Community Blue[SM] PPO – Plan 3
Benefits-at-a-Glance for Black Family Development # 68740-660

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.

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Member's responsibility (deductibles, copays and dollar maximums)	In-network	Out-of-network *
Deductibles	$250 for one member, $500 for the family (when two or more members are covered under your contract) each calendar year **Note:** Deductible may be waived if service is performed in a PPO physician's office.	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also apply toward the in-network deductible.
Fixed dollar copays	• $10 copay for office visits • $50 copay for emergency room visits	$50 copay for emergency room visits
Percent copays **Note:** Copays apply once the deductible has been met.	• 50% of approved amount for private duty nursing • 20% of approved amount for most other covered services (copay waived if service is performed in a PPO physician's office) See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.	• 50% of approved amount for private duty nursing • 40% of approved amount for most other covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.
Annual copay dollar maximums – applies to copays for all covered services – including mental health and substance abuse services – but **does not** apply to fixed dollar copays and private duty nursing percent copays **Note:** For groups with 50 or fewer employees or groups that are **not** subject to the MHP law, mental health care and substance abuse treatment copays **do not** contribute to the copay dollar maximum.	$1,000 for one member, $2,000 for two or more members each calendar year	$3,000 for one member, $6,000 for two or more members each calendar year **Note:** Out-of-network copays also apply toward the in-network maximum.
Lifetime dollar maximum	None	

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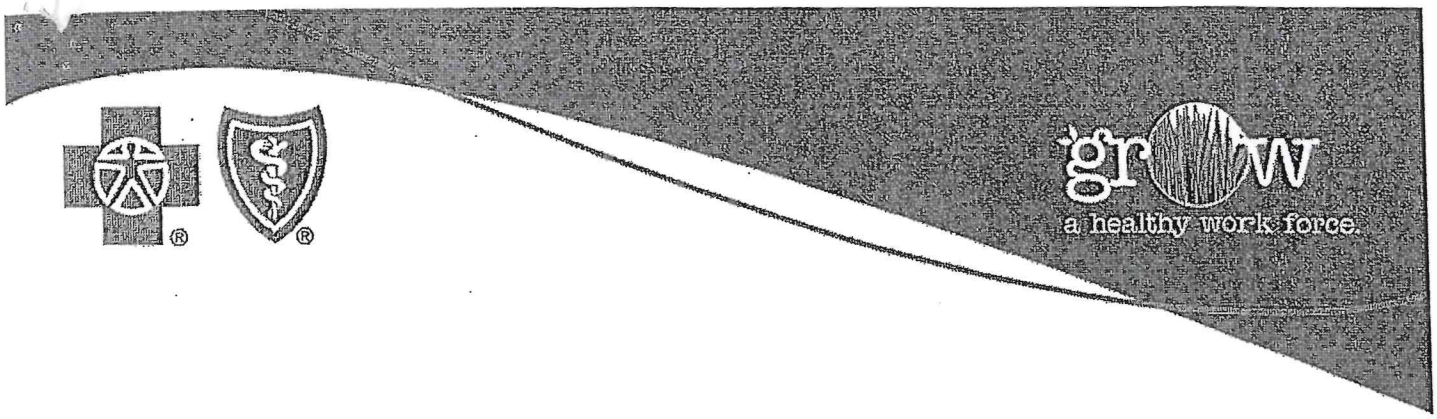
* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain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



	In-network	Out-of-network *
Preventive care services		
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
Well-baby and child care visits	100% (no deductible or copay) • 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
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) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	60% after out-of-network deductible **Note:** 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% for the first billed colonoscopy (no deductible or copay) **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	60% after out-of-network deductible
	One per member per calendar year	
Physician office services		
Office visits	$10 copay per office visit	60% after out-of-network deductible, must be medically necessary
Outpatient and home medical care visits	80% after in-network deductible	60% after out-of-network deductible, must be medically necessary
Office consultations	$10 copay per office visit	60% after out-of-network deductible, must be medically necessary
Urgent care visits	$10 copay per office visit	60% after out-of-network deductible, must be medically necessary

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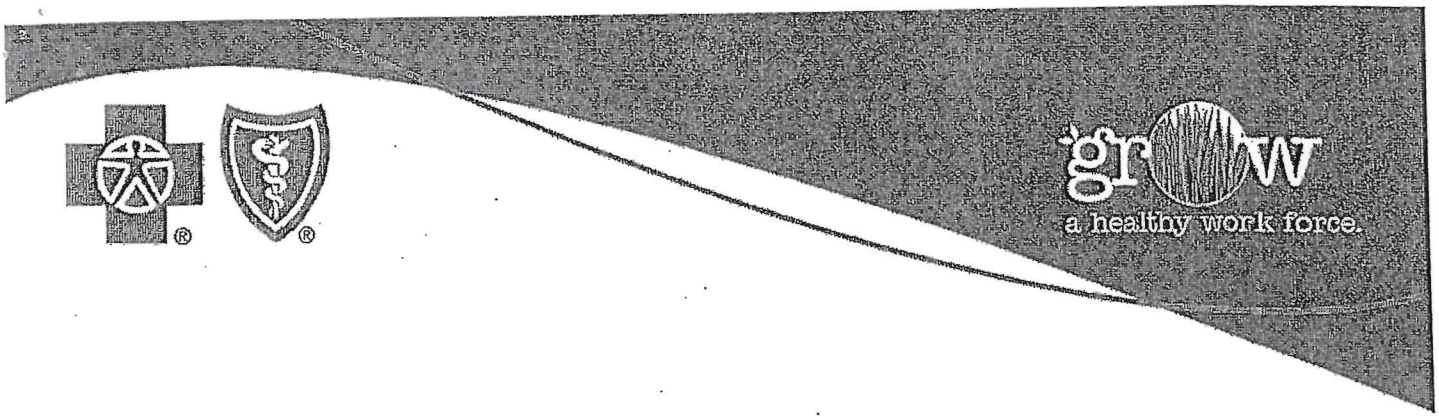

	In-network	Out-of-network *
Emergency medical care		
Hospital emergency room	$50 copay per visit (copay waived if admitted or for an accidental injury)	$50 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	80% after in-network deductible	80% after in-network deductible
Diagnostic services		
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible
Maternity services provided by a physician		
Prenatal and postnatal care	100% (no deductible or copay)	60% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	80% after in-network deductible	60% 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.	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care – must be in a **participating** skilled nursing facility	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% (no deductible or copay)	100% (no deductible or copay)
	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 (after reaching dollar maximum, member transitions into individual case management)	
Home health care – must be medically necessary and provided by a **participating** home health care agency	80% after in-network deductible	80% after in-network deductible
Home infusion therapy – must be medically necessary and given by **participating** home infusion therapy providers	80% after in-network deductible	80% after in-network deductible
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay)	60% after out-of-network deductible
Voluntary sterilization	80% after in-network deductible	60% after out-of-network deductible

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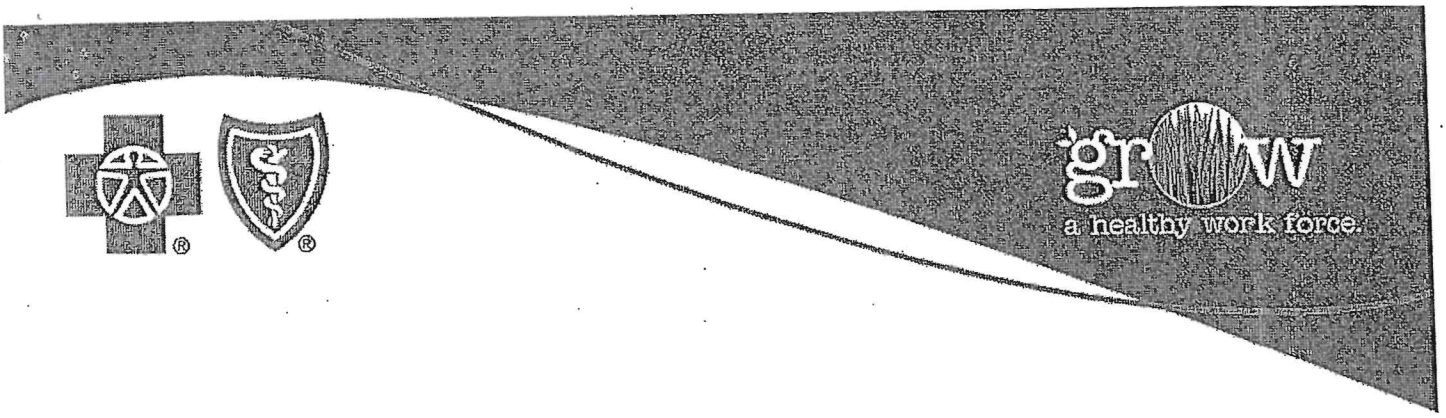

	In-network	Out-of-network *
Human organ transplants		
Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay)	100% (no deductible or copay) – in designated facilities **only**
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible
Mental health care and substance abuse treatment		
Inpatient mental health care	50% after in-network deductible	50% after out-of-network deductible
	Unlimited days	
Inpatient substance abuse treatment	50% after in-network deductible	50% after out-of-network deductible
	Unlimited days, up to $15,000 annual maximum	
Outpatient mental health care • Facility and clinic	50% after in-network deductible	50% after in-network deductible, in participating facilities **only**
• Physician's office	50% (no deductible)	50% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities **only**	50% after in-network deductible	50% after in-network deductible
	Up to the state-dollar amount that is adjusted annually	
Other covered services		
Outpatient Diabetes Management Program (ODMP)	80% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% (no deductible or copay)	60% after out-of-network deductible
	Limited to a **combined** maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy – provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** maximum of 60 visits per member per calendar year	
Durable medical equipment	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing	50% after in-network deductible	50% after in-network deductible

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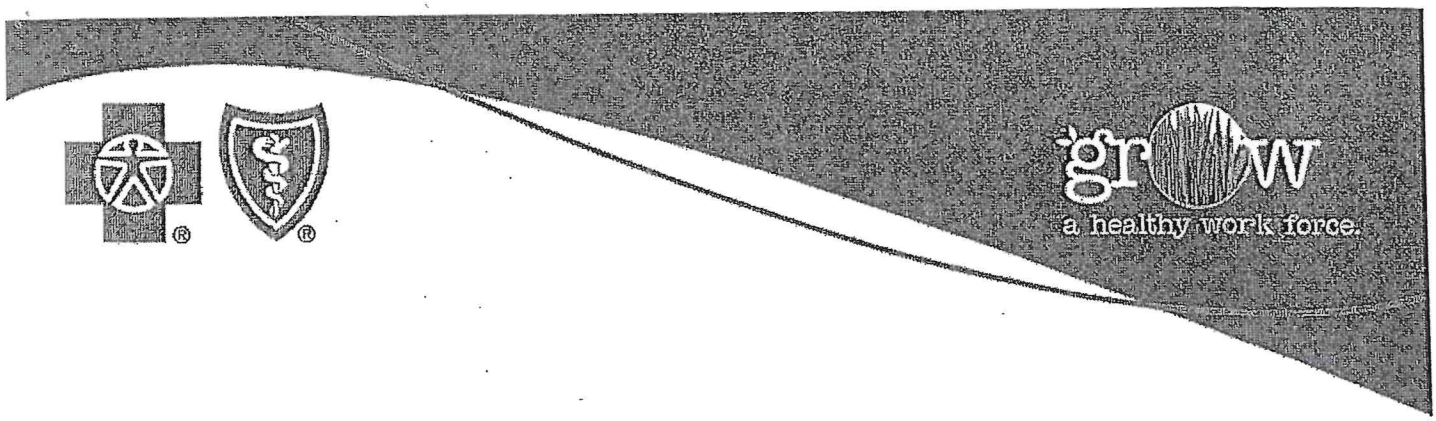

Additional riders included

Rider HC-A, hearing care	Provides coverage for hearing aids, including binaural hearing aids, and certain other hearing care services every 36 months.
Rider CI, contraceptive injections Rider PCD, prescription contraceptive devices Rider PD-CM, prescription contraceptive medications	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). **Note:** These riders are only available as part of a prescription drug package. Riders CI and PCD are part of your medical-surgical coverage, subject to the same deductible and copay, if any, you pay for medical-surgical services. (Rider PCD waives the copay for services provided by a network provider.) Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.

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Blue Preferred® Rx Prescription Drug Coverage with $10 Generic / $20 Brand Name Fixed Dollar Copay Benefits-at-a-Glance for Black Family Development # 68740-660

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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).

	Network pharmacy	Non-network pharmacy
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 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.		
Generic prescription drugs	$10 copay	$10 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
Brand name prescription drugs	$20 copay	$20 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	**Copay for up to a 30 day supply:** • $10 copay for generic drugs • $20 copay for each brand name drugs **Copay for a 31 to 90 day supply:** • $20 copay for each generic drugs • $40 copay for each brand name drugs	No coverage
Covered services		
FDA-approved drugs	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	75% of approved amount less plan copay
State-controlled drugs	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	75% of approved amount less plan copay for the insulin or other covered injectable legend drug
Mail order (home delivery) prescription drugs – up to a 90-day supply of medication by mail from Medco (BCBSM network mail order provider)	100% of approved amount less plan copay	No coverage

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

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.

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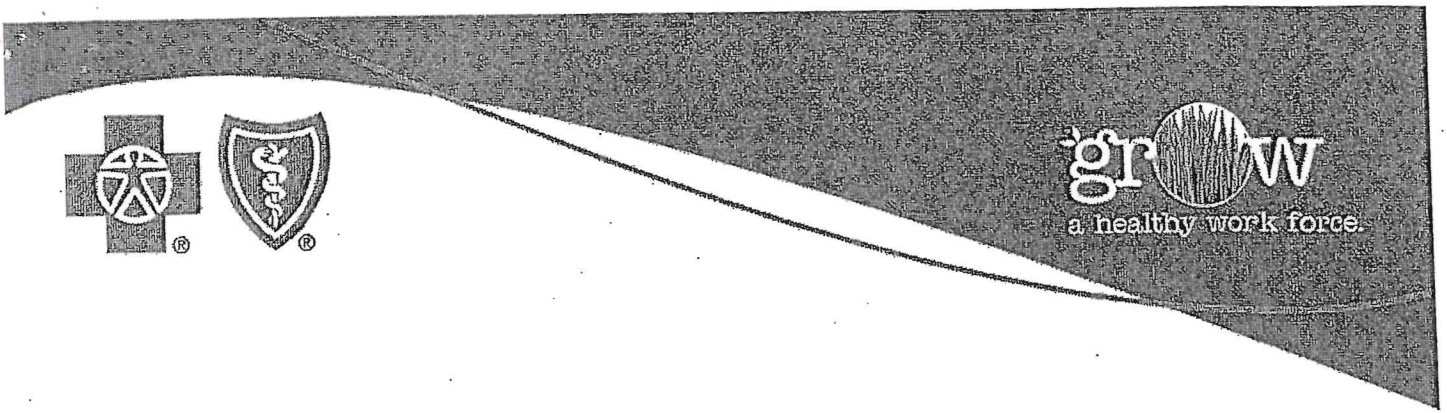

Features of your prescription drug plan

Drug interchange and generic copay waiver	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**. 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.
Quantity limits	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**.
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 filed 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 included

Rider CI, contraceptive injections **Rider PCD**, prescription contraceptive devices **Rider PD-CM**, prescription contraceptive medications	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). **Note:** These riders are only available as part of a prescription drug package. Riders CI and PCD are part of your medical-surgical coverage, subject to the same deductible and copay/coinsurance, if any, you pay for medical-surgical services. (Rider PCD waives the copay/coinsurance for services provided by a **network** provider.) Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.

Blue Vision SM 24/24/24
Benefits-at-a-Glance Black Family Development # 68740-660

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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 predetermined amount based on lense 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.	$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	

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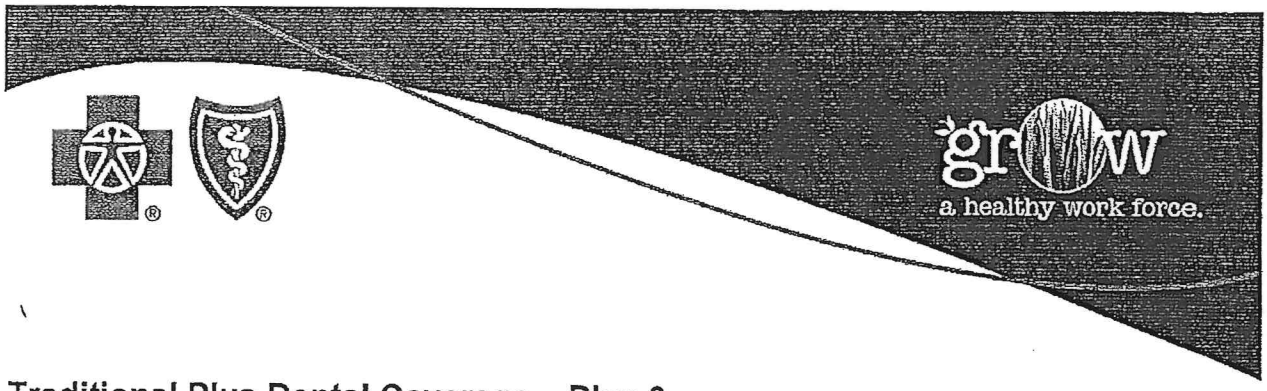

Traditional Plus Dental Coverage – Plan 3
Benefits-at-a-Glance

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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	50% of approved amount
Dollar maximums	
• Annual maximum (for Class I, II and III services)	$1,000 per member
• Lifetime maximum (for Class IV services)	$1,000 per member

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

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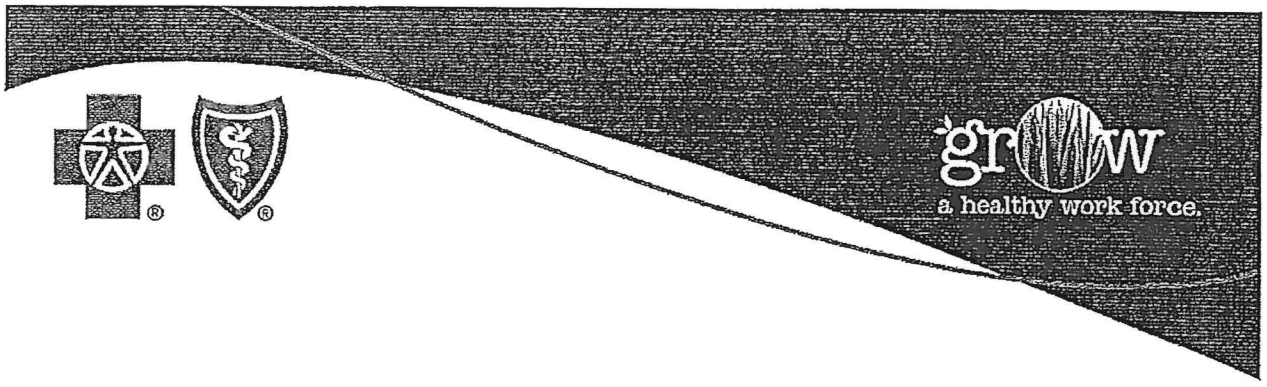

Class II services

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	50% of approved amount
Minor treatment to control harmful habits	50% of approved amount
Interceptive and comprehensive orthodontic treatment	50% of approved amount
Post-treatment stabilization	50% of approved amount
Cephalometric film (skull) and diagnostic photos	50% of approved amount

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.