



**Blue Care
Network
of Michigan**

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

Benefits-at-a-Glance

AXIOS HR

Group# 00286697 -- HMO \$1000-20% Plan

Effective Date: 07/01/2025

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 certificates 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.

Preauthorization for Select Services - Services listed in this summary 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 <https://bcbsm.com/priorauth>.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	
Deductible (Coinsurance and select fixed dollar copays as defined by your plan documents, apply once the deductible has been met.)	\$1,000 per member/\$2,000 per family per benefit year
Fixed Dollar Copays	\$5 for allergy injections \$20 for office visits \$50 for urgent care visits \$250 for emergency room visits \$40 for referral physician visits \$150 for high tech imaging
Coinsurance	50% for select services as noted below 20% for select services as noted below
Coinsurance Maximum	\$2,500 per member/\$5,000 per family per benefit year Services that DO NOT apply to the ACM: Deductible, Flat Dollar Copays, Infertility, Male Mastectomy, Reduction Mammoplasty, Male Sterilization, Elective Abortion, TMJ, Orthognathic Surgery, Weight Reduction, DME, P&O, Diabetic Supplies, Prescription Drugs
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	\$8,150 per member/\$16,300 per family per benefit year

Preventive services

Benefits	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%

Preventive services (continued)

Benefits	
Pap Smear Screening - laboratory services only	100%
Well-Baby and Well-Child Visits	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening - laboratory services only	100%
Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Sterilization of Female Reproductive Organs	100%
Breast Pumps (DME guidelines apply.)	100%
Routine Maternity Prenatal and Postnatal Care	100%

Physician office services

Benefits	
PCP Office Visits Note: Applicable cost sharing applies when other services are received in the office	\$20 Copay
Medical Online Visits - when performed by a BCN participating provider or BCN designated online vendor Note: Not all services delivered virtually are considered an online visit but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	\$20 Copay
Referral Physician Visits - when referred for other than preventive services Note: Applicable cost sharing applies when other services are received in the office	\$40 copay

Emergency medical care

Benefits	
Hospital Emergency Room - copay waived if admitted as inpatient	\$250 Copay after deductible
Urgent Care Center	\$50 Copay
Retail Health Clinic	\$50 Copay
Ambulance Services - medically necessary	80% after deductible

Diagnostic services

Benefits	
Laboratory and Pathology Tests	100%
Diagnostic Tests and X-rays	80% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	\$150 Copay after deductible
Radiation Therapy	80% after deductible

Maternity services provided by a physician

Benefits	
Routine Prenatal and Postnatal Care Visits	100%
Delivery and Nursery Care - professional services (see "Hospital Care" for facility charges)	100% after deductible

Hospital care

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

Alternatives to hospital care

Benefits	
Skilled Nursing Care	80% after deductible Up to 45 days per member per benefit year
Hospice Care	100% after deductible
Home Health Care	\$40 copay after deductible

Surgical services

Benefits	
Surgery - includes all related surgical services and anesthesia.	80% after deductible
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	50% after deductible
Elective Abortion Services	50% after deductible
Elective Abortion Coverage Limit	Limited to one procedure per two-year period of membership. Note: Abortions are not covered if rendered in a location where abortion is not legal.
Human Organ Transplants (subject to medical criteria)	80% after deductible
Reduction Mammoplasty (subject to medical criteria)	50% after deductible
Male Mastectomy (subject to medical criteria)	50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	50% after deductible
Orthognathic Surgery (subject to medical criteria)	50% after deductible
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	50% after deductible

Behavioral health services (mental health and substance use disorder treatment)

Benefits	
Inpatient Mental Health Care	80% after deductible
Residential Substance Use Disorder	80% after deductible
Outpatient Mental Health Care includes online and telemedicine visits Note: For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	\$20 Copay
Outpatient Substance Use Disorder	\$20 Copay

Autism spectrum disorders, diagnoses and treatment

Benefits	
Applied behavioral analysis (ABA) treatment Note: Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC)	\$20 Copay
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	\$40 copay 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

Benefits	
Allergy Testing and Therapy	50% after deductible
Allergy Office Visits	50%
Allergy Injections	\$5 copay
Chiropractic Spinal Manipulation - when referred	\$40 copay Limited to 30 visits per benefit year
Outpatient Physical, Speech and Occupational Therapy - Subject to meaningful improvement within 60 days	\$40 copay after deductible Limited to 60 visits per benefit year for any combination of outpatient rehabilitation therapies
Infertility Counseling and Treatment	50% (excludes in-vitro fertilization) after deductible
Durable Medical Equipment	50%
Prosthetic and Orthotic Appliances	50%
Diabetic Supplies Note: Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable prescription drug cost-sharing will apply.	80%
Hearing Aid	Not Covered

Prescription drugs

Benefits	
Preferred Generic Tier	\$10 copay
Nonpreferred Generic Tier	\$30 copay
Preferred Brand Tier	\$60 copay
Nonpreferred Brand Tier	\$80 copay
Preferred Specialty Tier	20% coinsurance (max \$200)
Nonpreferred Specialty Tier	20% coinsurance (max \$300)
Contraceptives	Women's Contraceptives - Preferred Generic - 100%, Non-Preferred Generic - \$30 copay, Preferred Brand - \$60 copay, Non-Preferred Brand - \$80 copay
Drugs for the Treatment of Sexual Dysfunction	50% coinsurance

Prescription drugs (continued)

Benefits

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. 90-day retail 84-90 day supply, 3X's the 30-day copay/coinsurance minus \$10.
Diabetic Supplies	Select diabetic supplies and equipment are covered, applicable cost sharing will apply. Cost sharing may not apply to certain preferred glucometers as defined on the drug list.
Specialty Drug Pharmacy	Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs
Variable Cost Share Coupon Program	Your plan includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum.
Prescription Drug Deductible	None
Custom Drug List	The list of prescription drugs that have been approved by the U.S. Food and Drug Administration and approved by the BCBSM/BCN Pharmacy and Therapeutics Committee. The list represents the clinical judgment of Michigan physicians, pharmacists and other experts in the diagnosis and treatment of disease and promotion of health. Medications are selected based on clinical effectiveness, safety and opportunity for cost savings. Some drugs included in the Custom Drug List require prior authorization and/or step therapy by BCN before they are covered. The drug list may be modified by BCN as needed to remove or add a covered drug or to modify the requirements for authorization of a covered drug. The list may be found at https://www.bcbsm.com/druglists

For Internal Purposes Only

Benefits Selected - CLSSLG : 25ECM,40RP,8150PM,90D3X,BENYR,C120%,CO20,D1000,DCCRM,DSR20%,ER250,IMG150,P103CL,UR50,VACR50,WDRPOV



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Benefits-at-a-Glance

AXIOS HR

Group# 00286697 -- HMO HDHP HSA \$1650-20% Plan

Effective Date: 07/01/2025

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Preauthorization for Select Services - Services listed in this summary 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 <https://bcbsm.com/priorauth>.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	
Deductible Note: The Deductible will apply to all services except preventive services	\$1,650 per member/\$3,300 per family per benefit year (no 4th quarter carry-over)
The deductible is combined for both medical and prescription drug coverage.	The deductible is aggregate. The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract.
Coinsurance Note: Coinsurance applies once the deductible has been met	50% for select services as noted below 20% for select services as noted below
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	\$4,000 per member/\$8,000 per family per benefit year The out-of-pocket maximum is aggregate. For a two-person or family contract, one person on the contract can meet the entire family out-of-pocket maximum.

Preventive services

Benefits	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening - laboratory services only	100%
Well-Baby and Well-Child Visits	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening - laboratory services only	100%

Preventive services (continued)

Benefits

Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Sterilization of Female Reproductive Organs	100%
Breast Pumps (DME guidelines apply.)	100%
Routine Maternity Prenatal and Postnatal Care	100%

Physician office services

Benefits

PCP Office Visits	80% after deductible
Medical Online Visits - when performed by a BCN participating provider or BCN designated online vendor Note: Not all services delivered virtually are considered an online visit but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	80% after deductible
Referral Physician Visits	80% after deductible

Emergency medical care

Benefits

Hospital Emergency Room	80% after deductible
Urgent Care Center	80% after deductible
Retail Health Clinic	80% after deductible
Ambulance Services - medically necessary	80% after deductible

Diagnostic services

Benefits

Laboratory and Pathology Tests	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

Benefits

Routine Prenatal and Postnatal Care Visits	100%
Delivery and Nursery Care	80% after deductible

Hospital care

Benefits

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

Alternatives to hospital care

Benefits

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

Surgical services

Benefits

Surgery - includes all related surgical services and anesthesia.	80% after deductible
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	50% after deductible
Elective Abortion Services	50% after deductible
Elective Abortion Coverage Limit	Limited to one procedure per two-year period of membership. Note: Abortions are not covered if rendered in a location where abortion is not legal.
Human Organ Transplants (subject to medical criteria)	80% after deductible
Reduction Mammoplasty (subject to medical criteria)	50% after deductible
Male Mastectomy (subject to medical criteria)	50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	50% after deductible
Orthognathic Surgery (subject to medical criteria)	50% after deductible
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	50% after deductible

Behavioral health services (mental health and substance use disorder treatment)

Benefits

Inpatient Mental Health Care	80% after deductible
Residential Substance Use Disorder	80% after deductible
Outpatient Mental Health Care includes online and telemedicine visits Note: For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	80% after deductible
Outpatient Substance Use Disorder	80% after deductible

Autism spectrum disorders, diagnoses and treatment

Benefits	
Applied behavioral analysis (ABA) treatment Note: Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC)	80% after deductible
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. 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

Benefits	
Allergy Testing and Therapy	80% after deductible
Allergy Injections	80% after deductible
Chiropractic Spinal Manipulation - when referred	80% after deductible Limited to 30 visits per benefit year
Outpatient Physical, Speech and Occupational Therapy - subject to meaningful improvement within 60 days	80% after deductible Limited to 60 visits per benefit year for any combination of outpatient rehabilitation therapies.
Infertility Counseling and Treatment	50% after deductible (excludes in-vitro fertilization)
Durable Medical Equipment	50% after deductible
Prosthetic and Orthotic Appliances	50% after deductible
Diabetic Supplies Note: Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable prescription drug cost-sharing will apply.	80% after deductible
Hearing Aid	Not Covered

Prescription drugs

Benefits	
Preferred Generic Tier	\$10 copay after deductible
Nonpreferred Generic Tier	\$30 copay after deductible
Preferred Brand Tier	\$60 copay after deductible
Nonpreferred Brand Tier	\$80 copay after deductible
Preferred Specialty Tier	20% coinsurance (max \$200) after deductible
Nonpreferred Specialty Tier	20% coinsurance (max \$300) after deductible
Contraceptives	Women's Contraceptives - Preferred Generic - 100%, Non-Preferred Generic- \$30 copay after deductible, Preferred Brand- \$60 copay after deductible, Non-Preferred Brand - \$80 copay after deductible
Drugs for the Treatment of Sexual Dysfunction	50% coinsurance after deductible
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 drugs (continued)

Benefits

Diabetic Supplies	Select diabetic supplies and equipment are covered, applicable cost sharing will apply. Cost sharing may not apply to certain preferred glucometers as defined on the drug list.
Prescription Drug Deductible	Prescription drug deductible integrated with the medical deductible
Variable Cost Share Coupon Program	Your plan includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum.
Custom Drug List	The list of prescription drugs that have been approved by the U.S. Food and Drug Administration and approved by the BCBSM/BCN Pharmacy and Therapeutics Committee. The list represents the clinical judgment of Michigan physicians, pharmacists and other experts in the diagnosis and treatment of disease and promotion of health. Medications are selected based on clinical effectiveness, safety and opportunity for cost savings. Some drugs included in the Custom Drug List require prior authorization and/or step therapy by BCN before they are covered. The drug list may be modified by BCN as needed to remove or add a covered drug or to modify the requirements for authorization of a covered drug. The list may be found at https://www.bcbsm.com/druglists

For Internal Purposes Only

Benefits Selected - HDHPLG : 1650HD,20COHD,4KOMHD,90D3X,BENYR,DCCRM,P136HD,VACR50



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Benefits-at-a-Glance

AXIOS HR

Group# 00286697 -- HMO HDHP HSA \$6350-0% MVP Plan

Effective Date: 07/01/2025

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Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	
Deductible Note: The Deductible will apply to all services except preventive services	\$6,350 per member/\$12,700 per family per benefit year (no 4th quarter carry-over)
The deductible is combined for both medical and prescription drug coverage.	The deductible is embedded. 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
Coinsurance Note: Coinsurance applies once the deductible has been met	None
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	\$6,350 per member/\$12,700 per family per benefit year The out-of-pocket maximum is embedded. For members with more than one person on the contract, if the one member maximum is met even if the family maximum is not, that member does not pay any more cost-sharing for the rest of the year

Preventive services

Benefits	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening - laboratory services only	100%
Well-Baby and Well-Child Visits	100%

Preventive services (continued)

Benefits	
Immunizations	100%
Prostate Specific Antigen (PSA) Screening - laboratory services only	100%
Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Sterilization of Female Reproductive Organs	100%
Breast Pumps (DME guidelines apply.)	100%
Routine Maternity Prenatal and Postnatal Care	100%

Physician office services

Benefits	
PCP Office Visits	100% after deductible
Medical Online Visits - when performed by a BCN participating provider or BCN designated online vendor Note: Not all services delivered virtually are considered an online visit but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	100% after deductible
Referral Physician Visits	100% after deductible

Emergency medical care

Benefits	
Hospital Emergency Room	100% after deductible
Urgent Care Center	100% after deductible
Retail Health Clinic	100% after deductible
Ambulance Services - medically necessary	100% after deductible

Diagnostic services

Benefits	
Laboratory and Pathology Tests	100% after deductible
Diagnostic Tests and X-rays	100% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	100% after deductible
Radiation Therapy	100% after deductible

Maternity services provided by a physician

Benefits	
Routine Prenatal and Postnatal Care Visits	100%
Delivery and Nursery Care	100% after deductible

Hospital care

Benefits

General Nursing Care, Hospital Services and Supplies	100% after deductible
Outpatient Surgery	100% after deductible

Alternatives to hospital care

Benefits

Skilled Nursing Care	100% after deductible Up to 45 days per benefit year
Hospice Care	100% after deductible
Home Health Care	100% after deductible

Surgical services

Benefits

Surgery - includes all related surgical services and anesthesia.	100% after deductible
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	100% after deductible
Elective Abortion Services	100% after deductible
Elective Abortion Coverage Limit	Limited to one procedure per two-year period of membership. Note: Abortions are not covered if rendered in a location where abortion is not legal.
Human Organ Transplants (subject to medical criteria)	100% after deductible
Reduction Mammoplasty (subject to medical criteria)	100% after deductible
Male Mastectomy (subject to medical criteria)	100% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	100% after deductible
Orthognathic Surgery (subject to medical criteria)	100% after deductible
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	100% after deductible

Behavioral health services (mental health and substance use disorder treatment)

Benefits

Inpatient Mental Health Care	100% after deductible
Residential Substance Use Disorder	100% after deductible
Outpatient Mental Health Care includes online and telemedicine visits Note: For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	100% after deductible
Outpatient Substance Use Disorder	100% after deductible

Autism spectrum disorders, diagnoses and treatment

Benefits	
Applied behavioral analysis (ABA) treatment Note: Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC)	100% after deductible
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	100% 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

Benefits	
Allergy Testing and Therapy	100% after deductible
Allergy Injections	100% after deductible
Chiropractic Spinal Manipulation - when referred	100% after deductible Limited to 30 visits per benefit year
Outpatient Physical, Speech and Occupational Therapy - subject to meaningful improvement within 60 days	100% after deductible Limited to 60 visits per benefit year for any combination of outpatient rehabilitation therapies.
Infertility Counseling and Treatment	100% after deductible
Durable Medical Equipment	100% after deductible
Prosthetic and Orthotic Appliances	100% after deductible
Diabetic Supplies Note: Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable prescription drug cost-sharing will apply.	100% after deductible
Hearing Aid	Not Covered

Prescription drugs

Benefits	
Generic Tier	Covered 100% after deductible
Preferred Brand Tier	Covered 100% after deductible
Nonpreferred Brand Tier	Covered 100% after deductible
Contraceptives	Women's Contraceptives - Generic - 100% after deductible, Preferred Brand - 100% after deductible, Non-Preferred Brand - 100% after deductible
Drugs for the Treatment of Sexual Dysfunction	Covered 100% after deductible
Mail Order Prescription Drugs	Covered 100% after deductible up to a 90 day supply. Specialty drugs are not covered through mail order pharmacies.
Diabetic Supplies	Select diabetic supplies and equipment are covered, applicable cost sharing will apply. Cost sharing may not apply to certain preferred glucometers as defined on the drug list.

Prescription drugs (continued)

Benefits

Specialty Drug Pharmacy	Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs
Prescription Drug Deductible	Prescription drug deductible is integrated with the medical deductible
Variable Cost Share Coupon Program	Your plan includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum.
Custom Drug List	The list of prescription drugs that have been approved by the U.S. Food and Drug Administration and approved by the BCBSM/BCN Pharmacy and Therapeutics Committee. The list represents the clinical judgment of Michigan physicians, pharmacists and other experts in the diagnosis and treatment of disease and promotion of health. Medications are selected based on clinical effectiveness, safety and opportunity for cost savings. Some drugs included in the Custom Drug List require prior authorization and/or step therapy by BCN before they are covered. The drug list may be modified by BCN as needed to remove or add a covered drug or to modify the requirements for authorization of a covered drug. The list may be found at https://www.bcbsm.com/druglists

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Benefits Selected - HDHPLG : 50CWHD,6350HD,63OMHD,BENYR,DCCRM,EDEPM,MOPD0,P0CHD,VACR

Delta Dental PPO™ (Point-of-Service) Summary of Dental Plan Benefits For Group# 12110-Axios International

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan - Delta Dental of Michigan

Benefit Year - January 1 through December 31

Covered Services -

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment - to temporarily relieve pain	100%	100%	100%
Sealants - to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services - fillings and crown repair	80%	80%	80%
Endodontic Services - root canals	80%	80%	80%
Periodontic Services - to treat gum disease	80%	80%	80%
Oral Surgery Services - extractions and dental surgery	80%	80%	80%
Other Basic Services - misc. services	80%	80%	80%
Relines and Repairs - to prosthetic appliances	80%	80%	80%
Major Services			
Major Restorative Services - crowns	50%	50%	50%
Prosthodontic Services - bridges, implants, dentures, and crowns over implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	up to age 19	up to age 19	up to age 19

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year. One additional periodontal maintenance procedure is payable in the same calendar year for individuals with a documented history of periodontal disease.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year for people age 13 and under.
- Space maintainers are payable once per area per lifetime for people age 15 and under.

- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are payable once per tooth per three-year period for first and second permanent molars for people age 15 and under. The surface must be free from decay and restorations.
- Veneers are payable on incisors, cuspids and bicuspid once per tooth per five-year period when necessary due to fracture or decay for people age 12 and older.
- Composite resin (white) restorations are payable on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Reline and rebase of dentures and tissue conditioning are payable once in any two-year period.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Benefit Waiting Period – There is a 6-month waiting period for certain services. Major Restorative Services and Prosthodontic Services will not be covered until after a person is enrolled in the dental plan for 6 consecutive months. Orthodontic Services will not be covered until after a person is enrolled in the dental plan for 12 consecutive months.

Maximum Payment – \$1,000 per person total per Benefit Year on all services except orthodontic services. \$1,000 per person total per lifetime on orthodontic services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by your Dentist to Delta Dental.

Deductible – \$50 Deductible per person total per Benefit Year limited to a maximum Deductible of \$150 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants, and orthodontic services.

Waiting Period – Enrollees who are eligible for dental benefits are covered as defined by the Contractor.

Eligible People – As defined by the Contractor.

Also eligible are your Spouse and your Children to the end of the month in which they turn 26, including your Children who are married, who no longer live with you, who are not your Dependents for Federal income tax purposes, and/or who are not permanently disabled.

Enrollees and dependents choosing this dental plan are required to remain enrolled for a minimum of 12 months. Should an Enrollee or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Enrollee is enrolled (except under COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled as both an Enrollee on your own application and as a Dependent on your Spouse's application. Your Dependent Children may be enrolled on both your and your Spouse's applications as well. Delta Dental will coordinate benefits between your coverage and your Spouse's coverage.

Benefits will cease as defined by the Contractor.

Axios International

Benefits overview¹

Exam/lens/frame frequency (months)	12/12/24
Contacts (instead of glasses) frequency (months)	12

In-network coverage

Exam copay	\$10
Materials copay (lenses and/or frame)	\$25- Lens Only
Single vision, lined bifocal, lined trifocal or lenticular lenses	Covered in full after copay
Frames allowance	\$130
Elective contact lenses allowance	\$130
Necessary contact lenses	Covered in full after copay
Contact lens fit and evaluation copay	up to \$60

DeltaVision®
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Out-of-network allowances

Exam	Up to \$40
Single vision lenses	Up to \$30
Bifocal lenses	Up to \$50
Trifocal lenses	Up to \$70
Progressive lenses	Up to \$50
Lenticular lenses	Up to \$100
Frames	Up to \$65
Elective contact lenses	Up to \$130
Necessary contact lenses	Up to \$210

Most popular lens enhancements (member cost)²

All lens enhancements are covered after a copay saving members 30% on average.

	Single	Multifocal
Standard anti-reflective coating	\$41	\$41
Premium anti-reflective coating	\$68	\$68
Custom anti-reflective coating	\$85	\$85
Polycarbonate lenses (adult)	\$35	\$35
Polycarbonate lenses (child)	Covered	Covered
Standard progressive lenses	N/A	Covered
Premium progressive lenses	N/A	\$95 or \$150
Custom progressive lenses	N/A	\$150 or \$175
Photochromic lenses	\$75	\$75
Scratch resistant coating	\$15	\$15

Additional savings³

Frames discount over allowance	An extra \$20 allowance on featured designer brands for frames. 20% savings on any amount above the retail allowance.
Additional pair	20% savings on unlimited additional pairs of prescription glasses and/or nonprescription sunglasses from any VSP network provider within 12 months of exam.
LASIK	Average 15% off the regular price, or 5% off the promotional price; discounts only available from contracted facilities.
Retinal imaging	Routine retinal screening covered after a maximum copay of \$39.
Essential Medical Eye Care ^{SM 5}	Supplemental coverage beyond routine care to treat urgent issues/monitor ongoing conditions like pink eye, sudden vision changes, dry eye, diabetic eye disease and glaucoma.
Low vision	Pre-approved low-vision supplemental testing covered every two years. 75% coverage for approved low-vision aids, up to \$1,000 (less any amount paid for supplemental testing) every two years.
Eyeconic®	Go to eyeconic.com ® for an easy-to-use, convenient online eyewear option that integrates with your in-network benefits.
TruHearing®	Save up to 60% on hearing aids and batteries. Visit truhearing.com/vsp or call 877-396-7194 for more information. ⁴

