



Simply BlueSM PPO Gold \$1500 Medical Coverage with Prescription Drugs Benefits-at-a-Glance

Effective for groups on their plan year

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/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.

Preauthorization for Select Services – Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: A list of services that require approval before they are provided is available online at bcbsm.com/importantinfo. Select **Approving covered services**.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals – BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

In-network

Out-of-network *

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

	In-network	Out-of-network *
Deductibles	\$1,500 for one member, \$3,000 for the family (when two or more members are covered under your contract) each calendar year	\$3,000 for one member; \$6,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	<ul style="list-style-type: none"> \$20 copay for office visits and office consultations with a primary care physician \$40 copay for office visits and office consultations with a specialist \$30 copay for chiropractic and osteopathic manipulative therapy \$60 copay for urgent care visits \$150 copay for emergency room visits 	\$150 copay for emergency room visits
Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.	<ul style="list-style-type: none"> 50% of approved amount for bariatric surgery 20% of approved amount for most other covered services 	<ul style="list-style-type: none"> 50% of approved amount for bariatric surgery 40% of approved amount for most other covered services

* Services from a provider for which there is no Michigan PPO network and services from an out-of-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 *****Member's responsibility (deductibles, copays, coinsurance and dollar maximums), *continued***

Annual coinsurance maximums – applies to coinsurance amounts for all covered services – but does not apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	\$1,000 for one member, \$2,000 for the family (when two or more members are covered under your contract) each calendar year	\$2,000 for one member, \$4,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.
Annual out-of-pocket maximums – applies to deductibles, flat-dollar copays and coinsurance amounts for all covered services – including prescription drugs cost-sharing amounts	\$6,600 for one member, \$13,200 for the family (when two or more members are covered under your contract) each calendar year	\$13,200 for one member, \$26,400 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

Preventive care services

Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 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/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

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**In-network****Out-of-network *****Preventive care services, *continued***

Routine mammogram and related reading	100% (no deductible or copay/coinsurance) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
One per member per calendar year.		
Colonoscopy – routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible
One per member per calendar year.		

Physician office services

Office visits – must be medically necessary	<ul style="list-style-type: none"> • \$20 copay for each office visit with a primary care physician • \$40 copay for each office visit with a specialist Note: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible
Outpatient and home medical care visits – must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations – must be medically necessary	<ul style="list-style-type: none"> • \$20 copay for each office consultation with a primary care physician • \$40 copay for each office consultation with a specialist Note: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible

Urgent care visits

Urgent care visits – must be medically necessary	\$60 copay per urgent care visit Note: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible
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**In-network****Out-of-network *****Emergency medical care**

Hospital emergency room	\$150 copay per visit (copay waived if admitted)	\$150 copay per visit (copay waived if admitted)
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 or certified nurse midwife

Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care	80% after in-network deductible	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

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/coinsurance)	100% (no deductible or copay/coinsurance)
	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 • must be provided by a participating home health care agency	80% after in-network deductible	80% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization – consult with your doctor	80% after in-network deductible	80% after in-network deductible

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**In-network****Out-of-network *****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/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males Note: For voluntary sterilizations for females, see "Preventive care services."	80% after in-network deductible	60% after out-of-network deductible
Elective abortions	Not covered	Not covered
Gender reassignment surgery	Not covered	Not covered
Bariatric surgery	50% after in-network deductible	50% after out-of-network deductible
Limited to a lifetime maximum of one bariatric procedure per member		

Human organ transplants

Specified human organ transplants – must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) – in designated facilities only
Bone marrow transplants – must be 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 Note: BCBSM covers clinical trials in compliance with PPACA.	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 and inpatient substance abuse treatment	80% after in-network deductible	60% after out-of-network deductible
Unlimited days		
Residential psychiatric treatment facility: • covered mental health services must be performed in a residential psychiatric treatment facility • treatment must be preauthorized • subject to medical criteria	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	80% after in-network deductible	80% after in-network deductible, in participating facilities only
• Physician's office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities only	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

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In-network

Out-of-network *

Autism spectrum disorders, diagnoses and treatment

Applied behavioral analysis (ABA) treatment – when rendered by an approved board-certified behavioral analyst – is covered through age 18, subject to preauthorization Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	80% after in-network deductible	80% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible
Physical, speech and occupational therapy with an autism diagnosis is unlimited		
Other covered services, including mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible

Other covered services

Outpatient Diabetes Management Program (ODMP) Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	<ul style="list-style-type: none"> 80% after in-network deductible for diabetes medical supplies 100% (no deductible or copay/coinsurance) for diabetes self-management training 	60% after out-of-network deductible
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$30 copay per visit Note: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam.	60% after out-of-network deductible
Limited to a combined 30-visit maximum per member per calendar year (visits are combined with outpatient physical and occupational therapy)		
Outpatient physical and occupational therapy – provided for rehabilitation/habilitation	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 30-visit maximum per member per calendar year Note: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy.		
Outpatient speech therapy	80% after in-network deductible	60% after out-of-network deductible
Limited to a 30-visit maximum per member per calendar year		
Durable medical equipment Note: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	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 care	Not covered	Not covered

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Blue Preferred[®] Rx Prescription Drug Coverage Custom Select Prescription Drug Plan, 5-Tier Copay/Coinsurance Benefits-at-a-Glance

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 in-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 Express Scripts. (Express Scripts 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/pharmacy. 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 quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs – BCBSM may limit the initial fill of select controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copays and coinsurance amounts, are subject to the same annual out-of-pocket maximum required under your medical coverage. The 25% member liability for covered drugs obtained from an out-of-network pharmacy will not contribute to your annual out-of-pocket maximum.

		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 – Generic drugs	1 to 30-day period	You pay \$15 copay	You pay \$15 copay	You pay \$15 copay	You pay \$15 copay <i>plus</i> an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay \$30 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay \$35 copay	No coverage	No coverage
	84 to 90-day period	You pay \$35 copay	You pay \$35 copay	No coverage	No coverage
Tier 2 – Preferred brand-name drugs	1 to 30-day period	You pay \$50 copay	You pay \$50 copay	You pay \$50 copay	You pay \$50 copay <i>plus</i> an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay \$100 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay \$140 copay	No coverage	No coverage
	84 to 90-day period	You pay \$140 copay	You pay \$140 copay	No coverage	No coverage

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



Member's responsibility (copays and coinsurance amounts), *continued*

		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 3 – Nonpreferred brand-name drugs	1 to 30-day period	You pay \$70 or 50% of the approved amount (whichever is greater), but no more than \$100	You pay \$70 or 50% of the approved amount (whichever is greater), but no more than \$100	You pay \$70 or 50% of the approved amount (whichever is greater), but no more than \$100	You pay \$70 or 50% of the approved amount (whichever is greater), but no more than \$100 <i>plus</i> an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay \$140 or 50% of the approved amount (whichever is greater), but no more than \$200	No coverage	No coverage
	61 to 83-day period	No coverage	You pay \$200 or 50% of the approved amount (whichever is greater), but no more than \$290	No coverage	No coverage
	84 to 90-day period	You pay \$200 or 50% of the approved amount (whichever is greater), but no more than \$290	You pay \$200 or 50% of the approved amount (whichever is greater), but no more than \$290	No coverage	No coverage
Tier 4 – Generic and preferred brand-name specialty drugs	1 to 30-day period	You pay 20% of approved amount, but no more than \$200	You pay 20% of approved amount, but no more than \$200	You pay 20% of approved amount, but no more than \$200	You pay 20% of approved amount, but no more than \$200 <i>plus</i> an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage
Tier 5 – Nonpreferred brand-name specialty drugs	1 to 30-day period	You pay 25% of approved amount, but no more than \$300	You pay 25% of approved amount, but no more than \$300	You pay 25% of approved amount, but no more than \$300	You pay 25% of approved amount, but no more than \$300 <i>plus</i> an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage

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



Covered services

	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved generic and select brand-name prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved brand-name prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved generic and select brand-name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved brand-name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes – when dispensed with insulin, or other covered injectable legend drugs Note: Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug

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



Features of your prescription drug plan

<p>Custom Select Drug List</p>	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> ▪ Tier 1 (generic) – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. ▪ Tier 2 (preferred brand) – Tier 2 includes brand-name drugs from the Custom Select Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. ▪ Tier 3 (nonpreferred brand) – Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs. ▪ Tier 4 (generic and preferred brand-name specialty) – Tier 4 includes covered specialty drugs listed as generic drugs (Tier 1) or preferred brand-name drugs (Tier 2) from the Custom Select Drug List. These drugs have a proven record for safety and effectiveness, and offer the best value to our members. They have the lowest specialty drug copay/coinsurance. ▪ Tier 5 (nonpreferred brand-name specialty) – Tier 5 includes covered specialty drugs listed as nonpreferred brand name (Tier 3). These drugs may not have a proven record for safety or their clinical value may not be as high as the specialty drugs in Tier 4. They have the highest specialty drug copay/coinsurance.
<p>Prior authorization/step therapy</p>	<p>A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. Step Therapy, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at bcbsm.com/pharmacy.</p>
<p>Drug Interchange and generic copay/coinsurance waiver</p>	<p>BCBSM's drug interchange and generic copay/coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent.</p> <p>If your physician rewrites your prescription for the recommended generic drug, you will only have to pay a generic copay/coinsurance. In select cases BCBSM may waive the initial copay/coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.</p>
<p>Quality limits</p>	<p>To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.</p>
<p>Exclusions</p>	<p>The following drugs are not covered:</p> <ul style="list-style-type: none"> • Over-the-counter drugs and drugs with comparable OTC counterparts (e.g., antihistamines, cough/cold and acne treatment) unless deemed an Essential Health Benefit or not considered a covered service • State-controlled drugs • Brand-name drugs that have a generic equivalent available • Drugs to treat erectile dysfunction and weight loss • Prenatal vitamins (prescribed and over-the-counter) • Brand-name drugs used to treat heartburn • Compounded drugs, with some exceptions • Cosmetic drugs

Delta Dental PPO (Point-of-Service) Summary of Dental Plan Benefits For Group# 3568-0001 North Star Academy

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Non-EHB Covered Services – includes all Covered Services that are not Essential Health Benefits (EHB) as defined by the Patient Protection and Affordable Care Act.

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	80%	80%	80%
Endodontic Services – root canals	80%	80%	80%
Periodontic Services – to treat gum disease	80%	80%	80%
Oral Surgery Services – extractions and dental surgery	80%	80%	80%
Other Basic Services – misc. services	80%	80%	80%
Relines and Repairs – to bridges, implants, and dentures	80%	80%	80%
Major Services			
Major Restorative Services – crowns	50%	50%	50%
Prosthodontic Services -- bridges, implants, and dentures	50%	50%	50%

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year for people up to age 19.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and

help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – \$1,000 per person total per Benefit Year on all services.

Out-of-Pocket Maximum Payment for Non-EHB Covered Services – An Out-of-Pocket Maximum is the maximum amount that you or your Eligible Dependent will pay for Covered Services throughout a Benefit Year. There is no Out-of-Pocket Maximum Payment for Non-EHB Covered Services. You will be responsible for all Copayments, Deductibles, Balanced Billing Amounts and other out-of-pocket expenses associated with all Non-EHB Covered Services provided to you or your Eligible Dependent throughout the Benefit Year.

Deductible – \$50 Deductible per person total per Benefit Year limited to a maximum Deductible of \$150 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, and X-rays.

The Deductible met under the previous carrier for the period January 1, 2015 through August 31, 2015 will be applied to the 2015 calendar year Deductible with Delta Dental. It is the Subscriber's responsibility to provide Delta Dental with adequate documentation of the Deductible met under the previous carrier.

Waiting Period – Employees who are eligible for dental benefits are covered on the date of hire.

Eligible People – All full-time employees of the Contractor working 40 hours per week who choose the dental plan and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees, if applicable. The Contractor and Subscriber share the cost of this plan.

Also eligible are your legal spouse and your children under age 26, including your children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled. You and your eligible dependents must enroll for a minimum of 12 months. If coverage is terminated after 12 months, you may not re-enroll prior to the open enrollment that occurs at least 12 months from the date of termination. Your dependents may only enroll if you are enrolled (except under COBRA) and must be enrolled in the same plan as you. Plan changes are only allowed during open enrollment periods, except that an election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

If you and your spouse are both eligible under this Contract, you may be enrolled together on one application or separately on individual applications, but not both. Delta Dental will not coordinate benefits. If you or your dependents have dental coverage under any other Contract, you or your dependents are not eligible for enrollment under this Contract.

Benefits will cease on the last day of the month in which the employee is terminated.

Assurant Employee Benefits Plan 3

A summary of vision care benefits for the employees of North Star Academy

Benefit	Frequency	In-Network Deductible/Co-pay	Out-of-Network Benefit
Vision Exam – focuses on your eye health and overall wellness	Every 12 months	\$10 copay	Up to \$52
Laser Vision Correction Discount	Once per eye per lifetime	<ul style="list-style-type: none"> Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities. 	N/A
Lenses Single Lined Bifocal Lined Trifocal Lenticular	Every 12 months	\$25 copay (for lenses and frame)	Up to \$55 Up to \$75 Up to \$95 Up to \$125
Frames	Every 24 months	\$130 allowance for frames of your choice and 20% off the amount over your allowance.	\$57
Elective Contact Lenses <i>Contact lenses are in place of lenses and frame.</i>	Every 12 months	\$130 allowance for contact lens exam (fitting and evaluation) and materials. If you choose contact lenses you will be eligible for frames 12 months from the date the contact lenses were obtained.	Up to \$105
Additional Glasses and Sunglasses Discount	30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your exam. Or get 20% off from any VSP doctor within 12 months of your last exam.		N/A

Locating an In-Network VSP Doctor

You get the most from your vision benefits when you visit a VSP doctor. You'll find a listing of doctors at vsp.com or by calling 800.877.7195. VSP doctors offer flexible hours, a variety of office settings, and eyewear choices.

Using your Vision Benefit

Once enrolled, simply tell your VSP doctor you're a member and they will handle the rest. No ID cards required!

Out-of-Network Providers

If you see a non-VSP provider, you'll receive a lesser benefit. Before seeing a non-VSP provider call VSP at 800.877.7195 for more details.

Eligibility

You are eligible to participate if you are a full-time employee, as defined by your employer, at active work and working in the United States. Other policyholder-defined eligibility requirements may apply. Temporary or seasonal workers are not eligible.

Dependent Eligibility

Those qualified to be covered under your vision plan include your spouse and children less than age 26. See your certificate or group insurance policy for additional eligibility details.

Late Entrants

If you elect coverage more than 31 days after your eligibility date, your effective date will be delayed to the next plan anniversary date.

This information is a summary of your benefit. In the event of a discrepancy between this information and the insurance contract, the terms of the contract will prevail.

Limitations & Exclusions

Limitations

In no event will coverage exceed the lesser of,

- the actual cost of the examination or materials, or
- the limits of coverage shown in the Vision Insurance Schedule.

The allowance for lenses shown in the Vision Insurance Schedule is for two lenses. If only one lens is needed, coverage will be 50% of the allowance shown for two lenses.

Benefits will not be payable for replacement of lost or broken materials until the next eligible benefit period.

The plan is designed to cover visually necessary materials rather than cosmetic materials. When you or a covered dependent select any of the following extras, the plan will pay the basic cost of the allowed lenses, and you or the covered dependent will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Progressive multifocal lenses.
- Photochromic lenses; tinted lenses except Pink #1 and Pink #2.
- UV (ultraviolet) protected lenses.
- Certain limitations may apply to low vision care benefits.
- A frame that costs more than the plan allowance.
- Contact lenses (except as noted in the Vision Insurance Schedule).

General Exclusions

Covered vision expenses do not include, and we will not pay benefits for, the following:

- Orthoptic or vision training and any associated supplemental testing.
- Plano lenses.
- Two or more pairs of glasses, in lieu of bifocals or trifocals.
- Medical or surgical treatment of the eye, eyes, or supporting structures, except for laser surgery as shown under the Vision Insurance Schedule.
- Materials, services or options not shown in the Vision Insurance Schedule.
- Treatment or materials of an experimental nature.



**North Star Academy
Life Insurance Benefit Summary**

Presented by: Assurant Employee Benefits

Effective: September 1, 2015

Policy: 5459892

Eligibility

You are eligible to participate if you are a full-time employee, as defined by your employer, at active work and working in the United States. Other policyholder-defined eligibility requirements may apply. Temporary or seasonal workers are not eligible.

Plan Description

Basic Life	1 times earnings
Life Maximum	\$50,000
Accidental Death & Dismemberment (AD&D)	1 times earnings
AD&D Maximum	\$50,000
Disability Premium Waiver	Included
Age Reduction	Included
Conversion Privilege	Included

Commonly asked questions about Life and Accidental Death & Dismemberment insurance:

Q: Who will pay the premium for this coverage?

A: Premiums are paid by your employer.

Q: What is Disability Premium Waiver?

A: If you meet the definition of disability and remain disabled through the qualifying period, your life insurance will continue without further payment of premium for up to 3 years. See your certificate of group insurance for complete details.

Q: What is a conversion privilege?

A: If any or all of your group life insurance ends (for example, due to an age reduction or termination of employment), you will have the opportunity to convert some or all of this coverage to an individual policy. Please contact us at 866.909.6065 within 31 days of coverage termination for more details.

Q: What happens to my benefits as I get older?

A: At age 65, your amount will be reduced by 33% of the original schedule amount; at age 70, it will be reduced by 33% of the in force amount. See your certificate of group insurance for complete details.

Q: What is Accidental Death and Dismemberment coverage?

A: AD&D pays a benefit for loss of life or dismemberment resulting from an accidental bodily injury. Your beneficiary will receive 100% of the AD&D amount if you die as the result of an accidental injury. You will receive an accidental dismemberment benefit if you lose a hand, a foot, or the sight of an eye due to an accidental injury. The benefit paid is 50% of the AD&D amount for any 1 loss and 100% of the AD&D amount for any 2 or more losses.

Your beneficiary will receive an additional 20% of the AD&D benefit, to a maximum of \$100,000, if you die as a direct result of automobile accident injuries and were wearing a seat belt at the time of the accident. Your AD&D benefit also includes a Higher Education Benefit that pays an additional \$3,000 per year for up to 4 consecutive years to eligible dependent students if you die as a direct result of an injury.

Q: What other benefits are included in this policy?

A: Your plan includes an Accelerated Benefit. This means that you can access a portion of your life insurance while you are still living if you are diagnosed with a life-threatening medical condition which results in an expected life span of 12 months or less.

This summary provides only a general overview and does not contain or describe all plan details. Issued insurance policies determine all plan features and policy benefits. Please consult your certificate or group policy for a complete description, including all applicable limitations, exclusions, reductions, and restrictions. Please contact Assurant Employee Benefits for additional information.

**For more information regarding claims and services, please visit our website at:
www.assurantemployeebenefits.com or call us at 800.733.7879**