

Blue Care Network

Benefits-at-a-Glance

BCN5, 50V15, ER50, UR35

This is intended as an easy-to-read summary. It is not a contract. An official description of benefits is contained in 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.

Preventive Services	
Health Maintenance Exam	Covered – \$15 copay
Annual Gynecological Exam	Covered – \$15 copay PCP; \$15 copay OB/GYN
Pap Smear Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit
Well-Baby and Child Care	Covered – \$15 copay
Immunizations – pediatric and adult	Covered – Office visit copay may apply per member, per visit
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit
Mammography	
Mammography Screening	Covered – Office visit copay may apply per member, per visit
Physician Office Services	
Office Visits	Covered – \$15 copay
Consulting Specialist Care – when referred	Covered – \$15 copay
Emergency Medical Care	
Hospital Emergency Room - copay waived if admitted	Covered – \$50 copay
Urgent Care Center	Covered – \$35 copay
Ambulance Services – medically necessary	Covered – 100%, ground and air service
Diagnostic Services	
Laboratory and Pathology Tests	Covered – Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered – Office visit copay may apply per member, per visit
Radiation Therapy	Covered – Office visit copay may apply per member, per visit
Maternity Services Provided by a Physician	
Pre-Natal and Post-Natal Care	Covered – \$15 copay
Delivery and Nursery Care	Covered – 100%
Hospital Care	
Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 100%, unlimited days
Outpatient Facility Services	Covered – 100%
Alternatives to Hospital Care	
Skilled Nursing Care	Covered – 100%, up to 45 days per calendar year
Hospice Care	Covered – 100%
Home Health Care	Covered – \$15 copay

Surgical Services	
Surgery – includes all related surgical services and anesthesia. See member certificate for specific surgical copays	Covered – 100%
Voluntary Sterilization	Covered – 50% on all associated costs
Human Organ Transplants	Covered – 100%, subject to medical criteria
Mental Health Care and Substance Abuse Treatment	
Inpatient Mental Health Care and Substance Abuse Care	Mental Health Care: Covered – 100%, up to 30 days per calendar year Substance Abuse Care: Covered – 50%, one program per 12-month period
Outpatient Mental Health Care	Covered – 50%, up to 20 visits per calendar year
Outpatient Substance Abuse Care	Covered – 50%, up to 20 visits per calendar year
Other Services	
Allergy Testing and Therapy	Covered – 50%, \$5 copay for allergy injections
Chiropractic Spinal Manipulation – when referred	Covered – \$15 copay
Outpatient Physical, Speech and Occupational Therapy – subject to significant improvement within 60 days	Covered – \$15 copay, limited to 60 consecutive days per episode
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%
Deductible, Copays and Dollar Maximums	
Deductible	None
Copays	
• Fixed Dollar Copay	\$5 for allergy injections, \$15 for PCP office visits, \$15 for specialist office visits, \$35 for urgent care visits, and \$50 for emergency room visits
• Percent Copay	50% for select services as noted above
Copay Dollar Maximums	
• Fixed Dollar Copay	None
▪ Percent Dollar Copay	None
Dollar Maximums	None

Blue Care Network Rx Prescription Drug Coverage

\$10/\$40 Copay with Contraceptive Coverage

Benefits-at-a-Glance

Covered Services	
Formulary Drug – Generic	Covered – \$10 copay
Formulary Drug – Brand Name	Covered – \$40 copay
Formulary Brand Name when Generic is available	Covered – Difference in cost between brand name drug and generic drug plus \$40
Non-Formulary Drugs	Not Covered
Sexual Dysfunction Drugs	Covered – 50% copay
Mail Order Prescription Drugs	Covered – 2 times the applicable generic, brand or sexual dysfunction copay for a 35 to 90 day supply
Definitions	
BCN Formulary	A list of all prescription drugs which have been approved for use by BCN and which shall be dispensed through participating pharmacies to members.
Brand Name Drugs	Prescription drugs which are manufactured and marketed under a registered trade name or trademark.
Covered Drugs	Prescription drugs (Generic, Brand Name, Compounded Medication, or Health Habit) which are prescribed by a BCN affiliated provider and obtained through a participating pharmacy. Certain covered drugs are a benefit only if a BCN affiliated provider certifies to BCN and BCN agrees that 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 the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a 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

1040DC, MOPD2C

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June04



Dental Program

offered to the employees of
Axios Incorporated

Preventive Services	Basic Services	Major Services	Orthodontia
Deductible Waived	\$50 Deductible		Deductible Waived
100%	80%	50%	50%
Emergency Treatment	Minor Restorative Services	Gold & Porcelain Fillings & Crowns	Child Orthodontia to age 19 50% to \$1000 Lifetime Maximum
Oral Examinations	Biopsy and Examination of oral tissue	Installation of Bridgework	
X-Rays	Laboratory Tests	Installation of Crowns	
Teeth Cleaning	Anesthesia	Dentures	
*Space Maintainers	Repair & Maintenance of Bridgework	Inlays	
*Topical Sealants	Periodontic Services, Including Oral Surgery	Onlays, in addition to inlay allowance	
*Fluoride Treatment	Fillings & Extractions		
*=For children only	Endodontics, including Root Canal		

Deductible: \$50 – 3 per Family
 Annual Plan Maximum per person: \$1000
 Orthodontia Lifetime Maximum: \$1000

Provider Information at: www.guardianlife.com, Provider Online Search, Find a Dentist, PPO plan, DentalGuard Preferred Network

Eligible Dependents: Your legal spouse; your unmarried dependent children who are under age 20; and your unmarried dependent children, from age 20 until their 26th birthday, who are enrolled as full-time students at accredited schools.

All benefits are based on usual, customary, and reasonable rates for a given area.

Late Entrants: Except for covered charges due solely to an accident he suffers while insured, we won't pay benefits for any charges incurred by a late entrant in the first: 1) 6 months he is insured for Basic Services; 2) 12 months he is insured for Major Services; and 3) 24 months he is insured for Orthodontic Services. A late entrant is any person who: 1) becomes insured more than 31 days after he is first eligible; or 2) becomes insured again, after his coverage lapsed because required payments were not made.

Guardian, Group Dental Claims:

PO Box 2459, Spokane, WA 99210-2459

1-800-541-7846



GUARDIAN™

VISION PLAN SUMMARY

Frequency of Service

Exam

Every 12 Months

Materials:

Lenses	Every 12 months
Frames	Every 24 months
	<u>Contact Lenses Every 12 months (in lieu of frames & lenses)</u>
Exam	\$10
Materials	\$25

In Network

Out Of Network

<u>Eye Exam</u>	<u>covered in full</u>	<u>up to \$46.00</u>
<u>Single Vision Lenses</u>	<u>covered in full</u>	<u>up to \$47.00</u>
<u>Bifocal Lenses</u>	<u>covered in full</u>	<u>up to \$66.00</u>
<u>Trifocal Lenses</u>	<u>covered in full</u>	<u>up to \$85.00</u>
<u>Lenticular Lenses</u>	<u>covered in full</u>	<u>up to \$125.00</u>
<u>Frames</u>	<u>covered in full ***</u>	<u>up to \$47.00</u>
Contact Lenses		
<u>Medically Necessary</u>	<u>covered in full</u>	<u>up to \$210.00</u>
<u>Elective</u>	<u>\$105.00 ****</u>	<u>up to \$105.00 ****</u>
<u>Laser Surgery</u>	<u>discounts available</u>	<u>discounts available</u>

**The Out-of-Network benefit schedule shown applies for the state of Michigan. In some states, coverage may be higher or lower.

***Approximately 13,000 frames are covered in full. All others are offered to patients at discounted cost based on wholesale price.

****Copay is waived for elective contact lenses.

To find a network doctor, call VSP at 1-800-VSP-7195. Your doctor will verify benefits using your social security number through this phone number. You can also access the provider directory at www.vsp.com.