Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Run Date: 04/2015

07390 07390
9644 HAWTHORNE GLEN DR
GROSSE ILE MI 48138

WOODWARD ACADEMY/SE-ACTIVE
951 E LAFAYETTE
DETROIT MI 48207

BENEFIT AND RATE SCHEDULE

WOODWARD ACADEMY/SE-ACTIVE

Rate Effective: 08/2015 Renewal Month: August

Customer ID:	276286	**Rating Type:**	Small Group(Reform)
Group-subgroup-class:	00276286-0001-0001	**Cluster Code:**	FA00
Endorsed By:	Not Applicable	**County:**	Oakland

CERTIFICATES

CERT	SG BDPPO Plus 80/50/50 Pediatric
CERT	BCN Pediatric Vision

MEDICAL RIDERS

CLSSSM	BCN Classic Certificate of Coverage for Small Groups (50 or less)
CI10%	10% Coinsurance Rider
1KECM	Amends the annual out of pocket maximum for coinsurance to $1000/$2000
5000PM	$5000/ $10000 Out of Pocket Maximum Rider
CO20	Office Visit Copay $20
30RP	$30 Referral Physician Office Visit Copayment Rider
UR35	Urgent Care $35 Copay Rider
ER150	$150 emergency room copay
IMG150	Applies a $150 copay or 50% of the approved amount to MRI, MRA, CAT and PET scans
WRCWR	Weight Reduction Coinsurance Waiver
DSR10%	Applies 10% coinsurance to diabetic supplies
VACR50	Adds coverage for first trimester elective term with 50% coinsurance

DRUG RIDERS

P415CS 90D3X 5000PM	Rx: $4/$15/$40/$80/20% MOPD3X (Med OPM applies)

DENTAL RIDERS

BDPPO+ 80/50/50	BD PPO Plus 80/50/50 Pediatric SG (placeholder)

Reference Number: NA

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WOODWARD ACADEMY/SE-ACTIVE

Rate Effective: 08/2015 Renewal Month: August

Customer ID: 276286 **Group-subgroup-class: 00276286-0001-0001**

Commercial Benefit Rates

Age Band	Total	Medical + Pharmacy	Dental	Vision
0 - 18	$242.70	$219.46	$23.24	$0.00
19	$219.46	$219.46	$0.00	$0.00
20	$219.46	$219.46	$0.00	$0.00
21	$345.60	$345.60	$0.00	$0.00
22	$345.60	$345.60	$0.00	$0.00
23	$345.60	$345.60	$0.00	$0.00
24	$345.60	$345.60	$0.00	$0.00
25	$346.98	$346.98	$0.00	$0.00
26	$353.89	$353.89	$0.00	$0.00
27	$362.19	$362.19	$0.00	$0.00
28	$375.67	$375.67	$0.00	$0.00
29	$386.73	$386.73	$0.00	$0.00
30	$392.26	$392.26	$0.00	$0.00
31	$400.55	$400.55	$0.00	$0.00
32	$408.84	$408.84	$0.00	$0.00
33	$414.03	$414.03	$0.00	$0.00
34	$419.56	$419.56	$0.00	$0.00
35	$422.32	$422.32	$0.00	$0.00
36	$425.09	$425.09	$0.00	$0.00
37	$427.85	$427.85	$0.00	$0.00
38	$430.62	$430.62	$0.00	$0.00
39	$436.15	$436.15	$0.00	$0.00
40	$441.68	$441.68	$0.00	$0.00
41	$449.97	$449.97	$0.00	$0.00
42	$457.92	$457.92	$0.00	$0.00
43	$468.98	$468.98	$0.00	$0.00
44	$482.80	$482.80	$0.00	$0.00
45	$499.05	$499.05	$0.00	$0.00
46	$518.40	$518.40	$0.00	$0.00
47	$540.17	$540.17	$0.00	$0.00
48	$565.06	$565.06	$0.00	$0.00
49	$589.59	$589.59	$0.00	$0.00
50	$617.24	$617.24	$0.00	$0.00
51	$644.54	$644.54	$0.00	$0.00
52	$674.61	$674.61	$0.00	$0.00
53	$705.02	$705.02	$0.00	$0.00
54	$737.86	$737.86	$0.00	$0.00
55	$770.69	$770.69	$0.00	$0.00
56	$806.28	$806.28	$0.00	$0.00
57	$842.23	$842.23	$0.00	$0.00
58	$880.59	$880.59	$0.00	$0.00
59	$899.60	$899.60	$0.00	$0.00
60	$937.96	$937.96	$0.00	$0.00
61	$971.14	$971.14	$0.00	$0.00
62	$992.91	$992.91	$0.00	$0.00
63	$1,020.21	$1,020.21	$0.00	$0.00
64	$1,036.80	$1,036.80	$0.00	$0.00
65+	$1,036.80	$1,036.80	$0.00	$0.00

Medicare Supplemental Benefit Rates

Age Band	Total	Medical + Pharmacy	Dental	Vision
All	$445.84	$445.84	$0.00	$0.00

The above rates include BCBSM's/BCN's estimates of applicable Federal and state taxes, fees and assessments. BCBSM's/BCN's estimates are subject to change. BCBSM/BCN will not reconcile or settle any amounts collected with actual amounts owed for such Federal and state taxes, fees and assessments.

Reference Number: NA

Blue Care Network of Michigan

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BCN HMO Platinum 10%SM

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 Dollar 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.	None
Fixed dollar copays	$20 for office visits, $30 for specialist visits, $35 for urgent care visits, $150 for emergency room visits, $150 for high tech imaging and $5 for allergy injections
Coinsurance	10% and 50% for select services as noted below
Annual Coinsurance Maximum – services with a fixed dollar copay or 50% coinsurance do not apply to the annual coinsurance maximum	$1,000 per member/$2,000 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	$5,000 per member/$10,000 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 (DME guidelines apply. Limited to no more than one per 24 month period)	Covered – 100%
Maternity Pre-Natal Care	Covered – 100%

Physician Office Services

PCP Office Visits	Covered – $20 copay
Consulting Specialist Care – when referred for other than preventive services	Covered – $30 copay

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered – $150 copay
Urgent Care Center	Covered – $35 copay
Ambulance Services – medically necessary	Covered – 90%

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100%
Diagnostic Tests and X-rays	Covered – 90%
High Technology Imaging (MRI, CAT, PET)	Covered – $150 copay
Radiation Therapy	Covered – 90%

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% for professional services; see Hospital Care for facility charges

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 90%; unlimited days
Outpatient Surgery – See member certificate for select surgical coinsurance	Covered – 90%

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 90% up to 45 days per calendar year
Hospice Care	Covered – 100% when authorized
Home Health Care	Covered – $30 copay

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 90%
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – 50%
Elective Abortion (One procedure per two year period of membership)	Covered – 50%
Human Organ Transplants (subject to medical criteria)	Covered – 90%
Reduction mammoplasty (subject to medical criteria)	Covered – 50%
Male Mastectomy (subject to medical criteria)	Covered – 50%
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50%
Orthognathic Surgery (subject to medical criteria)	Covered – 50%
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 100%

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	Covered – 90%
Outpatient Mental Health Care	Covered – $20 copay
Outpatient Substance Abuse Care	Covered – $20 copay

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	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 is unlimited.	Covered – $30 copay
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, serum and related office visits	Covered – 50%
Allergy Injections	Covered – $5 copay
Chiropractic Spinal Manipulation – when referred	Covered – $30 copay; up to 30 visits per calendar year
Rehabilitative Services – subject to meaningful improvement within 90 days • Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year • Outpatient Speech Therapy – limited to 30 visits per calendar year	Covered – $30 copay
Habilitative Services • Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per calendar year • Outpatient Speech Therapy – limited to 30 visits per calendar year	Covered – $30 copay
Outpatient Cardiac and Pulmonary Rehabilitation	Covered – $30 copay; limited to a benefit maximum of 30 visits per calendar year
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% on all associated costs
Durable Medical Equipment	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%
Diabetic Supplies	Covered – 90%
Pediatric Vision • Eye Exam – Limited to once per calendar year for members up to the age of 19 • Prescription Glasses – Frames (chosen from a select collection) and lenses are covered once per calendar year for members up to the age of 19	Covered – 100%
Prescription Drugs	Covered – • Tier 1A - $4 copay, Tier 1B - $15 copay, Tier 2 - $40 copay, Tier 3 - $80 copay, Tier 4 – 20% coinsurance (Max $200), Tier 5 – 20% coinsurance (Max $300); 30 day supply. • Excludes drugs for the treatment of sexual dysfunction, weight loss, cough & cold • 90 day supply for mail order and retail :Three times applicable copay less $10 • Contraceptives - Tier 1A – 100%, Tier 1B – $15 copay, Tier 2 - $40 copay, Tier 3 - $80 copay • Preventive Drugs covered in full

CLSSSM, CI10%, 1KECM, 5000PM, CO20, 30RP, ER150, UR35, IMG150, WRCWR, DSR10%, VACR50, PVSN, P415CS, 90D3X

Blue Cross Blue Shield of Michigan

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Blue Dental[SM] PPO Plus 80/50/50 Pediatric SG – Non-voluntary $25/$75 deductible 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 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.

Note: Pediatric dental benefits are available only to members who are age 18 or younger on the plan's effective date and are available to them through the end of the calendar year in which they turn 19.

Network access information

With Blue Dental PPO Plus, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.[1]

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

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

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

Blue Par Select[SM] arrangement – Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services – members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com**.

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

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

Deductible • Applies to Class II and Class III services only	$25 per member limited to a maximum of $75 per family per calendar year
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services	20%
• Class II services	50%
• Class III services	50%
• Class IV services	Not covered
Dollar maximums • Annual maximum for Class I, II and III services	None
• Lifetime maximum for Class IV services	Not applicable
Out-of-pocket maximum • The maximum out-of-pocket expense pediatric members will pay in a calendar year for deductible and coinsurance amounts applied to most covered in-network dental services. The out-of-pocket maximum **does not** apply to charges that exceed our approved PPO fee, services provided by non-PPO dentists, or non-covered services.	$350 for one pediatric member or $700 for two or more pediatric members per calendar year. **Note:** This out-of-pocket maximum is separate from the annual out-of-pocket maximum that applies under your hospital and medical coverage (if any).

Plan's responsibility

The plan's responsibility is subject to a review of the reported diagnosis, dental necessity verification and the availability of dental benefits at the time the claim is processed, as well as the conditions, exclusions and limitations, and deductible and coinsurance requirements under the applicable BCBSM certificates and riders.

Class I services

Most diagnostic and preventive services: • Routine oral examinations/evaluations – twice per calendar year	80% of approved amount
• Routine prophylaxes (cleanings) – three times per calendar year	80% of approved amount
• Fluoride treatments – twice per calendar year	80% of approved amount
• Topical fluoride varnish for moderate- to high-risk caries patients – four times per calendar year **for members age 3 and younger only** and two times per calendar year **for members age 4 to 14 only** in combination with fluoride treatments For example, two fluoride treatments **or** two topical fluoride varnishes **or** one fluoride treatment and one topical fluoride varnish are payable in a calendar year for high-risk members between the ages of 4 and 14. However, two fluoride treatments **and** two topical fluoride varnishes are not payable for these members.	80% of approved amount
• Dental sealants – once per tooth per 36 months for first and second permanent molars	80% of approved amount after deductible
Bitewing X-rays – one set (up to four films) per calendar year	80% of approved amount after deductible
Oral brush biopsy sample collection – twice per calendar year	80% of approved amount after deductible

Class II services

Other diagnostic and preventive services:	
• Diagnostic tests and laboratory examinations	50% of approved amount after deductible
• Space maintainers – once per quadrant per lifetime for missing posterior primary teeth (recementation of a space maintainer is payable three times per quadrant per lifetime)	50% of approved amount after deductible
Panoramic or full-mouth X-rays – once per 60 months	50% of approved amount after deductible
Emergency palliative treatment	50% of approved amount after deductible
Minor restorative services: • Amalgam and resin-based composite fillings and fillings of similar materials – once per tooth and surface per 48 months for permanent teeth; once per tooth and surface per 24 months for primary teeth	50% of approved amount after deductible
• Recementation or repair of posts, crowns, veneers, inlays and onlays – three times per tooth per calendar year	50% of approved amount after deductible
Extractions and surgical removal of non-impacted teeth	50% of approved amount after deductible
Non-surgical endodontic services: • Root canal treatments – once per tooth per lifetime (replacement of a root canal 12 or more months after the initial root canal treatment is payable once per tooth per lifetime)	50% of approved amount after deductible
• Therapeutic pulpotomies or pulpal debridement	50% of approved amount after deductible
• Vital pulpotomies on primary teeth	50% of approved amount after deductible
• Apexification	50% of approved amount after deductible
Non-surgical periodontic services: • Periodontal maintenance – three times per calendar year in place of routine dental prophylaxis	50% of approved amount after deductible
• Periodontal scaling and root planing – once per quadrant per 24 months	50% of approved amount after deductible
Adjustments, repairs, relines, rebases and tissue conditioning for removable prosthetic appliances: • Relines or rebases of partial dentures or complete dentures – once per 36 month per arch	50% of approved amount after deductible
• Tissue conditioning – once per 36 months per arch	50% of approved amount after deductible
Adjunctive general services: • General anesthesia or IV sedation	50% of approved amount after deductible
• Office visits after regularly scheduled hours	50% of approved amount after deductible

Class III services

Major restorative services: • Onlays, crowns and veneers – once per permanent tooth per 84 months **for members age 12 and older only**	50% of approved amount after deductible
• Substructures, including cores and posts	50% of approved amount after deductible
Oral surgery services: •	50% of approved amount after deductible
• Incision and drainage of cellulliitis or fascial space abscesses of intraoral soft tissue	50% of approved amount after deductible
• Removal of exostoses (excess bony growths of the upper and lower jaw)	50% of approved amount after deductible
• Excision of hyperplastic tissue per arch	50% of approved amount after deductible
• Soft tissue biopsies	50% of approved amount after deductible
• Frenulectomies	50% of approved amount after deductible
Surgical endodontic services: • Apical surgeries on permanent teeth	50% of approved amount after deductible
• Hemisections – once per tooth per lifetime	50% of approved amount after deductible
Surgical periodontic services: • Gingivectomies and gingivoplasties	50% of approved amount after deductible
• Clinical crown lengthening – hard tissue	50% of approved amount after deductible
• Gingival flap procedures	50% of approved amount after deductible
• Soft tissue grafts	50% of approved amount after deductible
Prosthodontic services: • Complete dentures – once per 84 months	50% of approved amount after deductible
• Removable partial dentures and fixed partial dentures (bridges), including abutment crowns and pontics – once per 84 months **for members age 16 and older only**	50% of approved amount after deductible
• Recementation and repairs of bridges	50% of approved amount after deductible
• Stayplates to replace recently extracted permanent anterior (front) teeth	50% of approved amount after deductible