Medical

Summary of Coverage

Plan Features	Blue Care Network HMO HRA
IN NETWORK	
Purchased Deductible	$4,000 individual / $8,000 family
* Employee Deductible *	* $500 individual / $1,000 family * *An HRA set-up with Blue Care Network pays the remaining Deductible after you meet your portion; Please see the HRA Flowchart on the next page for more information
Coinsurance	10% after Deductible; up to out of Pocket Maximum
Out-of-Pocket Max (Ind. / Family)	$6,350 / $12,700 (Includes Deductibles, Copays and Coinsurance Amounts)
Preventive Care	Covered at 100%
Primary Care Visit	$30 Copay
Specialist Visit	$30 Copay; Deductible Applies
X-Rays	10% Coinsurance; Deductible Applies
Complex Images	$150 Copay; Deductible Applies
Outpatient Procedure	10% Coinsurance; Deductible Applies
Inpatient Visit	10% Coinsurance; Deductible Applies
Emergency Room	$150 Copay waived if admitted; Deductible Applies
Urgent Care	$50 Copay
Pharmacy / RX (30 Day Supply)	$20 Generic/$60 Formulary Brand/50% ($80 min/$100 max) Non-Formulary Brand
Pharmacy / RX (90 Day Supply)	2 times the Copay
OUT OF NETWORK	**Not Covered**

Semi-Monthly Rates	
Employee	$24.02
Employee + 1	$55.02
Family	$66.40

NOTE: No "4th Quarter Carry-over" will be applied to the members on this plan. You must satisfy your deductible(s) as outlined in the HRA Flowchart, each plan year.

Benefits for 2017 - 2018

Health Reimbursement Account (HRA)

Health Reimbursement Arrangement (HRA) = Employer Money

Total Deductible Purchased = $4,000 individual/$8,000 family

You are responsible to pay the first **$500 individual/ $1,000 family** of In-Network Deductible Expenses.

Integrity Educational Services is reimbursing the next **$3,500 individual/ $7,000 family** Of In-Network Deductible Expenses through an HRA that is set-up directly with Blue Care Network.

The maximum that Integrity Educational Services will reimburse under the HRA plan is **$3,500 individual/ $7,000 family**

*only Deductible will be reimbursed, no Coinsurance or Co-Pays

Blue Care Network will send 1 Explanation of Benefits (EOB) that lists the charges, payments and HRA balances.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,040
- **Patient pays** $4,500

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$4,000
Co-pays	$20
Co-insurance	$330
Limits or exclusions	$150
Total	**$4,500**

$500 deductible paid by Employee, $3500 remaining deductible paid by HRA

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,370
- **Patient pays** $2,030

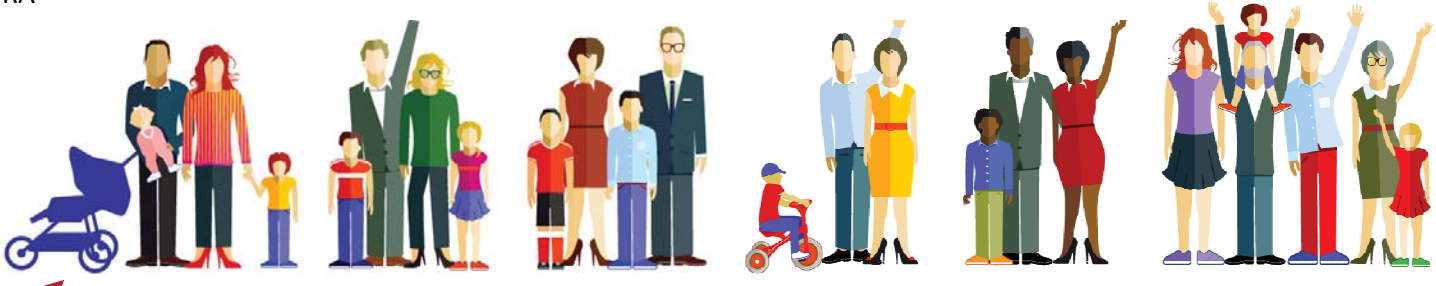
Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,150
Co-pays	$800
Co-insurance	$0
Limits or exclusions	$80
Total	**$2,030**

$500 deductible paid by Employee, $650 remaining deductible paid by HRA



Key Terms to Remember

Plan Types

HMO – A network that requires you to select a Primary Care Physician (PCP) who coordinates your health care

HRA – Employer Money that is set aside to reimburse specific expenses.

Out-of-Pocket Maximum

This is the total amount you can pay out of pocket each plan year before the plan pays 100 percent of covered expenses for the rest of the plan year. Most expenses that meet provider network requirements count toward the out-of-pocket maximum, including expenses paid to the deductible, copays and coinsurance.

Deductible

The amount you have to pay each plan year before the plan starts paying a portion of medical expenses. All family members' expenses that count toward a health plan deductible accumulate together in the aggregate; however, each person also has a limit on their own individual accumulated expenses.

Copays and Coinsurance

These expenses are your share of cost paid for covered health care services. **Copays** are a fixed dollar amount, and are usually due at the time you receive care. **Coinsurance** is your share of the allowed amount charged for a service, and is generally billed to you after the health insurance company reconciles the bill with the provider.

The Value of Preventive Care

Wellness and Health Management

Understanding the full value of covered benefits allows you to take responsibility for maintaining good health and incorporating healthy habits into your lifestyle. Some examples include getting regular physical examinations, mammograms and immunizations.

Through the plans offered by Integrity Educational Services , all covered individuals and family members are eligible to receive routine wellness services like these, at no cost; all copays, coinsurance, and deductibles are waived.

Which Preventive Care Services Are Covered?

The US Preventive Services Task Force maintains a regular list of recommended services that all Affordable Care Act (i.e. Health Care Reform) compliant insurance plans should cover at 100% for in-network providers. Below is a list of common services that are included in the plans offered this year:

- Routine Physical Exam
- Well Baby and Child Care
- Well Woman Visits
- Immunizations
- Routine Bone Density Test
- Routine Breast Exam
- Routine Gynecological Exam
- Screening for Gestational Diabetes
- Obesity Screening and Counseling
- Routine Digital Rectal Exam
- Routine Colonoscopy
- Routine Colorectal Cancer Screening
- Routine Prostate Test
- Routine Lab Procedures
- Routine Mammograms
- Routine Pap Smear
- Smoking Cessation Programs
- Health Education/Counseling Services
- Health Counseling for STDs and HIV
- Testing for HPV and HIV
- Screening and Counseling for Domestic Violence

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.BCBSM.com or by calling (800) 662-6667 .

Important Questions	Answers: Member / Family	Why this Matters:
What is the overall deductible?	$4000/$8000 Doesn't apply to lab, preventive care, DME/P&O, PCP office visits, urgent care, allergy injections	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $6350/$12700	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of BCN providers, see www.BCBSM.com or call (800) 662-6667	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes, in-network only. Paper or electronic.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In Network providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use Providers:		Limitations & Exceptions
		In Network	Out of Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-pay/visit	Not covered	————————none————————
	Specialist visit	$30 co-pay/visit	Not covered	Requires referral. $5 co-pay for allergy injections/50% co-insurance for allergy office visit and testing/Deductible applies
	Other practitioner office visit	$30 co-pay/visit	Not covered	Requires referral / 30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician/Deductible applies
	Preventive care/screening/immunization	No charge	Not covered	————————none————————
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance	Not covered	May require prior authorization / No charge for lab services/Deductible applies except for lab services
	Imaging (CT/PET scans, MRIs)	$150 co-pay	Not covered	Requires prior authorization/Deductible applies
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/customdruglist	Tier 1 - Formulary Preferred(Mostly Generic)	$20/30 days	Not covered	Prior-authorization & step-therapy apply to select drugs. 50% co-insurance for sexual dysfunction drugs Tier 1 contraceptives are covered in full. 90 day mail order and retail co-pays are 2x the standard retail co-pays.
	Tier 2 - Formulary Brand	$60/30 days	Not covered	
	Tier 3 - Non-Formulary	50% co-insurance $80 min-$100 max/30 days	Not covered	
	Specialty drugs	Tiered co-pays listed above apply	Not covered	Limited to a 30 day supply

Common Medical Event	Services You May Need	Your cost if you use Providers:		Limitations & Exceptions
		In Network	Out of Network	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	Not covered	May require prior authorization/50% co-insurance for weight reduction procedures,TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy/Deductible applies
	Physician/surgeon fees	10% co-insurance	Not covered	See "Outpatient surgery facility fee"
If you need immediate medical attention	Emergency room services	$150 co-pay/visit	$150 co-pay/visit	Copay waived if admitted/Deductible applies
	Emergency medical transportation	10% co-insurance	10% co-insurance	Non-emergent transport is covered when authorized/Deductible applies
	Urgent care	$50 co-pay/visit	$50 co-pay/visit	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	Not covered	Requires prior authorization/50% co-insurance for weight reduction procedures,TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy/Deductible applies
	Physician/surgeon fee	No charge	Not covered	See "Hospital stay facility fee"
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 co-pay/visit	Not covered	Requires prior authorization/Deductible applies
	Mental/Behavioral health inpatient services	10% co-insurance	Not covered	Requires prior authorization/Deductible applies
	Substance use disorder outpatient services	$30 co-pay/visit	Not covered	Requires prior authorization/Deductible applies
	Substance use disorder inpatient services	10% co-insurance	Not covered	Requires prior authorization/Deductible applies
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	Postnatal and non-routine prenatal office visits-$30 copay The deductible does not apply to routine maternity care.
	Delivery and all inpatient services	10% co-insurance for facility No charge for professional	Not covered	/Deductible applies to professional and facility services

Common Medical Event	Services You May Need	Your cost if you use Providers:		Limitations & Exceptions
		In Network	Out of Network	
If you need help recovering or have other special health needs	Home health care	$30 co-pay/visit	Not covered	Requires prior authorization/Deductible applies
	Rehabilitation services	$30 co-pay/visit	Not covered	Requires authorization/ One period of treatment for any combination of therapies within 60 consecutive days per benefit year/Deductible applies
	Habilitation services	ABA - $30 co-pay per visit	Not covered	PT/OT/ST for autism spectrum disorder has unlimited visits. Requires prior authorization./Deductible applies
	Skilled nursing care	10% co-insurance	Not covered	Requires prior authorization/Limited to 45 days per benefit year/Deductible applies
	Durable medical equipment	No charge	Not covered	Must be authorized and obtained from a BCN supplier/Diabetic supplies covered in full
	Hospice service	No charge	Not covered	Inpatient care requires authorization/Deductible applies
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Contact benefit administrator for coverage.
	Glasses	Not covered	Not covered	Contact benefit administrator for coverage.
	Dental check-up	Not covered	Not covered	Contact benefit administrator for coverage.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental Care (Adult)
- Elective Abortion
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (800) 662-6667. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Blue Care Network, Appeals and Grievance Unit, MC C248, P.O. Box 284, Southfield, MI 48086 or fax 1-888-458-0716.

For state of Michigan assistance contact the Department of Insurance and Financial Services, Healthcare Appeals Section, Office of General Counsel, 611 Ottawa, 3rd Floor, P. O. Box 30220, Lansing, MI 48909-7720**,** michigan.gov/difs; call 1-877-999-6442 or fax: 517-241-4168.

For Department of Labor assistance contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP), Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720, michigan.gov/difs; Ofir-hicap@michigan.gov.

Translation available

To get help reading in your language call the customer service number on the back of your ID card.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.(IMPORTANT: Blue Care Network of Michigan is assuming that your coverage provides for all Essential Health Benefits (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage for specific EHB categories, for example prescription drugs, through another carrier**.)**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,040
- **Patient pays** $4,500

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$4,000
Co-pays	$20
Co-insurance	$330
Limits or exclusions	$150
Total	**$4,500**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,370
- **Patient pays** $2,030

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,150
Co-pays	$800
Co-insurance	$0
Limits or exclusions	$80
Total	**$2,030**

If you are also covered by an account-type plan such as an integrated health reimbursement arrangement (HRA), and/or an health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses-like deductible, co-payments, or co-insurance or benefits not otherwise covered.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- Coverage examples are calculated based on individual coverage.
- The Coverage examples assume you have a combined medical and pharmacy out-of-pocket maximum.
- The coverage calculator examples do not include the co-insurance maximum if applicable to your coverage.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Deductible, Copays and Dollar Maximums

Note: The **Deductible** will apply to certain services as defined below.

Deductible	$4,000 individual/$8,000 family per benefit year
Fixed Dollar Copays	$5 for allergy injections
	$30 for office visits and online visits
	$50 for urgent care visits
	$150 for emergency room visits
	No fixed dollar copay for ambulance services. See below for applicable coinsurance.
	$30 for referral physician visits
Coinsurance	50% for select services as noted below
	10% for select services as noted below
Annual Coinsurance Maximum (ACM)	None
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$6,350 per individual/$12,700 per family

Preventive Services

Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening	100%
Well-Baby and Child Care	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening	100%
Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Female Sterilization	100%
Breast Pumps (DME guidelines apply.)	100%
Maternity Pre-Natal care	100%

Physician Office Services

Office Visits	$30 Copay
Online Visits	$30 Copay
Consulting Specialist Care	$30 Copay after deductible

Emergency Medical Care

Hospital Emergency Room - Copay waived if admitted	$150 Copay after deductible
Urgent Care Center	$50 Copay
Ambulance Services	90% after deductible

Benefits Selected -
CI10%,D4000,DSRCW,IMG150,DME5,ER150,CO30,6350PM,2065%C,MOPD2O,BENYR,P&O5,UR50

bcbsm.com
07/06/2016 08:40:44 am

Diagnostic Services

Laboratory and Pathology Tests	100%
Diagnostic Tests and X-rays	90% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	$150 copay after deductible
Radiation Therapy	90% after deductible

Maternity Services Provided by a Physician

Post-Natal and Non-routine Pre-Natal Care (See Preventive Services section for routine Pre-Natal Care)	$30 Copay
Delivery and Nursery Care	100% For professional services. (See Hospital Care for facility charges) after deductible

Hospital Care

General Nursing Care, Hospital Services and Supplies	90% after deductible
Outpatient Surgery - included all related surgical services and anesthesia - see member certificate for specific surgical copays.	90% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	90% after deductible
	Up to 45 days per member per benefit year
Hospice Care	100% (When authorized) after deductible
Home Health Care	$30 Copay after deductible

Surgical Services

Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	90% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	50% after deductible
Elective Abortion (One procedure per two year period of membership)	Not Covered
Human Organ Transplants	90% after deductible
Reduction Mammoplasty	50% after deductible
Male Mastectomy	50% after deductible
Temporomandibular Joint Syndrome	50% after deductible
Orthognathic Surgery	50% after deductible
Weight Reduction Procedures (Limited to one procedure per lifetime)	50% after deductible

Benefits Selected -
CI10%,D4000,DSRCW,IMG150,DME5,ER150,CO30,6350PM,2065%C,MOPD2O,BENYR,P&O5,UR50

bcbsm.com
07/06/2016 08:40:44 am

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care	90% after deductible
Inpatient Substance Abuse Care	90% after deductible
Outpatient Mental Health Care	$30 Copay after deductible
Outpatient Substance Abuse	$30 Copay after deductible

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	$30 Copay after deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18	$30 Copay after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit

Other Services

Allergy Testing and Therapy	50% after deductible
Allergy Injections	$5 copay
Chiropractic Spinal Manipulation - when referred	$30 Copay after deductible
	(up to 30 visits per benefit year)
Outpatient Physical, Speech and Occupational Therapy	$30 Copay after deductible
	One period of treatment for any combination of therapies within 60 consecutive days per benefit year
Infertility Counseling and Treatment (Excludes In-vitro fertilization)	50% after deductible
Durable Medical Equipment (DME)	100%
Prosthetic and Orthotic Appliances (P&O)	100%
Diabetic Supplies	100%
Prescription Drugs	Tier 1 - $20 copay, Tier 2 - $60 copay, Tier 3 - 50% (min $80/max $100); 30 day supply with contraceptives
	Sexual Dysfunction drugs - 50% coinsurance
	Women's Contraceptives - Tier 1 - 100%, Tier 2 - Tier 2 Copayment/Coinsurance above applies, Tier 3 - Tier 3 Copayment/Coinsurance above applies
Mail Order Prescription Drugs	Two times the applicable copay up to a 90 day supply
Prescription Drug Deductible	None
Hearing Aid	Not Covered

Benefits Selected -
CI10%,D4000,DSRCW,IMG150,DME5,ER150,CO30,6350PM,2065%C,MOPD2O,BENYR,P&O5,UR50

bcbsm.com
07/06/2016 08:40:45 am

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

CLSSLG with Deductibles

00279895 Integrity Educational Services

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 Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and copay amounts required by the plan. If there is a discrepancy between the Benefits-at-a-Glance and any applicable plan documents, the plan document will control. 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. **Services must be provided or arranged by member's primary care physician or health plan.**

Benefits Selected -
CI10%,D4000,DSRCW,IMG150,DME5,ER150,CO30,6350PM,2065%C,MOPD2O,BENYR,P&O5,UR50

bcbsm.com
07/06/2016 08:40:45 am