American International Academy

Access Point Educational Services

2019-2020
Employee Benefits
Summary Plan Descriptions

Medical Option 1

Blue Cross Blue Shield

BCBS Simply Blue $500

MBPA/ACCESS EDUCATIONAL HR L
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62886002
0070392180002
Simply Blue PPO℠ LG
Effective Date: On or after July 2018
Benefits-at-a-glance

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. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. 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 diseases 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.

Benefits	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 count toward the in-network deductible.
Flat-dollar copays	• $20 copay for office visits and office consultations with a **primary care physician** • $40 copay for office visits and office consultations with a **specialist** • $20 copay for medical online visits • $30 copay for chiropractic and osteopathic manipulative therapy • $150 copay for emergency room visits • $60 copay for urgent care visits	• $150 copay for emergency room visits
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
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	$1,500 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 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 the family (when two or more members are covered under your contract) each calendar year	$12,700 for one member, $25,400 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

Benefits	In-network	Out-of-network
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

Benefits	In-network	Out-of-network
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
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 One per member per calendar year	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.
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 One per member per calendar year	60% after out-of-network deductible

Physician office services

Benefits	In-network	Out-of-network
Office visits -must be medically necessary	• $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
Online visits - must be medically necessary **Note:** Online visits by a non-BCBSM selected vendor are not covered	$20 copay per online 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 **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

Benefits	In-network	Out-of-network
Urgent care visits	$60 copay for each 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

Emergency medical care

Benefits	In-network	Out-of-network
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

Benefits	In-network	Out-of-network
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

Benefits	In-network	Out-of-network
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

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	80% after in-network deductible	60% after out-of-network deductible
Note: Nonemergency services must be rendered in a **participating** hospital.	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

Benefits	In-network	Out-of-network
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

Surgical services

Benefits	In-network	Out-of-network
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

Human organ transplants

Benefits	In-network	Out-of-network
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 use disorder treatment

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder 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**
• Online visits **Note:** Online visits by a non-BCBSM selected vendor are not covered	80% after in-network deductible	60% after out-of-network deductible
• Physician's office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder 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)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
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

Benefits	In-network	Out-of-network
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	$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** 12-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy -provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 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

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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 will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The 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 copay 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

Benefits		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 $15 copay	You pay $15 copay	You pay $15 copay	You pay $15 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $30 copay	No coverage	No coverage
	84 to 90-day period	You pay $30 copay	You pay $30 copay	No coverage	No coverage

Benefits		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 $50 copay	You pay $50 copay	You pay $50 copay	You pay $50 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $100 copay	No coverage	No coverage
	84 to 90-day period	You pay $100 copay	You pay $100 copay	No coverage	No coverage
Tier 3 - Non Preferred brand-name drugs	1 to 30-day period	You pay $70 copay or 50% of the approved amount (whichever is greater), but no more than $100	You pay $70 copay or 50% approved amount (whichever is greater), but no more than $100	You pay $70 copay or 50% of the approved amount (whichever is greater), but no more than $100	You pay $70 copay or 50% of the approved amount (whichever is greater), but no more than $100 plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $140 copay or 50% of the approved amount (whichever is greater), but no more than $200	No coverage	No coverage
	84 to 90-day period	You pay $140 copay or 50% of the approved amount (whichever is greater), but no more than $200	You pay $140 copay or 50% of the approved amount (whichever is greater), but no more than $200	No coverage	No coverage
Tier 4 - Generic and preferred brand-name specialty drug	1 to 30-day period	You pay 20% of the approved amount, but no more than $200	You pay 20% of the approved amount, but no more than $200	You pay 20% of the approved amount, but no more than $200	You pay 20% of the approved amount, but no more than $200 plus an additional 25% of BCBSM approved amount for the drug
	31 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 the approved amount, but no more than $300	You pay 25% of the approved amount, but no more than $300	You pay 25% of the approved amount, but no more than $300	You pay 25% of the approved amount, but no more than $300 plus an additional 25% of BCBSM approved amount for the drug
	31 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

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.

Covered services

Benefits	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

Benefits	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
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	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	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
Adult and childhood select preventive 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% of approved amount	No coverage	100% of approved amount	75% of approved amount
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	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

Note: Needles and syringes have no copay/ coinsurance.

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

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. • **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 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.
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 preauthorization) 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 preauthorization. Details about which drugs require preauthorization or step therapy are available online site at **bcbsm.com/pharmacy**.
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.
Mandatory maximum allowable cost drugs	If your prescription is filled by any type of 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 regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a nonformulary 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. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

Medical Option 2

Blue Cross Blue Shield

BCBS Simply Blue $1,500

Blue Cross Blue Shield of Michigan

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

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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 diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

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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.

Benefits	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	• $30 copay for office visits and office consultations • $30 copay for medical online visits • $30 copay for chiropractic and osteopathic manipulative therapy • $150 copay for emergency room visits • $30 copay for urgent care visits	• $150 copay for emergency room visits
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
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 the family (when two or more members are covered under your contract) each calendar year	$12,700 for one member, $25,400 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

Benefits	In-network	Out-of-network
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

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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.

Benefits	In-network	Out-of-network
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
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	

Benefits	In-network	Out-of-network
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 One per member per calendar year	60% after out-of-network deductible

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	$30 copay for each 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
Online visits - must be medically necessary **Note:** Online visits by a non-BCBSM selected vendor are not covered	$30 copay per online 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	$30 copay for each office consultation **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

Benefits	In-network	Out-of-network
Urgent care visits	$30 copay for each 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

Emergency medical care

Benefits	In-network	Out-of-network
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

Benefits	In-network	Out-of-network
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

Benefits	In-network	Out-of-network
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

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	80% after in-network deductible	60% after out-of-network deductible
Note: Nonemergency services must be rendered in a **participating** hospital.	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

Benefits	In-network	Out-of-network
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)	

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Benefits	In-network	Out-of-network
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

Surgical services

Benefits	In-network	Out-of-network
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

Benefits	In-network	Out-of-network
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 use disorder treatment

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder 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**

Benefits	In-network	Out-of-network
• Online visits **Note:** Online visits by a non-BCBSM selected vendor are not covered	80% after in-network deductible	60% after out-of-network deductible
• Physician's office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder 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)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
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

Benefits	In-network	Out-of-network
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	$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** 12-visit maximum per member per calendar year	

Benefits	In-network	Out-of-network
Outpatient physical, speech and occupational therapy - provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 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

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BCBSM Preferred RX Program
Effective Date: On or after July 2019
Benefits-at-a-glance

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 will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The 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.

Benefits		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 plus 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

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Benefits		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 $50 copay	You pay $50 copay	You pay $50 copay	You pay $50 copay plus 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
Tier 3 - Non Preferred brand-name drugs	1 to 30-day period	You pay $70 copay or 50% of the approved amount (whichever is greater) but no more than $100	You pay $70 copay or 50% of the approved amount (whichever is greater) but no more than $100	You pay $70 copay or 50% of the approved amount (whichever is greater) but no more than $100	You pay $70 copay or 50% of the approved amount (whichever is greater) but no more than $100 plus an additional 25% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $140 copay 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 copay 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 copay or 50% of the approved amount (whichever is greater) but no more than $290	You pay $200 copay 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 drug	1 to 30-day period	You pay 20% of the approved amount, but no more than $200	You pay 20% of the approved amount, but no more than $200	You pay 20% of the approved amount, but no more than $200	You pay 20% of the approved amount, but no more than $200 plus 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 the approved amount, but no more than $300	You pay 25% of the approved amount, but no more than $300	You pay 25% of the approved amount, but no more than $300	You pay 25% of the approved amount, but no more than $300 plus 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

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

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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.

Covered services

Benefits	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	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	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
Adult and childhood select preventive 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% of approved amount	No coverage	100% of approved amount	75% of approved amount
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	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

Note: Needles and syringes have no copay/coinsurance.

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

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Features of your prescription drug plan

Custom Select 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. • **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 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.
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 preauthorization) 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 preauthorization. Details about which drugs require preauthorization or step therapy are available online site at **bcbsm.com/pharmacy**.
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.
Exclusions	The following drugs are not covered: • 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

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Medical Option 3

Blue Care Network

BCN–HMO $500

Blue Care Network of Michigan

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

BCN 500 Plan

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificate and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

Member's Responsibility: Deductible, Copays, Coinsurance and Out-of-Pocket Maximums

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

Deductible **Note:** Coinsurance and select fixed dollar copays apply once the deductible has been met.	$500 per individual/$1,000 per family per calendar year
Fixed dollar copays	$20 for office visits, $20 for medical online visits, $40 for specialist visits, $40 for urgent care visits, $150 for emergency room visits, $150 for high tech imaging and $5 for allergy injections
Coinsurance	20% and 50% for select services as noted below
Annual Coinsurance Maximum – The following services DO NOT apply to the Annual Coinsurance Maximum if they are included in your coverage: • Deductible amounts • Services with a flat dollar copay • Infertility services • Male Mastectomy • Reduction Mammoplasty • Male Sterilization • Elective Abortion • TMJ • Orthognathic Surgery • Weight Reduction procedures • Durable Medical Equipment • Prescription Drugs • Prosthetics and Orthotics • Diabetic Supplies	$1,500 per member/$3,000 per family per calendar year
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays	$6,350 per member/$12,700 per family per calendar year

Preventive Services – as defined by the Affordable Care Act and included in your Certificate of Coverage

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%
Routine Colonoscopy	Covered – 100%
Mammography Screening	Covered – 100%
Voluntary Female Sterilization	Covered – 100%
Breast Pumps	Covered – 100%
Maternity Pre-Natal Care	Covered – 100%

Physician Office Services

PCP Office Visits	Covered – $20 copay
Online Visits	Covered – $20 copay
Consulting Specialist Care – when referred for other than preventive services	Covered – $40 copay

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered – $150 copay after deductible
Urgent Care Center	Covered – $40 copay
Ambulance Services – medically necessary	Covered – 80% after deductible

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100%
Diagnostic Tests and X-rays	Covered – 80% after deductible
High Technology Imaging (MRI, CAT, PET)	Covered – $150 copay after deductible
Radiation Therapy	Covered – 80% after deductible

Maternity Services Provided by a Physician

Post-Natal Care. See Preventive Services section for Pre-Natal Care	Covered – $20 copay
Delivery and Nursery Care	Covered – 100% after deductible for professional services; see Hospital Care for facility charges

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 80% after deductible; unlimited days
Outpatient Surgery – See member certificate for select surgical coinsurance	Covered – 80% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 80% after deductible up to 45 days per calendar year
Hospice Care	Covered – 100% after deductible when authorized
Home Health Care	Covered – $40 copay after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 80% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – 50% after deductible
Human Organ Transplants (subject to medical criteria)	Covered – 80% after deductible
Reduction mammoplasty (subject to medical criteria)	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 50% after deductible

Mental Health Care and Substance Use Disorder Treatment

Inpatient Mental Health Care and Substance Use Disorder	Covered – 80% after deductible
Outpatient Mental Health Care includes online visits **Note:** For diagnostic and therapeutic services, the medical benefit applies.	Covered – $20 copay
Outpatient Substance Use Disorder	Covered – $20 copay

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment through age 18	Covered – $20 copay
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18 Physical, speech and occupational therapy for autism spectrum disorder diagnosis is unlimited.	Covered – $40 copay after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit

Other Services

Allergy Testing and Therapy	Covered – 50% after deductible
Allergy office visits	Covered – 50% after deductible
Allergy Injections	Covered – $5 copay
Chiropractic Spinal Manipulation – when referred	Covered – $40 copay; up to 30 visits per calendar year
Outpatient Physical, Speech and Occupational Therapy – subject to meaningful improvement within 60 days	Covered – $40 copay after deductible; limited to 60 visits per calendar year for any combination of therapies
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%
Diabetic Supplies	Covered – 50%

CLSSLG, CO20, 40RP, ER150, UR40, IMG150, D500, CI20%, 15ECM, 6350PM, WDRPOV, OMRR

This benefit design applies to the BCN, BCN Local Southeast, and BCN Local West networks. Network availability is based on group offerings and member location.

Blue Care Network of Michigan

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

Benefits-at-a-Glance for $4/$15/$40/$80/20%/20%
Prescription Drug Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificate and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

Prescription Drugs

Tier 1A – Value Generics	$4 Copayment
Tier 1B - Generics	$15 Copayment
Tier 2 – Preferred Brand Drugs	$40 Copayment
Tier 3 – Non-Preferred Drugs	$80 Copayment
Tier 4 – Preferred Specialty	20% Coinsurance of the BCN Approved Amount (Maximum Copayment $200)
Tier 5 Non-Preferred Specialty	20% Coinsurance of the BCN Approved Amount (Maximum Copayment $300)
Sexual Dysfunction Drugs	50% Coinsurance of the BCN Approved Amount
Contraceptives **Note:** Your cost sharing may be waived for Tier 1B, Tier 2 or Tier 3 contraceptive drugs if there are no appropriate generic products or preferred drugs available.	• Tier 1A – Covered in Full • Tier 1B – $15 Copay • Tier 2 - $40 Copay • Tier 3 - $80 Copay
Preventive Medications	• Tier 1A – Covered in Full • Tier 1B Generic – Covered in Full • Tier 2 Preferred Brand – Covered in Full • Tier 3 Non-Preferred Drugs – Covered in Full
31-90 day supply for Mail-Order Pharmacy	Two times applicable copay
84-90 day supply for Retail Pharmacy	Two times applicable copay
Out-of-Pocket Maximum	Your medical out-of-pocket maximum is integrated with your BCN covered Prescription Drugs. The out-of-pocket maximum amount is listed with your medical benefits.

Definitions

Brand Name Drug	Manufactured and marketed under a registered trade name and trademark. • Multi-source Brand Name Drug: a drug that is available from a brand name manufacturer and also has a generic version. • Single Source Brand Name Drug: the drug can only be produced by the company holding the patent; no generics are available.
Generic Drugs	Prescription drugs that have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark.
Non-Preferred Drugs	Prescription drugs that may not have a proven record for safety or their clinical record may not be as high as the BCN preferred alternatives.
Non-Preferred Specialty Drugs	Specialty drugs that may not have a proven record for safety or their clinical value may not be as high as the Specialty Drugs.
Out-of-Pocket Maximum	The highest amount of money you have to pay for covered services during the Calendar Year.
Preferred Brand Drugs	Prescription drugs that are Single Source Brand drugs that have a proven record for safety and effectiveness.
Preferred Specialty Drugs	Generic or Single Source Brand Specialty drugs that have a proven record for safety and effectiveness and offer the best value to our members.
Value Generic Drugs	Prescription drugs that have a proven clinical value essential for treatment of chronic conditions.

P415CL, MOPD20

Optional rider: XHHRX (Health Habit Prescription Drug Exclusion Rider). Rider removes coverage for sexual dysfunction and weight loss prescription drugs.

Medical Option 4

Blue Care Network

BCN HSA HMO $1,000

Blue Care Network of Michigan

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

BCN 1000 Plan

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Member's Responsibility: Deductible, Copays, Coinsurance and Out-of-Pocket Maximums

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

Deductible **Note:** Coinsurance and select fixed dollar copays apply once the deductible has been met.	$1,000 per individual/$2,000 per family per calendar year
Fixed dollar copays	$30 for office visits, $30 for medical online visits, $50 for specialist visits, $50 for urgent care visits, $150 for emergency room visits, $150 for high tech imaging and $5 for allergy injections
Coinsurance	20% and 50% for select services as noted below
Annual Coinsurance Maximum – The following services DO NOT apply to the Annual Coinsurance Maximum if they are included in your coverage: • Deductible amounts • Services with a flat dollar copay • Infertility services • Male Mastectomy • Reduction Mammoplasty • Male Sterilization • Elective Abortion • TMJ • Orthognathic Surgery • Weight Reduction procedures • Durable Medical Equipment • Prescription Drugs • Prosthetics and Orthotics • Diabetic Supplies	$2,500 per member/$5,000 per family per calendar year
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays	$6,350 per member/$12,700 per family per calendar year

Preventive Services – as defined by the Affordable Care Act and included in your Certificate of Coverage

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%
Routine Colonoscopy	Covered – 100%
Mammography Screening	Covered – 100%
Voluntary Female Sterilization	Covered – 100%
Breast Pumps	Covered – 100%
Maternity Pre-Natal Care	Covered – 100%

Physician Office Services

PCP Office Visits	Covered – $30 copay
Online Visits	Covered – $30 copay
Consulting Specialist Care – when referred for other than preventive services	Covered – $50 copay

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered – $150 copay after deductible
Urgent Care Center	Covered – $50 copay
Ambulance Services – medically necessary	Covered –80% after deductible

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100%
Diagnostic Tests and X-rays	Covered – 80% after deductible
High Technology Imaging (MRI, CAT, PET)	Covered – $150 copay after deductible
Radiation Therapy	Covered – 80% after deductible

Maternity Services Provided by a Physician

Post-Natal Care. See Preventive Services section for Pre-Natal Care	Covered – $30 copay
Delivery and Nursery Care	Covered – 100% after deductible for professional services; see Hospital Care for facility charges

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 80% after deductible; unlimited days
Outpatient Surgery – See member certificate for select surgical coinsurance	Covered – 80% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 80% after deductible up to 45 days per calendar year
Hospice Care	Covered – 100% after deductible when authorized
Home Health Care	Covered – $50 copay after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 80% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – 50% after deductible
Human Organ Transplants (subject to medical criteria)	Covered – 80% after deductible
Reduction mammoplasty (subject to medical criteria)	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 50% after deductible

Mental Health Care and Substance Use Disorder Treatment

Inpatient Mental Health Care and Substance Use Disorder	Covered – 80% after deductible
Outpatient Mental Health Care includes online visits **Note:** For diagnostic and therapeutic services, the medical benefit applies.	Covered – $30 copay
Outpatient Substance Use Disorder	Covered – $30 copay

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment through age 18	Covered – $30 copay
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18 Physical, speech and occupational therapy for autism spectrum disorder diagnosis is unlimited.	Covered – $50 copay after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit

Other Services

Allergy Testing and Therapy	Covered – 50% after deductible
Allergy office visits	Covered – 50% after deductible
Allergy Injections	Covered – $5 copay
Chiropractic Spinal Manipulation – when referred	Covered – $50 copay; up to 30 visits per calendar year
Outpatient Physical, Speech and Occupational Therapy – subject to meaningful improvement within 60 days	Covered – $50 copay after deductible; limited to 60 visits per calendar year for any combination of therapies
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%
Diabetic Supplies	Covered – 50%

CLSSLG, CO30, 50RP, ER150, UR50, IMG150, D1000, CI20%, 25ECM, 6350PM, WDRPOV, OMRR

This benefit design applies to the BCN, BCN Local Southeast, and BCN Local West networks. Network availability is based on group offerings and member location.

Blue Care Network of Michigan

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

Benefits-at-a-Glance for $4/$15/$40/$80/20%/20% Prescription Drug Coverage

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Prescription Drugs

Tier 1A – Value Generics	$4 Copayment
Tier 1B - Generics	$15 Copayment
Tier 2 – Preferred Brand Drugs	$40 Copayment
Tier 3 – Non-Preferred Drugs	$80 Copayment
Tier 4 – Preferred Specialty	20% Coinsurance of the BCN Approved Amount (Maximum Copayment $200)
Tier 5 Non-Preferred Specialty	20% Coinsurance of the BCN Approved Amount (Maximum Copayment $300)
Sexual Dysfunction Drugs	50% Coinsurance of the BCN Approved Amount
Contraceptives **Note:** Your cost sharing may be waived for Tier 1B, Tier 2 or Tier 3 contraceptive drugs if there are no appropriate generic products or preferred drugs available.	• Tier 1A – Covered in Full • Tier 1B – $15 Copay • Tier 2 - $40 Copay • Tier 3 - $80 Copay
Preventive Medications	• Tier 1A – Covered in Full • Tier 1B Generic – Covered in Full • Tier 2 Preferred Brand – Covered in Full • Tier 3 Non-Preferred Drugs – Covered in Full
31-90 day supply for Mail-Order Pharmacy	Two times applicable copay
84-90 day supply for Retail Pharmacy	Two times applicable copay
Out-of-Pocket Maximum	Your medical out-of-pocket maximum is integrated with your BCN covered Prescription Drugs. The out-of-pocket maximum amount is listed with your medical benefits.

Definitions

Brand Name Drug	Manufactured and marketed under a registered trade name and trademark. • Multi-source Brand Name Drug: a drug that is available from a brand name manufacturer and also has a generic version. • Single Source Brand Name Drug: the drug can only be produced by the company holding the patent; no generics are available.
Generic Drugs	Prescription drugs that have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark.
Non-Preferred Drugs	Prescription drugs that may not have a proven record for safety or their clinical record may not be as high as the BCN preferred alternatives.
Non-Preferred Specialty Drugs	Specialty drugs that may not have a proven record for safety or their clinical value may not be as high as the Specialty Drugs.
Out-of-Pocket Maximum	The highest amount of money you have to pay for covered services during the Calendar Year.
Preferred Brand Drugs	Prescription drugs that are Single Source Brand drugs that have a proven record for safety and effectiveness.
Preferred Specialty Drugs	Generic or Single Source Brand Specialty drugs that have a proven record for safety and effectiveness and offer the best value to our members.
Value Generic Drugs	Prescription drugs that have a proven clinical value essential for treatment of chronic conditions.

P415CL, MOPD20

Optional rider: XHHRX (Health Habit Prescription Drug Exclusion Rider) - Rider removes coverage for sexual dysfunction and weight loss prescription drugs.

Medical Option 5

Blue Care Network

BCN HSA HMO $3,000

Blue Care Network of Michigan

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

HDHPLG

00420261 0001 0004 Advance Educational

Deductible, Copays and Dollar Maximums	
Deductible - Combined for both medical and drug coverage.	$3,000 for a one-person contract/$6,000 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)
	The Deductible paid by all Members will be combined to satisfy the family Deductible. However, one individual Member cannot contribute more than the individual Deductible amount toward the family Deductible.
Fixed Dollar Copays	None
Coinsurance	50% for select services as noted below
	20% for select services as noted below
Out of Pocket Maximum	$6,350 for a one-person contract. $12,700 for a family contract (2 or more members) each calendar year
	Out of Pocket Maximum – An individual member can't contribute in excess of the individual OOPM amount. The remaining members in the family contract must combine to meet the Family OOPM.

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

Physician Office Services	
PCP Office Visits	80% after deductible
Online Visits	80% after deductible
Consulting Specialist Care	80% after deductible

Emergency Medical Care	
Hospital Emergency Room	80% after deductible
Urgent Care Center	80% after deductible
Retail Health Clinic	80% after deductible
Ambulance Services	80% after deductible

Benefits Selected - EDEPM,20COHD,3000HD,63OMHD,OMRR,P415DL,90D3X

Diagnostic Services	
Laboratory and Pathology Services	80% after deductible
Diagnostic Tests and X-rays	80% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	80% after deductible
Radiation Therapy	80% after deductible

Maternity Services Provided by a Physician	
Post-Natal and Non-routine Pre-Natal Care (See Preventive Services section for routine Pre-Natal Care)	80% after deductible (Does not apply to routine services)
Delivery and Nursery Care	80% after deductible

Hospital Care	
General Nursing Care, Hospital Services and Supplies	80% after deductible
Outpatient Surgery	80% after deductible

Alternatives to Hospital Care	
Skilled Nursing Care	80% after deductible
	Up to 45 days per calendar year
Hospice Care	80% after deductible
Home Health Care	80% after deductible

Surgical Services	
Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	80% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Male - 50% after deductible
Elective Abortion (One procedure per two year period of membership)	Not Covered
Human Organ Transplants	80% after deductible
Reduction Mammoplasty	50% after deductible
Male Mastectomy	50% after deductible
Temporomandibular Joint Syndrome	50% after deductible
Orthognathic Surgery	50% after deductible
Weight Reduction Procedures	50% after deductible

Benefits Selected - EDEPM,20COHD,3000HD,63OMHD,OMRR,P415DL,90D3X

Mental Health Care and Substance Use Disorder Treatment	
Inpatient Mental Health Care	80% after deductible
Inpatient Substance Use Disorder	80% after deductible
Outpatient Mental Health Care includes online visits Note: For diagnostic and therapeutic services, the medical benefit applies.	80% after deductible
Outpatient Substance Use Disorder	80% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment	
Applied Behavioral analysys (ABA) treatment	80% after deductible
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	80% after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visit and preventive benefit.

Other Services	
Allergy Testing and Therapy	80% after deductible
Allergy Injections	80% after deductible
Chiropractic Spinal Manipulation - when referred	80% after deductible
	(up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy	80% after deductible
	60 visits per calendar year for any combination of therapies
Infertility Counseling and Treatment (Excludes In-vitro fertilization)	50% after deductible
Durable Medical Equipment	50% after deductible
Prosthetic and Orthotic Appliances	50% after deductible
Diabetic Supplies	80% after deductible
Prescription Drugs	Tier 1A - $4 copay after ded, Tier 1B - $15 copay after ded, Tier 2 - $40 copay after ded, Tier 3 - $80 copay after ded, Tier 4 -20% coinsurance after ded (max $200)/Tier 5 - 20% coinsurance after ded (max $300); 30 day supply
	Sexual Dysfunction drugs - 50% coinsurance after deductible
	Female contraceptives - Tier 1A - Covered in full, Tier 1B - $15 copay after ded, Tier 2 - $40 copay after ded, Tier 3 - $80 copay after ded
Mail Order Prescription Drugs	30 day supply or less - applicable tiered copay/coinsurance, 31-90 day supply - 3x's the 30 day copay/coinsurance minus $10 after deductible
Prescription Drug Deductible	Prescription drug deductible integrated with the medical deductible
Hearing Aid	Not covered

Benefits Selected - EDEPM,20COHD,3000HD,63OMHD,OMRR,P415DL,90D3X

Blue Care Network of Michigan

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HDHPLG

00420261 0001 0004 Advance Educational

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Preauthorization for Specialty Services – Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCN 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.*

Medical	0000D160	MED

Benefits Selected - EDEPM,20COHD,3000HD,63OMHD,OMRR,P415DL,90D3X

Dental Option 1

Guardian Dental - Optimal

Guardian Dental Insurance – Optimal Plan

AccessPoint

Plan Number: 527756

SMILE. THERE'S AN AFFORDABLE WAY TO CARE FOR YOUR TEETH.

Taking care of your teeth can be expensive. That's why the right dental insurance is so important — it not only pays for preventive care that can keep you and your family healthy, but it also helps pay for more extensive, costly and often unexpected expenses, such as fillings, crowns and root canals. Plus, you save money and have the assurance that you are getting the right care when you use one of our in-network dentists.

Why choose Guardian® for your Dental Coverage

We have been providing outstanding dental plans to millions of Americans for more than 50 years. When you enroll in Guardian Dental plans you have access to one of the nation's largest dental networks with over 114,000 dental providers at more than 319,000 dental service nationwide. You can feel confident there is always high quality dental care close by.
From preventive checkups and cleanings, to comprehensive oral care treatments, we have you covered.

Why Going to an In-Network PPO Provider is Important

Your benefit plan offers 100% coverage for preventive services, but what if you have a more serious condition and need more costly services? Seeking care for those services from an in-network dentist can help! An example is listed below:

Average cost of a root canal, associated dental work, and a crown*

Cost with no dental insurance	Your in-network cost with Guardian Dental Insurance	Your estimated savings with Guardian Dental Insurance
$2,400	$1,600	$800

It's Easy to Use Guardian Dental Benefits

- Using an in-network provider helps you save more money and assures quality dental care, however, you still have the freedom to choose any dentist for care.
- Quick and easy claims payment directly to your dentist
- Find a Provider or View Your ID Card any time of day at www.GuardianAnytime.com or by using Guardian's Mobile App

Did you know...?

- 1 in 5 Americans has untreated cavities[1]
- For every $1 spent on preventive services an estimated $50 is saved on more complicated procedures[2]
- Tooth decay is the most common childhood disease — impacting sleeping or eating habits, and can contribute to school absences[3]

Guardian®

*The above example only. See your plan for specific details regarding covered services. 1. "1 in 5 Americans Has Untreated Cavities: CDC," HealthDay, May 31, 2015 [illegible] 2. [illegible] Connecting With A Dentist Doesn't Mean An Office Visit [illegible] Health News, July 25, 2014. 3. Centers for Disease Control. Guardian's Dental Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY or its subsidiaries. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. Policy Form #GP-1-R-G2000 et al.

AccessPoint

Guardian Dental Insurance – Optimal Plan

Plan Number: 527756

EMPLOYEE BENEFITS*	In Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE		
Individual Deductible (up to 3 per Family)	$0	$50
PLAN MAXIMUMS		
Annual Maximum (Applies to Basic and Major Services Only)	$1,200	
Lifetime Orthodontia Maximum, per Child	$1,000	
MAXIMUM ROLLOVER		
Members may roll over unused Annual Max dollars for use in future years.	INCLUDED	
PREVENTIVE CARE– INCLUDES PREVENTIVE ADVANTAGE (Preventive Services do not track to Annual Maximum)		
Cleaning (prophylaxis) – *2 per calendar year*	100%	100%
Fluoride Treatments – *under age 19*	100%	100%
Oral Exams	100%	100%
Sealants	100%	100%
Sealants – *under age 16*	100%	100%
X-Rays	100%	100%
BASIC CARE		
Fillings – including Posterior Composite (white) Fillings	80%	80%
Anesthesia	80%	80%
Repair & Maintenance of Crowns, Bridges & Dentures	80%	80%
Periodontal Maintenance Services and Surgery	80%	80%
Endodontic Services (Root Canals)	80%	80%
Oral Surgery & Extractions	80%	80%
MAJOR CARE		
Bridges & Dentures	50%	50%
Inlays/Onlays/Crowns & Veneers	50%	50%
Single Crowns	50%	50%
Implants	50%	50%
ORTHODONTIA		
Orthodontia (applicable to dependent children only)	50%	50%
DEPENDENT AGE LIMITS		
Dependent Age Limits	19, or 26 if full-time college student	

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Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred PPO Plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. Waiting periods may also apply for some services. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments, any treatment to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic and prosthodontic services. The services, exclusions, and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Policy Form #GP-1-DG2000, et al.

Guardian®

GUARDIAN DENTAL INSURANCE MAXIMUM ROLLOVER

Guardian

Rollover Dollars...for Your Dental Plan!

Earning Rollover Dollars for Use in Future Years can be Simple!

1) **Go see the dentist at least once during the plan year.**
2) **Incur less than the plan Threshold of $600 in paid dental claims. That's it!**

With Maximum Rollover, you have more dental benefits available when you need them.

- **Promotes Preventive Care:** Participants receive rollover dollars in their Maximum Rollover Account if they visit the dentist at least once during the year and do not exceed the Threshold.
- **Easy to Track**: Members can look up their Maximum Rollover Account Balance online; They will see their current balance available for use during the current plan year.
- **Annual Maximum + Rollover Account Balance = Maximum Dental Coverage**: Members accumulate Rollover Dollars every year until they reach their Maximum Rollover Account Balance Limit of $1,250.

Jane's Dental PPO Plan Example: $1,250 Annual Maximum

YEAR ONE Jane's Maximum Dental Coverage: $1,200

Jane has $150 in dental claims (less than this plan's threshold of $600). Jane receives $300 Rollover Dollars for use in Year Two.

YEAR TWO Jane's Maximum Dental Coverage: $1,500

Jane has $250 in dental claims (less than the plan threshold of $600). This year, Jane also seeks care from only Guardian In-Network PPO Dentists, so Jane receives $400 Rollover Dollars (members receive more Rollover Dollars when they see only In-Network Dentists).

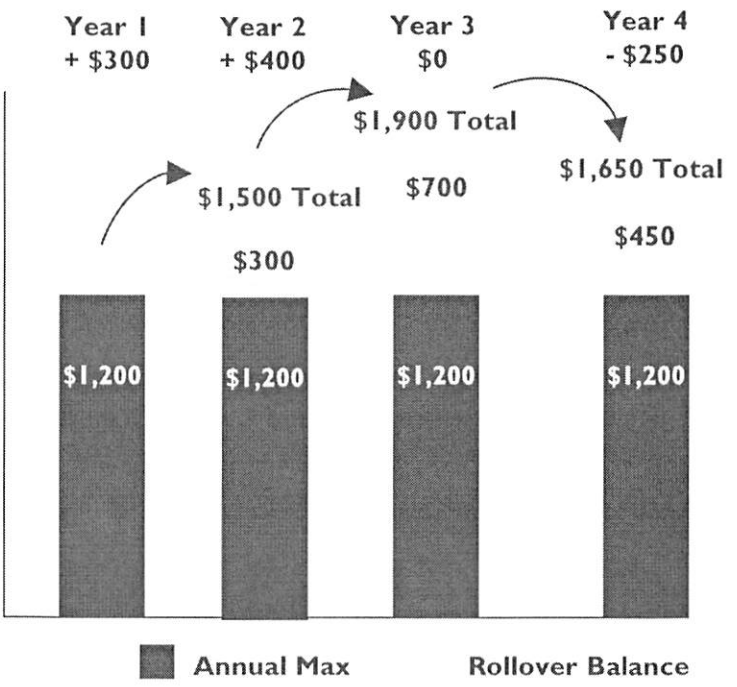
YEAR THREE Jane's Maximum Dental Coverage: $1,900

Jane has $1,450 in dental claims (greater than threshold of $600).

Since Jane had claims higher than $600 this year, she does not receive any additional Rollover Dollars.

Jane's claims are higher than the plan's Annual Maximum of $1,200, so she uses $250 out of her Maximum Rollover Account to cover her claims.

Jane still has $450 Rollover Dollars left in her Maximum Rollover Account, so she will have $1,650 of Maximum Dental Coverage in Year Four.



After your coverage starts, you can check your Max Rollover Account Balance by visiting www.GuardianAnytime.com

Dental Option 2

Guardian Dental - Value

Guardian Dental Insurance – Value Plan

AccessPoint

Plan Number: 527756

SMILE. THERE'S AN AFFORDABLE WAY TO CARE FOR YOUR TEETH.

Taking care of your teeth can be expensive. That's why the right dental insurance is so important — it not only pays for preventive care that can keep you and your family healthy, but it also helps pay for more extensive, costly and often unexpected expenses, such as fillings, crowns and root canals. Plus, you save money and have the assurance that you are getting the right care when you use one of our in-network dentists.

Did you know...?

- 1 in 5 Americans has untreated cavities[1]
- For every $1 spent on preventive services an estimated $50 is saved on more complicated procedures[2]
- Tooth decay is the most common childhood disease — impacting sleeping or eating habits, and can contribute to school absences[3]

Why choose Guardian® for your Dental Coverage

We have been providing outstanding dental plans to millions of Americans for more than 50 years. When you enroll in Guardian Dental plans you have access to one of the nation's largest dental networks with over 114,000 dental providers at more than 319,000 dental service nationwide. You can feel confident there is always high quality dental care close by.
From preventive checkups and cleanings, to comprehensive oral care treatments, we have you covered.

Why Going to an In-Network PPO Provider is Important

Your benefit plan offers comprehensive coverage for preventive services, but what if you have a more serious condition and need more costly services? Seeking care for those services from an in-network dentist can help! An example is listed below:

Average cost of a root canal, associated dental work, and a crown*

Cost with no dental insurance	Your in-network cost with Guardian Dental Insurance	Your estimated savings with Guardian Dental Insurance
$2,400	$1,600	$800

It's Easy to Use Guardian Dental Benefits

- Using an in-network provider helps you save more money and assures quality dental care, however, you still have the freedom to choose any dentist for care.
- Quick and easy claims payment directly to your dentist
- Find a Provider or View Your ID Card any time of day at www.GuardianAnytime.com or by using Guardian's Mobile App

Guardian®

Guardian Dental Insurance – Value Plan

AccessPoint

Plan Number: 527756

EMPLOYEE BENEFITS*	In-Network	Out-of Network
Claim Payments Based On	Fee Schedule	Fee Schedule
CALENDAR YEAR DEDUCTIBLE		
Individual Deductible (up to 3 per Family)	$0	$50 Applies to All Services
PLAN MAXIMUMS		
Annual Maximum		$1,000
PREVENTIVE CARE – INCLUDES PREVENTIVE ADVANTAGE **(Preventive Services rendered by In-Network Dentists do not accumulate toward Annual Maximum)**		
Cleaning (prophylaxis) – *2 per calendar year*	100%	100%
Fluoride Treatments – *under age 19*	100%	100%
Oral Exams	100%	100%
Sealants	100%	100%
Sealants – *under age 16*	100%	100%
BASIC CARE		
X-rays	80%	50%
Fillings	80%	50%
Periodontal Maintenance	80%	50%
Anesthesia	80%	50%
Repair & Maintenance of Crowns, Bridges and Dentures	80%	50%
MAJOR CARE		
Bridges & Dentures	50%	50%
Periodontal Maintenance Services and Surgery	50%	50%
Endodontic Services (Root Canals)	50%	50%
Oral Surgery	50%	50%
Inlays/Onlays, Crowns and Veneers	50%	50%
Single Crowns	50%	50%
ORTHODONTIA		
Orthodontia	Not Covered	Not Covered
DEPENDENT AGE LIMITS		
Dependent Age Limits	19, or 26 if full-time college student	

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Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred PPO Plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. Waiting periods may also apply for some services. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments, any treatment to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic and prosthodontic services. The services, exclusions, and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Policy Form #GP-1-DG2000, et al.

Guardian®

Vision

Guardian Vision VSP Signature

Guardian Vision Insurance – VSP Choice B
EDUCATIONAL SERVICES

AccessPoint

Plan Number: 527756

KEEP AN EYE ON YOUR VISION HEALTH AND SAVINGS.

Whether you have perfect vision, or require some type of corrective lenses, preventive eye care is an important part of your overall health.

And as we go through life, having a good vision insurance plan can help you reduce the expensive costs of exams, frames, contact lenses, laser corrective surgery and more.

Regular Eye Exams Can Detect Major Medical Problems

Research shows that regular vision exams can help identify vision issues before they become serious1. Having a vision plan can also benefit your family, and in particular your children, since problems with vision can affect their progress in school. Other conditions that can be detected with regular vision exams include:

- Diabetes
- High blood pressure
- Increased stroke risk
- Autoimmune diseases
- High blood pressure
- Excessive thyroid hormones

Vision Insurance with Guardian

With Guardian vision coverage, you have access to an extensive network of vision specialists and medical professionals. For just a few dollars a month, you and your family can take advantage of affordable coverage that can save you time and money.

A Plan with Real Benefits

- No ID cards needed
- Nationally recognized vision providers
- Nationwide network
- Quick and easy claims payment

See the Value of Healthy Vision

- Two out of three Americans are affected by vision problems.[2]
- 70% of adults in the U.S. experience some form of digital eye strain due to use of their electronic devices.[3]
- Nearly 25% of school-age children have vision problems that can impact learning.[4]

Guardian®

Guardian Vision Insurance – VSP Choice B
EDUCATIONAL SERVICES

AccessPoint

Plan Number: 527756

Primary Benefits	Plan Option 1: VSP Choice B	
Exams	$10	
Materials	$25	
Child Age Limit	To Age 26	
	In-Network Co-Pay	**Out-of-Network Allowance**
EYE EXAMS	Once per calendar year	
Exam	$10	$39
LENSES	Once per calendar year	
Lens – Single Vision	$25	$23
Lens – Bifocal	$25	$37
Lens – Trifocal	$25	$49
Lens – Lenticular	$25	$64
CONTACT LENSES	Once per calendar year	
Elective Allowance *(in lieu of complete set of glasses)*	$130 maximum	$100 maximum
FRAMES	Once every other calendar year	
Allowance	$130 retail maximum + 20% off balance after $25 Co-pay	$46 maximum After $25 Co-pay

ADDITIONAL FEATURES – VSP CHOICE NETWORK PROVIDERS ONLY

Members receive

- 30% off the retail price of additional pairs of glasses purchased the same day from the same provider that performed the exam
- 20% off any additional pairs of glasses purchased within 12 months of the exam
- 20% off the amount exceeding the copay and allowance on frames purchased
- 15% off providers' professional services for prescription contact lenses.

These discounts only apply to services from an in-network provider.

Guardian

Guardian Vision Insurance – VSP Choice B
EDUCATIONAL SERVICES

AccessPoint

Plan Number: 527756

Lens Options – Member Cost	In-Network	Out-of Network
Solid Tints and Dyes (Pink I and II)	Included	N/A
Solid Tints and Dyes (Except Pink I and II)	$13	N/A
Plastic Gradient Dye	$15	N/A
Photochromatic	$62-$76	N/A
Ultraviolet Coating	$14	N/A
Scratch-Resistant Coating	$15	N/A
Polycarbonate Lenses	$0[1]/$23-$28 for adults	N/A
Standard Anti-Reflective (AR) Coating	$37	N/A
Standard Progressive Lenses	$50	Up to $67
Premium Progressives Lenses (Varilux®, etc.)	$80-$90	
Custom Progressive Lenses	$120-$160	

ADDITIONAL VSP CHOICE NETWORK FEATURES *(In-Network Only)*	
Lasik	Average 15% off the provider's Usual & Customary Charges, or 5% off promotional price
Retinal Screening	No more than $39

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A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS

VSP Vision Plan • Coverage is limited to those charges that are necessary to prevent, diagnose and treat a vision condition. • FREQUENCIES MANAGED TO CONFORM WITH LOWEST NUMBER OF YEARS if the member purchases contact lenses they must wait one calendar year/two calendar years to purchase frames. • Members cannot bank unused allowance amounts for future use; they must use their allowance during the same office visit. • The plan does not pay for: Orthoptics or vision training and any associated supplemental testing. Medical or surgical treatment of the eyes. Eye examination to corrective eyewear required by an employer as a condition of employment. Lenses and frames furnished under this plan which are lost or tried on (except when services are otherwise available). • The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, coated or laminated lenses, a frame that exceeds plan allowance, tinted lenses, UV protected lenses, and optional cosmetic processes. • Medically necessary contact lenses are covered only if needed: (1) after cataract surgery, (2) to correct extreme visual acuity problem that cannot be corrected with eyeglasses, (3) for certain conditions of keratoconus, or (4) for aphakia. • The services, exclusions, and limitations listed above do not constitute a contract and are a summary only. • Please refer to certificate of coverage for full plan coverage. plan documents are the final arbiter of coverage. • GP-VSP-SOB-16

Guardian®

Employer Paid Life Insurance

Guardian Life Insurance
Basic $20,000

Guardian Basic Life and Basic AD&D Insurance - $20,000

AccessPoint

Your employer helps to keep your family and finances safe with Life Insurance.

Your life is about those you love and protect. We all want to live a long and happy life but life can be unpredictable, and few things in life are guaranteed. Having life insurance for you and those who depend on you can help by providing financial protection.

Life insurance is not just about final expenses. Depending on your situation, it could take years to financially recover from the loss of an income earner. Life insurance can ease the burden of covering expenses such as:

Mortgage / rent	Childcare assistance
Auto payments	Education / college tuition
Legal or medical fees	Outstanding debts

Good News: Your employer provides Basic Life and AD&D Insurance at no cost to you

The coverage is guarantee issue, which means you won't have to answer any health questions or provided any evidence of insurability.

How it works:

Your plan comes with features and benefits that you can use during your lifetime, including Accelerated Life benefits. Take a moment to review some of the provisions highlighted below.

Can I take my coverage with me if I retire or leave the company?

Yes, you may continue your coverage through direct payment to Guardian.

Does my coverage continue if I become disabled?

If you become totally disabled prior to age 60 and your disability lasts for at least 6 months, you may apply to Guardian to continue your life insurance at no cost to you.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 pm EST.

Refer to your plan number: **527857**

Guardian

Availability will vary based on employer sponsored plan. [illegible] Guardian Group Life Insurance [illegible] The Guardian Life Insurance Company of America, New York, [illegible] CP-LR-OPT-94 [illegible]

AccessPoint

Guardian Basic Life and Basic AD&D Insurance - $20,000

Primary Benefits	Description
Basic Life Benefit Amount	$20,000
Basic AD&D Benefit Amount	$20,000 Dismemberment Schedule of Benefits Included
Benefit Reductions	35% at age 65, 65% at age 70, 75% at age 75, 90% at age 80
Waiver of Premium	Premiums will not need to be paid if you are totally disabled; insurance continues until the earlier of age 65 or until you are no longer disabled.
Portability	Allows you to take your term life coverage with you if you terminate employment. If you choose to this option, you may be required to provide evidence of insurability.
Conversion	Allows you to convert your existing Guardian term life coverage to a permanent whole life policy. You will not be required to provide evidence of insurability.
Accelerated Death Benefit	A lump sum benefit up to 75% of your coverage amount is paid to you if you are diagnosed with a terminal condition, as defined by the plan.
Guarantee Issue	$20,000

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A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS • In order to be eligible for coverage: Employees must be legally working (a) in the United States or (b) outside the United States, for a U.S. based employer, in a country or region approved by Guardian. • We pay no benefits if the insured's death is due to suicide within two years from the insured's original effective date. This two year limitation also applies to any increase in benefit. This exclusion may vary according to state law. • Employees must be working full-time on the effective date of coverage; otherwise, coverage becomes effective after the completion of the specific waiting period. • Evidence of insurability is required for all late enrollees. Benefit increases may require underwriting. • This proposal is subject to satisfactory financial evaluation. • Please refer to certificate of coverage for full plan description; plan documents are the final arbiter of coverage. • In order to be eligible for coverage: Employees must be legally working (a) in the United States or (b) outside the United States, for a US based employer, in a country or region approved by Guardian. • We pay no benefits if the insured's death is due to suicide within two years from the insured's original effective date. This two year limitation also applies to any increase in benefit. This exclusion may vary according to state law. • Employees must be working full-time on the effective date of your coverage; otherwise, coverage becomes effective after the completion of the specific waiting period. • Evidence of insurability is required for all late enrollees. Benefit increases will require underwriting. • We pay no Accidental Death benefits for an insured where death occurs as the result of a disease or a bodily infirmity. These exclusions may include but are not limited to the following: through willful self-injury; by declared or undeclared war, act of war, armed aggression, or while a member of armed forces; may vary by state while driving motor vehicle without a current, valid driver's license; while legally intoxicated; while participating in civil disorder or committing a felony; traveling on any type of aircraft while having any duties on that aircraft; while voluntarily using a non-prescription controlled substance. • Policy Form #GP-1-GPL14

Guardian®

Voluntary
Short-Term Disability Insurance

Guardian Short-Term Disability

Guardian Short Term Disability Insurance: Up to $500 per Week

AccessPoint

Plan Number: 527857

Protect your paycheck if you are unable to work.

Your income is one of your most valuable assets

No one plans on becoming disabled, but a serious illness or injury can strike anyone at any time, and at any age, taking away your ability to earn a paycheck.

Nearly 25% of Americans will become disabled before they retire[1], so this *could* happen to you. And disabilities can result not just from accidents, but illnesses such as heart attack, cancer, and stroke.

How long can you live on your savings if you became disabled?

The value of Disability Insurance for you and your family

Disability Insurance should be an integral part of your financial safety net — it provides a steady stream of income to ease the financial stress of a covered illness or injury when you are no longer receiving a paycheck.

For just a few dollars a month, you can help to provide financial security for yourself and those who depend on you. And enrolling for disability insurance at the workplace is simple and cost effective — with convenient payroll deductions.

Disability coverage with Guardian

For over 50 years, Guardian Disability Insurance has helped protect the income, lifestyle, and financial future for millions of Americans, and Guardian is the #1 insurance carrier for disability cases.[2]

Disability Insurance with Guardian is easy

- **Affordable** group rates
- Extensive **resources** and **support** to help you get back to work and live a productive life.
- **Timely** and **efficient** claims review and payment
- **File your Claims Telephonically** – without claim forms
- Guardian will obtain information **directly from your doctor**
- Guardian will notify you and AccessPoint of your claim status.
- **Check your claim status online** at GuardianAnytime.com

Be sure to continue following the rules at your place of work for reporting time off. Check with your supervisor for clarification of this procedure.

You might be underestimating your risk of a disabling illness or injury

- More than 50% of disabled Americans are in their working years, from 18-64[1]
- A typical female has a 24% chance of becoming disabled for 3 months or longer during her working career[1]
- A typical male has a 21% chance of becoming disabled for 3 months or longer during his working career[1]
- 95% of disabilities are not covered by Workman's Comp[1]

Need Assistance?
Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 pm EST.
Refer to your plan number: **527857**

Guardian®

Guardian Short Term Disability Insurance: Up to $500 per Week

Plan Design Provisions	Employee Coverage*
Weekly Benefit	60% to $500
Maximum Payment Period	26 Weeks
Benefits Begin	8th Day, Accident or Illness
Definition of Disability	Own Job
Pre-Existing Limitation	There are No Pre-Existing Limitations; if you waive coverage at your initial enrollment opportunity and later decide to elect it, evidence of insurability is required.
Rehabilitation Benefit	When deemed appropriate, participation is mandatory, 110% Enhanced Benefit
Return to Work	Zero Day Residual; Part time Earnings Calculation: Greater of direct reduction or proportionate loss
Integration Method	Direct Offset, Full Family (benefits reduced by other group disability benefits, plus insured and dependent Social Security benefits)
Minimum Weekly Benefit	Greater of 10% of your Gross Weekly Benefit or $25
Earnings Definition	Standard Annual Base Earnings, Including Average Commissions
Maternity Benefits	Included
Coverage Type	Non-Occupational

Sample Premiums

Weekly Benefit	$100	$150	$200	$250	$300	$350	$400	$450	$500
Monthly Premium	$4.90	$7.35	$9.80	$12.25	$14.70	$17.15	$19.60	$22.05	$24.50
Weekly Premium	$1.14	$1.70	$2.27	$2.83	$3.40	$3.96	$4.53	$5.09	$5.66

To Calculate Your Estimated Weekly Short Term Disability Benefit:

Your Annual Earnings: $_____ Divide by 52 = $_____ Multiply by 60%: $_____

Compare the amount in the circle to the $500 benefit maximum. Your estimated Weekly Short Term Disability Benefit is the lesser of $500 or the amount on this line. You will use the amount in the circle to complete your premium calculation below if it is less than $500. If it is more than $500, use $500 in the calculation below.

To Calculate Your Estimated Weekly Short Term Disability Premium:

Your Weekly STD Benefit $_____ (the lesser of the amount in the circle or $500)

Divide by 10 = $_____ Multiply by $0.49 = $_____ This is your Monthly Premium.

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STD SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS • We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder; intentionally injuring themselves or attempting suicide while sane or insane; or for the voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless it has been prescribed by a doctor and is used as prescribed. • We do not pay benefits during any period in which a covered person is confined to a correctional facility; an employee is not under the care of a doctor; an employee is receiving treatment outside of the U.S. or Canada; the employee's loss of earnings is not solely due to disability. • In order to be eligible for coverage: employees must be legally working (a) in the United States or (b) outside the United States, for a U.S. based employer in a country or region approved by Guardian. Subject to state specific variations. • This policy provides disability income insurance only. It does not provide "basic hospital," "basic medical," or "major medical" insurance as defined by the New York State Insurance Department. • Please refer to certificate of coverage for full plan description; plan documents are the final arbiter of coverage.

Guardian®

Voluntary
Long-Term Disability Insurance

Guardian Long-Term Disability

Guardian Long Term Disability Insurance: $5,000 per Month up to Social Security Normal Retirement Age (SSNRA) (180 Day Elimination Period)

AccessPoint

Plan Number: 527857

Protect your paycheck if you are unable to work.

Your income is one of your most valuable assets

No one plans on becoming disabled, but a serious illness or injury can strike anyone at any time, and at any age, taking away your ability to earn a paycheck.

Nearly 25% of Americans will become disabled before they retire[1], so this *could* happen to you. Disabilities can result not just from accidents, but illnesses such as heart attack, cancer, and stroke.

How long can you live on your savings if you became disabled?

The value of Disability Insurance for you and your family

Disability Insurance should be an integral part of your financial safety net. It provides a steady stream of income to ease the financial stress of a covered illness or injury when you are no longer receiving a paycheck.

For just a few dollars a month, you can help to provide financial security for yourself and those who depend on you. Enrolling for disability insurance at the workplace is simple and cost effective — with convenient payroll deductions.

Disability coverage with Guardian

For over 50 years, Guardian Disability Insurance has helped protect the income, lifestyle, and financial future for millions of Americans, and Guardian is the #1 insurance carrier for disability cases.[2]

Disability Insurance with Guardian is easy

- **Affordable** group rates.
- Extensive **resources** and **support** to help you get back to work and live a productive life.
- **Timely** and **efficient** claims review and payment.
- Guardian will notify you and AccessPoint of your claim status.
- **Check your claim status online** at GuardianAnytime.com

Be sure to continue following the rules at your place of work for reporting time off. Check with your supervisor for clarification of this procedure.

You might be underestimating your risk of a disabling illness or injury

- More than 50% of disabled Americans are in their working years, from 18-64[1]
- A typical female has a 24% chance of becoming disabled for 3 months or longer during her working career[1]
- A typical male has a 21% chance of becoming disabled for 3 months or longer during his working career[1]
- 95% of disabilities are not covered by Workman's Comp[1]

Need Assistance?
Call the Guardian Helpline
(888) 600-1600, weekdays,
8:00 AM to 8:30 pm EST.
Refer to your plan number: **527857**

Guardian®

Guardian Long Term Disability Insurance:
$5,000 per Month up to (SSNRA) (180 Day Elimination Period)

Plan Design Provisions	Employee Coverage*
Monthly Benefit	60% to $5,000
Definition of Disability	2 Year Own Occupation; Any Occupation thereafter
Maximum Payment Period	Social Security Normal Retirement Age (SSNRA)
Benefits Begin	180th Day, Accident or Illness
Pre-Existing Condition Exclusion	3 Month lookback period/12 month exclusion
Evidence of Insurability	Not applicable as a New Hire; Late Entrants subject to Evidence of Insurability
Rehabilitation Benefit	When deemed appropriate, participation is mandatory, 110% enhanced benefit
Return to Work & Part Time Earnings Offset	Zero Day Residual; Greater of direct reduction or proportionate loss; Includes 12 month work incentive
Integration Method	Direct Offset Family - benefits reduced by other group disability benefits plus insured and dependent Social Security benefits; includes offset with salary continuation
Salary Continuation	Direct Offset, up to 100% of pre-disability earnings
Minimum Benefit	Greater of 10% or $100
Mental Health & Substance Abuse	24 Month combined limit
Earnings Definition	Standard annual base earnings, including average commissions
Coverage Type	24 hour
Survivor Benefit	3 Month, Lump Sum Payment of Gross Benefit Amount

Long Term Disability: Estimated Monthly Premiums

Monthly Benefit	$1,000	$1,500	$2,000	$2,500	$3,000	$3,500	$4,000	$4,500	$5,000
Monthly Premium	$7.17	$10.75	$14.33	$17.92	$21.50	$25.08	$28.67	$32.25	$35.83
Weekly Premium	$1.66	$2.49	$3.31	$4.14	$4.97	$5.79	$6.62	$7.45	$8.27

To Calculate Your Estimated Monthly Earnings:

Your Annual Earnings: $_____ Divide by 12 = $_____

Compare the amount in the circle to the $8,333.00 which is the maximum earnings covered under this plan. If the amount in the circle is less than $8,333.00 you will use this amount as your monthly earnings in the calculation below. If it is greater than $8,333.00 use $8,333.00 in the calculation below.

To Calculate Your Estimated Monthly Long Term Disability Premium:

Your Monthly Earnings: $_____ (the lesser of the amount in the circle or $8,333.00)

Divide by 100 = $_____ Multiply by $0.43 = $_____ That will be your monthly *premium* amount.

To Calculate Your Estimated Monthly Benefit:

Your Annual Earnings: $_____ Divide by 12 = $_____ Multiplied by $0.60 = $_____ That will be your monthly *benefit* amount.

*The services, exclusions, and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. *This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. Coverage terms may vary by state and employer-sponsored plan.*

LTD SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS • We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse. • We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder; intentionally injuring themselves or attempting suicide while sane or insane; or for the voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless it has been prescribed by a doctor and is used as prescribed. • We do not pay benefits during any period in which a covered person is confined to a correctional facility; an employee is not under the care of a doctor; an employee is receiving treatment outside of the U.S. or Canada; or the employee's loss of earnings is not solely due to disability. • During the exclusion/limitation period, this disability plan does not pay charges relating to a pre-existing condition. If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition exclusion/limitation period. A pre-existing condition includes any condition for which an employee, in a specified period of time prior to coverage in this plan, consults with a physician, receives treatment, or takes prescribed drugs. Please refer to the plan details for specific time periods. • In order to be eligible for coverage; employees must be legally working (a) in the United States or (b) outside the United States, for a U.S. based employer in a country or region approved by Guardian. • This policy provides disability income insurance only. It does not provide "basic hospital," "basic medical," or "major medical" insurance as defined by the New York State Insurance Department. Please refer to certificate of coverage for full plan description; plan documents are the final arbiter of coverage. • GP-1-LTD-94-A, B, C-1; GP-1-LTD2K-1

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