Chiropractic spinal manipulation	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
	Limited to a combined maximum of 24 visits per member per calendar year	
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

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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.

Specialty Drugs – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, 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. 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. Log in under "I am a Member." If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

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).

<p>Flexible BlueSM Rx Prescription Drug Plan:</p> <ul style="list-style-type: none"> • FDA-approved 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 plus an additional 20% of the BCBSM approved amount for the drug</p> <p>Note: The 20% prescription drug out-of-network copay will not be applied toward your annual Flexible Blue deductible, out-of-pocket copay dollar maximum or lifetime dollar maximum.</p>
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Note: 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.

Features of your prescription drug plan

<p>Drug interchange and generic copay waiver</p>	<p>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 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>

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<p>Prescription drug preferred therapy</p>	<p>A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications before prescribing a more expensive brand-name drug. It applies only to prescriptions being filed for the first time of a targeted medication.</p> <p>Before filling your initial 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 bcbsm.com, along with the preferred medications.</p> <p>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 all targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.</p>
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Additional riders

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

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