



Flexible BlueSM Plan 3 Medical Coverage with Flexible BlueSM RX Prescription Drugs Benefits-at-a-Glance For Johannesburg- Lewiston Schools #39700-009

This is intended as an easy-to-read summary. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificate and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by the plan. 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.

| | In-network | Out-of-network |
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| Member's responsibility (deductibles, copays and dollar maximums) | | |
| Note: If a PPO provider refers you to a non-network provider, all covered services obtained from that non-network provider will be subject to applicable out-of-network cost-sharing. 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. | | |
| Deductibles Note: Your deductible combines the deductible amounts paid under your Flexible Blue medical coverage and your Flexible Blue prescription drug coverage. Note: The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract. | \$2,000 for a one-person contract or \$4,000 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over) | \$4,000 for a one-person contract or \$8,000 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over) |
| Deductibles are based on amounts defined annually by the federal government for Flexible Blue-related health plans. Please call your customer service center for an annual update. | | |
| Copays | | |
| • Fixed dollar copays | None | None |
| • Percent copays | None | 20% of approved amount |
| Copay dollar maximums | | |
| • Fixed dollar copays | Not applicable | Not applicable |
| • Percent copays | Not applicable | \$1,000 for a one-person contract or \$2,000 for a family contract (2 or more members) each calendar year (excludes 20% out-of-network prescription drug copays) Note: Your copay dollar maximum combines the copay amounts paid under your Flexible Blue medical coverage and your Flexible Blue prescription drug coverage. |
| Dollar maximums | Combined \$5 million lifetime per member for Flexible Blue medical coverage and Flexible Blue prescription drug coverage and a separate \$1 million lifetime per member per covered specified human organ transplant type | |

Preventive care services – *Payment for preventive services is limited to a combined maximum of \$500 per member per calendar year

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| Health maintenance exam – includes chest X-ray, EKG, cholesterol screening and other select lab procedures | Covered – 100% (no deductible or copay)*, one per member per calendar year | Not covered |
| Gynecological exam | Covered – 100% (no deductible or copay)*, one per member per calendar year | Not covered |
| Pap smear screening – laboratory and pathology services | Covered – 100% (no deductible or copay)*, one per member per calendar year | Not covered |
| Well-baby and child care | Covered – 100% (no deductible or copay) * • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15 | Not covered |



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| Childhood immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics | Covered – 100% (no deductible or copay)* | Not covered |
| Fecal occult blood screening | Covered – 100% (no deductible or copay)*, one per member per calendar year | Not covered |
| Flexible sigmoidoscopy exam | Covered – 100% (no deductible or copay)*, one per member per calendar year | Not covered |
| Prostate specific antigen (PSA) screening | Covered – 100% (no deductible or copay)*, one per member per calendar year | Not covered |

Mammography

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| Mammography screening | Covered – 100% (no deductible or copay) One per member per calendar year, no age restriction | Covered – 80% after out-of-network deductible |
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Physician office services

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| Office visits | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible |
| Outpatient and home medical care visits | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible |
| Office consultations | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible |
| Urgent care visits | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible |

Emergency medical care

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| Hospital emergency room | Covered – 100% after in-network deductible | Covered – 100% after in-network deductible |
| Ambulance services – must be medically necessary | Covered – 100% after in-network deductible | Covered – 100% after in-network deductible |

Diagnostic services

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| Laboratory and pathology services | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible |
| Diagnostic tests and x-rays | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible |
| Therapeutic radiology | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible |

Maternity services provided by a physician

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| Prenatal and postnatal care | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible Includes care provided by a certified nurse midwife |
| Delivery and nursery care | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible Includes delivery provided by a certified nurse midwife |

Hospital care

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| Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital. | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible Unlimited days |
| Inpatient consultations | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible |
| Chemotherapy | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible |

Alternatives to hospital care

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| Skilled nursing care | Covered – 100% after in-network deductible, in participating skilled nursing facilities only Limited to 90 days per member per calendar year |
| Hospice care | Covered – 100% after in-network deductible, through a participating hospice program only Limited to dollar maximum that is reviewed and adjusted periodically |
| Home health care – must be medically necessary | Covered – 100% after in-network deductible, by a participating home health care agency only |
| Home infusion therapy – must be medically necessary | Covered – 100% after in-network deductible, by participating providers only |

Surgical services



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| Surgery – includes presurgical consultations, related surgical services and medically necessary facility services by a participating ambulatory surgery facility | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible |
| Colonoscopy | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible |
| One per member per calendar year | | |
| Voluntary sterilization | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible |

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| In-network | Out-of-network |
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| Human organ transplants | | |
| Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504) | Covered – 100% after in-network deductible, in designated facilities only , limited to \$1 million lifetime maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services | |
| Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504) | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible |
| Specified oncology clinical trials | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible |
| Kidney, cornea and skin transplants | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible |

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| Mental health care and substance abuse treatment | | |
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| Inpatient mental health care and inpatient substance abuse treatment | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible |
| Limited to a combined maximum of 60 days per calendar year with 120 days lifetime per member | | |
| Outpatient mental health care | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible, in participating facilities only |
| Limited to a combined maximum of 120 visits per member per calendar year | | |
| Outpatient substance abuse treatment – in approved facilities only | Covered – 100% after in-network deductible | Covered – 100% after in-network deductible, in approved facilities only |
| Limited to annual state-dollar amount (that combines outpatient and residential substance abuse) | | |

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| Other covered services | | |
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| Outpatient Diabetes Management Program (ODMP) | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible |
| Allergy testing and therapy | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible |
| Osteopathic manipulative therapy Chiropractic spinal manipulation | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible |
| Up to 24 visits per member per calendar year, subject to applicable cost-sharing | | |
| Outpatient physical, speech and occupational therapy services – provided for rehabilitation | Covered – 100% after in-network deductible | Covered – 80% after out-of-network deductible Note: Outpatient physical therapy is not covered at nonparticipating facilities. |
| Limited to a combined maximum of 60 visits per member per calendar year | | |
| Durable medical equipment | Covered – 100% after in-network deductible | Covered – 100% after in-network deductible |
| Prosthetic and orthotic appliances | Covered – 100% after in-network deductible | Covered – 100% after in-network deductible |
| Private duty nursing services | Covered – 100% after in-network deductible | Covered – 100% after in-network deductible |



Prescription drug coverage

Your Flexible Blue prescription drug benefits, including mail order drugs, are subject to the same deductible, copay, out-of-pocket copay maximum and lifetime dollar maximum required under your Flexible Blue medical coverage.

Note: Effective October 1, 2006, the mail order pharmacy for **specialty drugs** changed to Option Care, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Option Care will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blue members.) A list of specialty drugs is available on our Web site at bcbsm.com. Log in under "I am a Member." If you have any questions, please call Option Care customer service at 866-515-1355.

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| <p>Flexible BlueSM Rx Prescription Drug Plan:</p> <ul style="list-style-type: none"> • "Rx only" drugs • Prescribed over-the-counter drugs – when covered by BCBSM • State-controlled drugs • Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs <p>Note: Needles and syringes have no copay.</p> <ul style="list-style-type: none"> • Mail order (home delivery) prescription drugs – up to a 90-day supply of prescribed medication by mail from Medco (no coverage out-of-network) | <p>Network pharmacy: 100% of approved amount after Flexible Blue medical coverage deductible</p> <p>Note: If you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber has not indicated "Dispensed as Written" (DAW) on the prescription, you must pay the difference in cost between the brand name drug dispensed and the maximum allowable cost for the generic, plus your copay, if applicable. This cost difference will not be applied toward your in-network deductible, nor your out-of-pocket or lifetime maximums, if applicable.</p> <p>Non-network pharmacy: 80% of approved amount after Flexible Blue medical coverage deductible (The 20% out-of-network copay will not be applied toward your annual Flexible Blue deductible, out-of-pocket copay maximum or lifetime dollar maximum.)</p> |
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Note: A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a MedImpact pharmacy outside Michigan. MedImpact is an independent company providing pharmacy benefit services for Blue members. A **non-network** pharmacy is a pharmacy NOT in the Preferred Rx or MedImpact networks.

Features of your prescription drug plan

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| <p>Drug interchange and generic copay waiver</p> | <p>Certain drugs may not be covered for a second prescription if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at bcbsm.com.</p> <p>If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.</p> |
| <p>Quantity limits</p> | <p>Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at bcbsm.com.</p> |
| <p>Additional Riders</p> | |
| <p>Rider FB – OCSM-24</p> | <p>Adds coverage for osteopathic and chiropractic spinal manipulation, up to 24 visits per member per calendar year, subject to applicable cost-sharing</p> |
| <p>Rider FB – RM100 and Rider FB – PC 500M</p> | <p>Removes copay and deductible for screening mammography services provided by PPO providers. Adds coverage for preventive care benefits provided by PPO providers, up to a combined maximum of \$500 per member per calendar year. Mammography services are not included in the \$500 annual maximum.</p> <p>Note: These riders are available only as a "package" of preventive care services.</p> |
| <p>Rider CI, Rider PCD2 and Rider PD-CM</p> | <p>Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and IUDs, and Rx only oral or injectable contraceptive medications.</p> <p>Note: These riders are only available as a "prescription drug package" with the Flexible Blue Prescription Drug Plan.</p> <p>Riders CI and PCD2 are part of your medical-surgical coverage and Rider PD-CM is part of your prescription drug coverage.</p> |

Johannesburg-Lewiston Area Schools

Health Reimbursement (HRA) Account

Deductible and Prescription Drug Reimbursement Form

Johannesburg-Lewiston Area Schools has set up a Health Reimbursement Program (HRA) designed to reimburse eligible **Medical Deductible and Prescription Drug Copay expenses** incurred by employees (and their dependents) enrolled in our Blue Cross Blue Shield of Michigan (BCBSM) Medical Plan for the 2010 Plan Year (*January 1-December 31, 2010*).

PROGRAM HIGHLIGHTS:

1. **Eligible Expenses:**

- **Medical Plan Deductibles:**

Employee deductibles have been increased to **\$2,000 Single, \$4,000 2-Person and Family coverage**. Johannesburg-Lewiston Area Schools will reimburse 100% of eligible deductible expenses through the HRA Program.

- **Prescription Drug Copays:**

Johannesburg-Lewiston Area Schools will reimburse 100% of eligible prescription drug copays through the HRA Program.

2. KorthaseFlinn Insurance & Financial Services administers our HRA Program. All requests for reimbursement should be submitted to the Employee Benefits Department at KorthaseFlinn Insurance. Along with your claim form you **must** also send the following (**please keep your original documentation**).

- **For Medical Deductible Expenses:** Blue Cross Blue Shield of Michigan (BCBSM) "Explanation of Benefit Payments" (EOB) Statements. ***Please note that these statements are often double-sided and all pages must be submitted.***

- **For Prescription Drug Expenses:** Prescription receipts must contain the following information:
 Patient Name Prescription Name or Number Date Prescription was Filled
******Cash register receipts are not acceptable.***

→ **Claims submitted without this substantiation will be rejected.**

3. Eligible claims that are submitted by the **5th** of the month will be paid on the **10th** of the month.

4. You can elect to receive your reimbursements via a check mailed to your home or via Direct Deposit. If you choose Direct Deposit, please fill out the "Authorization Agreement for Automatic Deposits (ACH) Credits" Form.

Please feel free to contact us should you have any questions about the Health Reimbursement program for 2010.

KorthaseFlinn Insurance & Financial Services

Attn: Employee Benefits Department

1150 Boyne Avenue

Boyne City, MI 49712

Ph#: (231) 582-6512 **or** (800) 303-4113

Fax: (231) 582-7130 **or** (866) 866-9557

