Blue Cross Blue Shield Supplemental Coverage Benefits-at-a-Glance

This is not a Medicare document. It is intended as an easy-to-read summary of many important features of Blue Cross Blue Shield Supplemental health care 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 certificates and riders. For more detailed information on Medicare benefits, please call or visit your local Social Security office or consult the Medicare Handbook (available on the Medicare Web site at **medicare.gov** or at any Social Security office).

	Medicare	**Blue traditional supplemental coverage** Blue Cross option 2/Blue Shield option 1
Member's responsibility (deductibles, copays and dollar maximums)		
Deductible amounts	• **Medicare Part A** $1,132* (days 1-60) each benefit period • **Medicare Part B** $162* each benefit period	None
Fixed dollar copays	• **Hospitalization** $283* (days 61-90) and $566* (days 91-150) each benefit period • **Skilled nursing facility care** $141.50* (days 21-100) each benefit period	None
Coinsurance/percent copay amounts	• 20% of Medicare approved amount for most general services • 45% of Medicare approved amount for outpatient mental health care • 50% of Medicare approved amount for outpatient substance abuse	None
Preventive care services		
Health maintenance exam	Covered at 100% of Medicare approved amount**, once every 12 months **Note:** Your first yearly "Wellness" exam can't take place within 12 months of your "Welcome to Medicare" physical exam.	Covered in full by Medicare
Gynecological exam	Covered at 100% of Medicare approved amount**, once every 24 months	Covered in full by Medicare
Pap smear screening – laboratory services only	Covered at 100% of Medicare approved amount**, once every 24 months (more frequently if at high risk)	Covered in full by Medicare
Fecal occult blood test	Covered at 100% of Medicare approved amount**, once every 12 months, if age 50 and older	Covered in full by Medicare
Flexible sigmoidoscopy exam	Covered at 100% of Medicare approved amount**, once every 48 months, if age 50 and older	Covered in full by Medicare
Prostate specific antigen (PSA) test	Covered at 100% of Medicare approved amount**, once every 12 months, if over age 50	Covered in full by Medicare

Effective 10/1/07, Blue Cross Blue Shield of Michigan no longer markets Master Medical 65 as part of its supplemental coverage. If your employer makes a change to the medical plan it offers, Master Medical 65 will no longer be a part of your Medicare supplemental coverage.

* Medicare deductible and coinsurance amounts are effective January 1, 2011 and are subject to change yearly.

** Under Medicare coverage, you pay nothing for these services if the doctor accepts assignment. You may be required to pay 20% of the Medicare approved amount for the doctor's visit.

	Medicare	Blue traditional supplemental coverage Blue Cross option 2/Blue Shield option 1
Preventive care services, *continued*		
Flu shots	Covered at 100% of Medicare approved amount**, once per flu season in the fall or winter	Covered in full by Medicare
Hepatitis B shots – for those at high or medium risk of contracting the disease	Covered at 100% of Medicare approved amount**	Covered in full by Medicare
Pneumococcal shot	Covered at 100% of Medicare approved amount**	Covered in full by Medicare
Mammography screening	Covered at 100% of Medicare approved amount**, once every 12 months at age 40 and older	Covered in full by Medicare
Colonoscopy	Covered at 100% of Medicare approved amount**, once every 10 years (if at high risk every 24 months)	Covered in full by Medicare
Well-baby and child care visits	One health maintenance exam covered at 100% of Medicare approved amount** every 12 months, subsequent well baby and child care visits not covered	Covered at 100% of BCBSM approved amount • **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**
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 and not covered by Medicare	Not covered	Covered at 100% of BCBSM approved amount
Physician office services		
Office visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Outpatient and home visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Office consultations	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Emergency medical care		
Hospital emergency room (professional services) – must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance or set copayment
Ambulance services – must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Clinical laboratory services		
Laboratory and pathology tests – used in the diagnosis and treatment of an illness or injury	Covered at 100% of Medicare approved amount for most diagnostic laboratory and pathology services (covered at 80% of approved amount for certain laboratory services)	Covered in full by Medicare

** Under Medicare coverage, you pay nothing for these services if the doctor accepts assignment. You may be required to pay 20% of the Medicare approved amount for the doctor's visit.

	Medicare	Blue traditional supplemental coverage Blue Cross option 2/Blue Shield option 1
Hospital care		
Semi-private room, inpatient physician care, general nursing care, hospital services and supplies • Days 1-60	Covered at 100% of Medicare approved amount less Part A deductible (also includes inpatient mental health and residential substance abuse)	Covers Medicare deductible
• Days 61-90	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
• Lifetime reserve days (60 days)	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
• Additional days	Not covered	Covered at BCBSM approved amount, up to an additional 275 days
Chemotherapy	Covered at 80% of Medicare approved amount for administration and drugs, must meet Medicare criteria	Covers Medicare deductible and coinsurance
Alternatives to hospital care		
Skilled nursing facility care – specific criteria applies • Days 1-20	Covered at 100% of Medicare approved amount	Covered in full by Medicare
• Days 21-100	Covered at 100% of Medicare approved amount less daily coinsurance	Covers Medicare coinsurance
• Days 101 and after	Not covered	Not covered
Hospice care	Covered at Medicare approved amount less small copayment for outpatient drugs and less small coinsurance for inpatient respite care	Covers limited costs not covered by Medicare
Home health care – medically necessary	Covered at 100% of Medicare approved amount	Covered in full by Medicare
Surgical services provided by a physician		
Surgery – includes related surgical services	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Human organ transplants **Note:** Payment is based on medical necessity and must be rendered in an approved facility.		
Heart and liver transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Lung and heart-lung transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Pancreas transplants	Not covered **Note:** Pancreas transplants are covered under certain conditions. Please call Medicare for more information.	Not covered **Note:** Covers Medicare deductible and coinsurance when covered by Medicare.
Cornea transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Bone marrow and kidney transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance

	Medicare	Blue traditional supplemental coverage Blue Cross option 2/Blue Shield option 1
Mental health care		
Inpatient mental health care in psychiatric facility • Days 1-190 **lifetime**	See "Hospital care" benefits (Medicare pays the claim as part of your regular Part A hospital coverage, subject to Part A deductible and coinsurance) **Note:** In most cases, psychiatric care in general (as opposed to psychiatric) hospitals is not subject to the 190-day limit.	Covers Medicare deductible and coinsurance
• Additional days after 190 lifetime days are used	Not covered	Not covered
Outpatient mental health care	Covered at 55% of Medicare approved amount less Part B deductible (Diagnostic services are covered at 80% of Medicare approved amount less Part B deductible)	Covers Medicare deductible and coinsurance or set copayment
Other services		
Allergy testing and therapy – with approved diagnosis	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance for testing. Injections are not covered.
Chiropractic spinal manipulation – must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Outpatient physical, speech and occupational therapy	Covered at 80% of Medicare approved amount less Part B deductible **Note:** Services of independent physical or occupational therapist subject to annual dollar limit.	Covers Medicare deductible and coinsurance or set copayment
Durable medical equipment	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Prosthetic appliances	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Private duty nursing	Not covered	Not covered
Prescription drugs	Not covered	Not covered
Oral cancer drugs	Approved drugs are covered	Covered in full by Medicare
Foreign travel		
Hospital services	Not covered, except for inpatient hospital services in Canada or Mexico in rare situations	Covered at BCBSM approved amount, up to 30 days for covered services
Physician services	Not covered, except for services rendered in Canada or Mexico in connection with a covered inpatient stay	Covered up to BCBSM approved amount

Client: City of Springfield

Blue Preferred® Rx Prescription Drug Coverage with $10 Generic / $60 Brand Name Fixed Dollar Copay Benefits-at-a-Glance - w/PD-CM

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, copay and/or coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, 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.

Specialty Pharmaceutical 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, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many network 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.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a **90-Day Retail Network provider or** mail-order provider. We may make exceptions if a member requires more than a 30-day supply. 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).

Member's responsibility (copays)

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 did not write "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.

		90-day retail network pharmacy	*** Network mail order provider**	**Network pharmacy** (not part of the 90-day retail network)	**Non-network pharmacy**
Generic or prescribed over-the-counter drugs	1 to 30-day period	$10 copay	$10 copay	$10 copay	$10 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	$20 copay	No coverage	No coverage
	84 to 90-day period	$20 copay	$20 copay	No coverage	No coverage
Brand-name drugs	1 to 30-day period	$60 copay	$60 copay	$60 copay	$60 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	$120 copay	No coverage	No coverage
	84 to 90-day period	$120 copay	$120 copay	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.

***** BCBSM will not pay for drugs obtained from non-network mail order providers, including Internet providers.

Covered services

	90-day retail network pharmacy	* Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
State-controlled drugs	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay.	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	75% of approved amount less plan copay for the insulin or other covered injectable legend drug

* BCBSM will not pay for drugs obtained from non-network mail order providers, including Internet providers.

Features of your prescription drug plan

Drug interchange and generic copay waiver	BCBSM's drug interchange and generic copay waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic 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.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits. A list of these drugs is available at **bcbsm.com**.
Prescription drug preferred therapy	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 filled for the first time of a targeted medication. 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**. 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.

Additional Riders Selected

Rider PD-CM, prescription contraceptive medications	Adds coverage for "RX only" FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered).

Client: City of Springfield

Traditional Plus Dental Coverage – Plan 2
Benefits-at-a-Glance

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 any other plan documents your group uses, 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.

With Traditional Plus Dental, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Dental Network of America (DNoA) Preferred Network of PPO dentists.

DNoA Preferred Network – Blue Dental members have unmatched access to PPO dentists through the DNoA Preferred Network, which offers nearly 200,000 dentist access points* nationwide. DNoA Preferred Network dentists agree to accept our approved amount as payment in full and participate on all claims. Members also receive discounts on noncovered services when they use PPO dentists. To find a DNoA Preferred Network dentist near you, please visit **BCBSM.com/bluedental** or call 1-888-826-8152.

** A dentist access point is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two locations would be two access points.*

Blue Par Select℠ arrangement– Most dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services — members pay only applicable copays and deductibles, along with any fees for noncovered services. To find a dentist who may participate with BCBSM, please visit **BCBSM.com/bluedental**.

Note: Members who go to nonparticipating dentists may be billed for any difference between our approved amount and the dentist's charge.

Member's responsibility (copays and dollar maximums)

Copays	
• Class I services	None
• Class II services	25% of approved amount
• Class III services	50% of approved amount
• Class IV services	Not applicable
Dollar maximums	
• Annual maximum (for Class I, II and III services)	$1,000 per member for all covered services
• Lifetime maximum (for Class IV services)	Not applicable

Class I services

Oral exams	100% of approved amount, twice per calendar year
A set (up to 4 films) of bitewing x-rays	100% of approved amount, twice per calendar year
Full-mouth and panoramic x-rays	100% of approved amount, once every 60 months
Dental prophylaxis (teeth cleaning)	100% of approved amount, twice per calendar year
Pit and fissure sealants – for members age 19 or under	100% of approved amount, once per tooth every 36 months when applied to the first and second permanent molars
Palliative (emergency) treatment	100% of approved amount
Fluoride treatment	100% of approved amount, two per calendar year
Space maintainers – missing posterior (back) primary teeth – for members under age 19	100% of approved amount, once per quadrant per lifetime

Class II services

Fillings – permanent (adult) teeth	75% of approved amount, replacement fillings covered after 24 months or more after initial filling
Fillings – primary (baby) teeth	75% of approved amount, replacement fillings covered after 12 months or more after initial filling
Onlays, crowns and veneer fillings – permanent teeth – for members age 12 or older	75% of approved amount, once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	75% of approved amount, three times per tooth per calendar year after six months from original restoration
Oral surgery including extractions	75% of approved amount
Root canal treatment – permanent tooth	75% of approved amount, once every 12 months for tooth with one or more canals
Scaling and root planing	75% of approved amount, once every 24 months per quadrant
Limited occlusal adjustments	75% of approved amount, **limited** occlusal adjustments covered up to five times in a 60-month period
Occlusal biteguards	75% of approved amount, once every 12 months
General anesthesia or IV sedation	75% of approved amount, when medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	75% of approved amount, six months or more after it is delivered
Relining or rebasing of a partial or complete denture	75% of approved amount, once every 36 months per arch
Tissue conditioning	75% of approved amount, once every 36 months per arch

Class III services

Removable dentures (complete and partial)	50% of approved amount, once every 60 months
Bridges (fixed partial dentures) – for members age 16 or older	50% of approved amount, once every 60 months after original was delivered
Endosteal implants – for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount, once per tooth in a member lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services – Orthodontic services for dependents under age 19

Minor treatment for tooth guidance appliances	Not covered
Minor treatment to control harmful habits	Not covered
Interceptive and comprehensive orthodontic treatment	Not covered
Post-treatment stabilization	Not covered
Cephalometric film (skull) and diagnostic photos	Not covered

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.

Client: City of Springfield

Blue Vision SM 24/24/24 Benefits-at-a-Glance

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 any other plan documents your group uses, 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.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com**.

Note: Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

	VSP network doctor	Non-VSP provider
Member's responsibility (copays)		
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	A **combined** $10 copay	Member responsible for difference between approved amount and provider's charge, less $10 copay
Medically necessary contact lenses	$10 copay	Member responsible for difference between approved amount and provider's charge, less $10 copay
Eye exam		
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$5 copay	Reimbursement up to $35 less $5 copay (member responsible for any difference)
	One eye exam in any period of 24 **consecutive** months	
Lenses and frames		
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. **Note:** Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	$10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $10 copay (member responsible for any difference)
	One pair of lenses, with or without frames, in any period of 24 **consecutive** months	
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $10 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $45 less $10 copay (member responsible for any difference)
	One frame in any period of 24 **consecutive** months	
Contact lenses		
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$10 copay	Reimbursement up to $210 less $10 copay (member responsible for any difference)
	One pair of contact lenses in any period of 24 **consecutive** months	
Elective contact lenses that improve vision (prescribed, but do **not** meet criteria of medically necessary)	$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	One pair of contact lenses in any period of 24 **consecutive** months	