

## Benefits-at-a-Glance for OSG Deductible Option 3000

### Prepared for members of Michigan Association of REALTORS®

This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

The **Deductible** is applicable to all covered services except (1) **preventive services** provided by the member's PCP; (2) **preventive services** obtained as a result of referral from the PCP; (3) routine maternity care; and (4) services paid by a provider or vendor under the delegation of a claim payment arrangement.

<b>Deductible, Copays and Dollar Maximums</b>	
<b>Deductible</b>	\$3,000 per member / \$6,000 per family per calendar year
<b>Copays</b>	\$30 office visits, \$50 urgent care visits, \$150 emergency room visits, \$5 allergy inject.
• Fixed Dollar Copay	
• Percent Copay	25%, 30% and 50% for select services as noted below
<b>Copay Dollar Maximums</b>	
• Fixed Dollar Copay	None
• Percent Dollar Copay–Med. Serv; excl.serv.w/50% copay	\$1,500 per member, \$3,000 per family per calendar year
• Percent Dollar Copay – Inpatient Mental Health Care	\$1,000 per member, \$2,000 per family per calendar year
<b>Dollar Maximums</b>	Applies only to Substance Abuse dollar limitation; adj. annually by the state
<b>Preventive Services</b>	
Health Maintenance Exam	Covered – \$30 copay
Annual Gynecological Exam	Covered – \$30 copay
Pap Smear Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit
Well-Baby and Child Care	Covered – \$30 copay
Immunizations – pediatric and adult	Covered – Office visit copay may apply per member, per visit
Prostate Specific Antigen (PSA) Screening – lab.serv.only	Covered – Office visit copay may apply per member, per visit
<b>Mammography</b>	
Mammography Screening	Covered – 100%
<b>Physician Office Services</b>	
Office Visits	Covered – \$30 copay
Consulting Specialist–when referred other than preventive services	Covered – \$30 copay after deductible
<b>Emergency Medical Care</b>	
Hospital Emergency Room – copay waived if admitted, inpatient hospital benefits apply	Covered – \$150 copay after deductible
Urgent Care Center	Covered – \$50 copay
Ambulance Services – medically necessary	Covered–70% after deduct.grnd/air service,w/30% coinsur.up to \$1,500/mbr,\$3,000/fam/yr
<b>Diagnostic Services</b>	
Laboratory and Pathology Tests	Covered – Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered–70% after deduct.w/30% coinsur. up to 1,500/mbr, \$3,000/fam. cal. yr
Radiation Therapy	Covered–70% after deduct.w/30% coinsur. up to 1,500/mbr, \$3,000/fam. cal. yr
<b>Maternity Services Provided by a Physician</b>	
Pre-Natal and Post-Natal Care	Covered – \$30 copay
Delivery and Nursery Care	Covered – 100% after deduct for prof. chrgs. See Hospital Care below facility chrgs
<b>Hospital Care</b>	
General Nursing Care, Hospital Services and Supplies	Covered–70% after deduct.w/30% coinsur. up to 1,500/mbr, \$3,000/fam. cal. yr unltd.days
Outpatient Surgery – see .cert.specific surg. copays	Covered–70% after deduct.w/30% coinsur. up to 1,500/mbr, \$3,000/fam. cal. yr
<b>Alternatives to Hospital Care</b>	
Skilled Nursing Care	Covered–70% after deduct. 45 days/cal.yr; w/30% coinsur. \$1,500/mbr \$3,000/fam.cal yr
Hospice Care	Covered – 100% after deductible
Home Health Care	Covered – \$30 copay after deductible
<b>Surgical Services</b>	
Surgery – incl. all related surg. serv/anesthesia. See mem cert specific surgical copays.	Covered – 70% after deductible, with a 30% coinsurance up to \$1,500 per member, \$3,000 per family per calendar year
Voluntary Sterilization	Covered – 50% after deductible on all associated costs
Human Organ Transplants	Covered – 70% after deductible, with a 30% coinsurance up to \$1,500 per member, \$3,000 per family per calendar year; subject to medical criteria

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<b>Mental Health Care and Substance Abuse Treatment</b>	
Inpatient Mental Health Care and Substance Abuse Care	<b>Mental Health Care:</b> Covered – 75%, with a 25% coinsurance, up to \$1,000 per member, \$2,000 per family per calendar year, up to 30 days per calendar year <b>Substance Abuse Care:</b> Covered – 50%, one program of treatment per year, up to state mandated dollar limitation which is adjusted annually by the state
Outpatient Mental Health Care	Covered – 50%, up to 20 visits per calendar year
Outpatient Substance Abuse Care	Covered – 50%, one program of treatment per year, up to state mandated dollar limitation which is adjusted annually by the state <b>Note:</b> A program of treatment may include outpatient or intermediate services or both.
<b>Other Services</b>	
Allergy Testing and Therapy	Covered – 50% after deductible
Allergy Injections	Covered – \$5 copay
Chiropractic Spinal Manipulation – when referred	Covered – \$30 copay after deductible
Outpatient Physical, Speech and Occupational Therapy – subject to significant improvement within 60 days	Covered – \$30 copay after deductible, limited to 60 consecutive days per episode for a combination of therapies
Infertility Counseling and Treatment (excl. In-vitro fertilization)	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%

## Benefits-at-a-Glance for 50% Prescription Drug Coverage

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<b>Covered Services</b>	
Formulary Drug – Generic	Covered – 50% with \$5 minimum copay and \$100 maximum copay
Formulary Drug – Brand Name	Covered – 50% with \$5 minimum copay and \$100 maximum copay
Formulary Brand Name when Generic is available	Covered – Difference in cost between brand name drug and generic drug plus 50% coinsurance
Non-Formulary Drugs	Covered – 50% with \$5 minimum copay and \$100 maximum copay
Sexual Dysfunction Drugs	Covered – 50%
Contraceptives	Covered – 50% with \$5 minimum copay and \$100 maximum copay
Mail Order Prescription Drugs	Covered – 50% w/\$10 min, \$200 max copay, 90 day supply. Sexual dysfunction rx 50%.
<b>Definitions</b>	
BCN Formulary	List of all prescription drugs approved for use by BCN and dispensed through participating pharmacies to members.
Brand Name Drugs	Prescription drugs manufactured and marketed under registered trade name or trademark.
Covered Drugs	Prescription drugs (Generic, Brand Name, Compounded Medication, or Health Habit) prescribed by BCN affiliated provider and obtained through participating pharmacy. Certain covered drugs are benefit only if BCN affiliated provider certifies to BCN and BCN agrees the covered drug in question is medically necessary. Those drugs are not payable without preauthorization by BCN.
Generic Drugs	Prescription drugs which have been determined by FDA bioequivalent to Brand Name Drugs and not manufactured/marketed under registered trade name or trademark.
Mail Order Prescription Drugs	Up to a 90-day supply of covered drugs
Participating Pharmacy	A network of licensed pharmacies selected by or authorized by BCN