

Flexible BlueSM Medical Coverage, Flexible Blue RxSM Prescription Drugs With Preventative Care Benefits-at-a-Glance Plan 3

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 of Michigan certificate 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 the plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.

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.

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)* • 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
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 member per calendar year, no age restriction		

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

Emergency Medical Care

Hospital Emergency Room	Covered – 100% after in-network deductible	Covered – 100% after in-network deductible
Ambulance Services – 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

In-Network

Out-of-Network

Diagnostic Services (cont.)		
Therapeutic Radiology	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	
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	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Note: Nonemergency services must be rendered in a participating hospital	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 – medically necessary	Covered – 100% after in-network deductible, by a participating home health care agency only	
Home Infusion Therapy – 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
Voluntary Sterilization	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Human Organ Transplants		
Specified 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 – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504); specific criteria applies	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
	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
Prosthetics	Covered – 100% after in-network deductible	Covered – 100% after in-network deductible
Orthotic Appliances (excludes shoe inserts)	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

In-Network

Out-of-Network

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.

<p>Flexible Blue RxSM Prescription Drug Plan:</p> <ul style="list-style-type: none"> • Federal-legend drugs • State-controlled drugs • Disposable needles and syringes – dispensed with insulin • 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>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. A non-network pharmacy is a pharmacy NOT in the Preferred Rx or MedImpact networks.

Deductible, 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. 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.

<p>Deductible</p> <p>Note: Your deductible combines the deductible amounts paid under your Flexible Blue medical coverage and your Flexible Blue prescription drug coverage.</p>	<p>\$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)</p>	<p>\$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)</p>
<p>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.</p>		
<p>Copays</p> <ul style="list-style-type: none"> • Fixed Dollar Copays • Percent Copays 	<p>None</p> <p>None</p>	<p>None</p> <p>20% of approved amount</p> <p>Note: Services without a PPO network and emergency services are covered at the in-network level.</p>
<p>Copay Dollar Maximums</p> <ul style="list-style-type: none"> • Fixed Dollar Copays • Percent Copays 	<p>Not applicable</p> <p>Not applicable</p>	<p>Not applicable</p> <p>\$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)</p> <p>Note: Your copay dollar maximum combines the copay amounts paid under your Flexible Blue medical coverage and your Flexible Blue prescription drug coverage.</p>
<p>Dollar Maximums</p>	<p>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</p>	

Optional 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.</p>
<p>Rider FB – RM100 and Rider FB – PC 500M</p>	<p>Removes copay and deductible for 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.</p> <p>Note: These riders are available only as a “package” of preventive care services.</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 federal legend oral or injectable contraceptive medications.</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>
<p>Rider XVA</p>	<p>Excludes benefits for voluntary abortions.</p>
<p>Rider DC</p>	<p>Covers dependents to the end of the year they turn 25. Cost of rider included in family rate.</p>

THE PLANS AT A GLANCE

Effective Date of Plan

This plan became effective on September 1, 2006.

Dental Plan Structures

Eaton Rapids Public Schools Dental Plan (ERPSPD) consists of various levels of dental coverage based upon the dental procedures. The types of dental treatment are indicated by classes, which are explained in detail under Covered Dental Expenses.

Class I – 100%	Diagnostic and Preventive
Class II – 80%	Restorative
Class III – 80%	Major
Class IV – 50%	Orthodontics

Maximum Benefit Allowance

Annual Maximum Benefit - \$1000 per benefit year for Class I, II and III dental services combined

Lifetime Ortho Maximum Benefit - \$1200 per patient lifetime for Class IV (orthodontic) services

Covered Employee Groups

Administrators
Non-Union Employees
Bus Drivers

SECTION IV – SCHEDULE OF BENEFITS

PROPOSED SELF-FUNDED VISION BENEFIT PLAN

ELIGIBILITY: Each eligible participant and their covered dependents are entitled to one vision examination, one pair of glasses (*lenses or contacts*) and frames once every 12- months.

BENEFITS: For each benefit, the UCR is charged up to a maximum of the plan allowance listed below:

Service or Material	Frequency	Participating Provider Plan Maximum	Non-Participating Provider Plan Maximum
* Vision Examination	12-Months	\$38.00	\$35.00
Lenses: (pair) must meet Z80.1 or Z80.2 standards of American National Standards Institute (ANSI) and meet or exceed FDA standards for impact resistant lenses. Pink #1 and #2 tints, ± 6 sphere, ± 4 cylinder, hardening to conform to FDA standards and dropball.			
* Lenses			
Single Vision (pair)	12-Months	\$36.00	\$26.00
Bifocal (pair)		\$48.00	\$46.00
Trifocal (pair)		\$58.00	\$56.00
Lenticular (pair)		\$95.00	\$58.00
Covered Lens Options:			
Tints	12-Months	\$10.00	Single \$4.00 Bifocal \$10.00 Trifocal \$12.00
Polarized		\$75.00	Single \$44.00 Bifocal \$76.00 Trifocal \$98.00 Lenticular \$88.00
No-line Bifocals		\$50.00	\$50.00
Transitions Single		\$65.00	\$60.00
Transitions Multi		\$70.00	\$65.00
Frames (<i>plastic, metal or combination</i>) This will purchase a retail frame up to \$65.00	12-Months	\$35.00 Maximum Wholesale Cost	\$24.00 Toward Retail cost

Contacts Lenses	12-Months	
Medically Required ¹	\$200.00	\$200.00
Cosmetic – provider shall charge U/C minus 25%.	\$115.00 allowance In lieu of all other services.	\$115.00 allowance In lieu of all other services.
Mail Order	Through CFI Mechanicsburg at significant discounts from retail	
LASIK Surgery	Discount 15-30%	
* Panel Providers accept NVA reimbursement as payment in full.		

Non-Covered Options available to member on s self-pay basis:

Polycarbonate lens	\$25.00	
Prism Single	\$20.00	
Prism Multi	\$30.00	
Scratch Coating	\$10.00	
Ultra Violet Coating	\$12.00	
Hi-Index	\$55.00	

***Lens options not listed above will be charged to the member at the provider's wholesale cost, plus 25%.**

EXCLUSIONS: Following items are not covered benefits.

- Eyeglasses for member not requiring corrective lenses
- Charges for any service or materials not covered by this program
- Medical or surgical treatment
- Treatment for any condition, disease, ailment or injury arising out of employment
- All drugs and medications unrelated to eye examinations
- Procedures determined to be special or experimental in nature
- Services provided or glasses ordered:
 - Before member became eligible for coverage under this Co/op Optical program
 - After termination of coverage
- Charges for eye examination, lenses, or frames that do not meet accepted standards of ophthalmic practice
- Replacement of lost lenses or frames, unless participant meets all eligibility requirements
- Replacement of scratched lenses

PRIOR AUTHORIZATION: NVA requires a letter from the provider specifying the prescription, reason for medical necessity and the cost of services.

Following cataract surgery

To correct extreme visual acuity problems not correctable to 20/70 with spectacle lenses

To correct for significant Anisometropia

Keratoconus

The specified plan allowances will be reimbursed by NVA with the difference billed to the eligible member.

FRAMES: The excess over \$65 retail will be discounted by 30%.