Blue Cross Blue Shield of Michigan

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

Client: Onsted Comm Schools

Simply Blue^{SM} PPO Plan LG $500 Medical Coverage 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.

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	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network deductible amounts also **Note:** Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $20 copay for office visits and office consultations with a non-specialist provider • $20 copay per online visit • $20 copay for office visits and office consultations with a specialist provider • $20 copay for urgent care visits • $20 copay for chiropractic services and osteopathic manipulative therapy • $150 copay for emergency room visits	$150 copay for emergency room visit
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing care • 20% of approved amount for most other covered services	• 50% of approved amount for private duty nursing care • 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	$2,500 for one member, $5,000 for the family (when two or more members are covered under your contract) each calendar year	$5,000 for one member, $10,000 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 cost-sharing amounts for prescription drugs, if applicable	$6,350 for one member, $12,700 for two or more members each calendar year	$12,700 for one member, $25,400 for two or more members 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	• $20 copay per office visit with a non-specialist • $20 copay per 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	• $20 copay for each office consultation with a non-specialist • $20 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
Online visits – must be medically necessary	$20 copay per online visit	60% after out-of-network deductible
Urgent care visits		
Urgent care visits – must be medically necessary	$20 copay per office 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	80% after in-network deductible	60% after out-of-network deductible
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.	• 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	$20 copay per office 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** 12-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy – when 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** 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	50% after in-network deductible	50% after in-network deductible
Prescription drugs	Not covered	Not covered

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Blue Cross Blue Shield of Michigan

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Blue Preferred® Rx LG Prescription Drug Coverage 3-Tier Copay/Coinsurance 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.

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 following prescription drug expenses will not apply to your annual out-of-pocket maximum:

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

		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 or **select** prescribed over-the-counter drugs	1 to 30-day period	You pay $10 copay	You pay $10 copay	You pay $10 copay	You pay $10 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $20 copay	No coverage	No coverage
	84 to 90-day period	You pay $20 copay	You pay $20 copay	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs.

***** 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 2 – Preferred brand-name drugs	1 to 30-day period	You pay $40 copay	You pay $40 copay	You pay $40 copay	You pay $40 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $80 copay	No coverage	No coverage
	84 to 90-day period	You pay $80 copay	You pay $80 copay	No coverage	No coverage
Tier 3 – Nonpreferred brand-name drugs	1 to 30-day period	You pay $80 copay	You pay $80 copay	You pay $80 copay	You pay $80 copay ***plus*** an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $160 copay	No coverage	No coverage
	84 to 90-day period	You pay $160 copay	You pay $160 copay	No coverage	No coverage

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
Prescribed over-the-counter drugs – when covered by BCBSM	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
State-controlled 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

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

Covered services, *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
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

Features of your prescription drug plan

Custom Drug List	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. ▪ **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 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.
Prior authorization/step therapy	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. Some over-the-counter medications may be covered under step therapy guidelines. 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**.
Mandatory maximum allowable cost drugs	If your prescription is filled by an in-network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your applicable copay/coinsurance regardless of whether you or your physician requests the brand-name drug. **Exception:** If your physician requests and receives authorization for a nonpreferred brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay/coinsurance. **Note:** This MAC difference will not be applied toward your annual in-network deductible, your annual coinsurance maximum or your annual out-of-pocket maximum, if applicable.
Drug interchange and generic copay/coinsurance waiver	BCBSM's drug interchange and generic copay/coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/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.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

Blue Cross Blue Shield of Michigan

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

Blue Dental℠ PPO Plus 100/80/50/50 $50/$150 Deductible; $1,250 Annual Maximum LG Benefits-at-a-Glance

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Network access information

With Blue Dental PPO Plus, 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 Blue Dental PPO network.[1]

Blue Dental PPO network – Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services – members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152**.

[1]*Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.*

[2]*A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.*

Blue Par Select℠ arrangement – Most non-PPO 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 coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com**.

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

Member's responsibility (deductible, coinsurance and dollar maximums)

Deductible • Applies to Class II and Class III services only	$50 per member limited to a maximum of $150 per family per calendar year
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services	None (covered at 100%)
• Class II services	20%
• Class III services	50%
• Class IV services	50%
Dollar maximums • Annual maximum for Class I, II and III services	$1,250 per member per calendar year
• Lifetime maximum for Class IV services	$1,250 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 • For members age 15 and younger	100% of approved amount, once per calendar year
• For members age 16 and older	100% of approved amount, once in any 24 consecutive months
Panoramic or full-mouth x-rays	100% of approved amount, once in any 84 consecutive months
Diagnostic x-rays	100% of approved amount, any combination of 6 individual or sets of films each calendar year
Dental prophylaxis (teeth cleaning)	100% of approved amount, twice per calendar year
Pit and fissure sealants – for members age 16 and younger	100% of approved amount, once per tooth in any 36 consecutive months when applied to the first and second permanent molars

Class I services, *continued*

Palliative (emergency) treatment	100% of approved amount
Fluoride treatment – for members age 14 and younger	100% of approved amount, once per calendar year
Space maintainers – missing posterior (back) primary teeth – for members age 16 and younger	100% of approved amount, once per quadrant per lifetime

Class II services

Fillings – permanent (adult) teeth	80% of approved amount after deductible, replacement fillings covered after 48 months or more after initial filling
Fillings – primary (baby) teeth	80% of approved amount after deductible, replacement fillings covered after 24 months or more after initial filling
Recementation of crowns, veneers, inlays, onlays and bridges	80% of approved amount after deductible, three times per tooth per calendar year after six months from original restoration
Oral surgery including extractions	80% of approved amount after deductible
Root canal treatment – permanent tooth	80% of approved amount after deductible, once per tooth per lifetime; retreatment of previous root canal therapy (after 36 months from the date of the original therapy) once per tooth per lifetime.
Scaling and root planing	80% of approved amount after deductible, once per quadrant in any 36 consecutive months
Limited occlusal adjustments	80% of approved amount after deductible, **limited** occlusal adjustments covered up to five times in any 60 consecutive months
Occlusal biteguards	80% of approved amount after deductible, once in any 60 consecutive months (Repairs and relines to occlusal biteguards covered once in any 60 consecutive months)
General anesthesia or IV sedation	80% of approved amount after deductible, when medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	80% of approved amount after deductible, six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	80% of approved amount after deductible, once per arch in any 36 consecutive months
Tissue conditioning	80% of approved amount after deductible, once per arch in any 36 consecutive months
Periodontic maintenance	80% of approved amount after deductible

Class III services

Onlays, crowns and veneer restorations – permanent teeth – for members age 12 and older	50% of approved amount after deductible, once per tooth in any 84 consecutive months
Removable dentures (complete and partial)	50% of approved amount after deductible, once in any 84 consecutive months
Bridges (fixed partial dentures) – for members age 16 and older	50% of approved amount after deductible, once in any 84 consecutive months
Endosteal implants – for members age 16 and older who are covered at the time of the actual implant placement	50% of approved amount after deductible, 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 after deductible
Minor treatment to control harmful habits	50% of approved amount after deductible
Interceptive and comprehensive orthodontic treatment	50% of approved amount after deductible
Post-treatment stabilization	50% of approved amount after deductible
Cephalometric film (skull) and diagnostic photos	50% of approved amount after deductible

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.