Blue Cross Blue Shield of Michigan

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

EMERGING MARKETS
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Simply Blue℠ HSA PPO with Rx ASC
Effective Date: On or after January 2025
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.

Prior authorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, receive prior authorization 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.

Prior authorization 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 prior authorization of the drugs. **If prior authorization 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.

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

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Eligibility Information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage until the end of the year in which they turn age 26
Sponsored dependents	• Dependents of the subscriber related by blood, marriage or legal adoption, over age 19 and not eligible as a dependent under the provisions of the subscriber's contract, provided the dependent meets all eligibility requirements. The subscriber is responsible for paying the cost of this coverage.
Principally supported (grand)children	Principally supported children are also covered when specific requirements are met.
Employees and their dependents that are called to active military duty	Extended coverage to subscribers who are called into military service for peacekeeping services or are placed on military peacetime leave status. BCBSM will continue to be the primary carrier for all members of the subscriber's contract, unless the subscriber or dependents elect TRICARE as their health care carrier.

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 **Note:** Your deductible **combines** deductible amounts paid under your Simply Blue HSA medical coverage **and** your Simply Blue prescription drug coverage. **Note:** The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract.	$1,650 for a one-person contract $3,300 for a family contract (two or more members) each calendar year **(no 4th quarter carry-over)**	$2,700 for a one-person contract $5,600 for a family contract (two or more members) each calendar year **(no 4th quarter carry-over)**
	Deductibles are based on amounts defined annually by the federal government for Simply Blue HSA-related health plans. Deductibles may increase annually. Please call your customer service center for an annual update.	
Flat-dollar copays	See "Prescription Drugs" section	See "Prescription Drugs" section
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 10% of approved amount for private duty nursing care • 20% of approved amount for most covered services	• 10% of approved amount for private duty nursing care • 40% of approved amount for most covered services
Annual out-of-pocket maximums-applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts	$2,600 for a one-person contract $4,600 for a family contract (two or more members) each calendar year	$5,200 for a one-person contract $9,200 for a family contract (two or more members) each calendar year
Lifetime dollar maximum	None	

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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
Gynecological exam	100% (no deductible or copay/coinsurance), two 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 sterilization of female reproductive organs	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)	60% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and Well-child 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

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Benefits	In-network	Out-of-network
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, if applicable.	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	
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for routine colonoscopy **Note:** Medically necessary colonoscopies performed during the **same** calendar year are subject to your deductible and coinsurance, if applicable.	60% after out-of-network deductible
	One routine colonoscopy per member per calendar year	
CA-125 screening **Note:** One per member, per calendar year	100% (no deductible or copay/coinsurance)	Not covered
Double contrast barium enema **Note:** One per member, per calendar year	100% (no deductible or copay/coinsurance)	Not covered

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Online visits - by physician or **BCBSM** selected vendor must be medically necessary **Note:** Online visits by a non-BCBSM selected vendor are not covered. 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 in-network deductible	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	80% after in-network deductible	60% after out-of-network deductible
Urgent care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	80% after in-network deductible	80% after in-network deductible
Ambulance services (including water ambulance - subject to additional criteria) - must be medically necessary	80% after in-network deductible	80% after in-network deductible

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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	100% (no deductible or copay/coinsurance)	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 **Note:** Nonemergency services must be rendered in a **participating** hospital.	80% after in-network deductible Unlimited days	60% after out-of-network deductible
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 Limited to a maximum of 90 days per member per calendar year	80% after in-network deductible
Hospice care	80% after in-network deductible 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)	80% after in-network deductible
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

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Benefits	In-network	Out-of-network
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 prior authorization-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	80% after in-network deductible	60% after out-of-network deductible
Voluntary sterilization of male reproductive organs **Note:** For voluntary sterilization of female reproductive organs, see **"Preventive care services."**	80% after in-network deductible	60% after out-of-network deductible
Expanded Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	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)	80% after in-network deductible	80% after in-network deductible-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

Behavioral Health Services (Mental Health and Substance Use Disorder)

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 requires prior authorization • subject to medical criteria	80% after in-network deductible	60% after out-of-network deductible

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Benefits	In-network	Out-of-network
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 behavior analysis (ABA) treatment - subject to prior authorization **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 in-network deductible	60% after out-of-network deductible **Note:** Services rendered by an approved licensed behavior analyst (LBA) will apply the in-network cost-sharing.
Outpatient physical therapy, speech therapy and occupational therapy 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 nutritional counseling and 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	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	80% after in-network deductible	60% after out-of-network deductible
	Limited to a **combined** 12-visit maximum per member per calendar year	

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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.
	Unlimited visits	
Durable medical equipment - including "routine maintenance" of purchased DME items, subect to additional criteria **Note:** DME items required under the preventive benefit 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 preventive DME items that PPACA requires to be covered at 100%, 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	90% after in-network deductible	90% after out-of-network deductible
Hair prosthesis and accessories: • covered only when the hair loss is the result of either chemotherapy and/or radiation treatment for malignant and non-malignant conditions, trichotillomania or alopecia • subject to medical and benefit criteria	80% after in-network deductible	80% after in-network deductible
	Note: Limited to one per member in a 12-month period	
Rabies vaccine for intramusclar use and intra-dermal use - benefits allowed for subsequent vaccines on days 3,7,14,and 28	80% after in-network deductible	60% after out-of-network deductible

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Prescription Drug Discount Program - Prescription drug manufacturers provide coupon programs for certain medications. Your benefit plan requires you to take advantage of BCBSM-approved coupon programs for select medications. This benefit may lower the cost-sharing typically required for these drugs. Your out-of-pocket expense will be no more than your benefit cost-sharing. When a manufacturer coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum.

NOTE: Adjustments may be required to accurately reflect your annual out-of-pocket maximum to reflect your true out-of-pocket cost.

This program may be discontinued at any time if it is no longer supported by the vendor.

Specialty Pharmaceutical Drugs - The preferred pharmacy for specialty drugs is **Walgreens Specialty Pharmacy**. Specialty drugs are covered only when dispensed through the Walgreens Specialty Pharmacy or any in-network participating pharmacy.

A list of specialty drugs is available on our website at **bcbsm.com/pharmacy**. Click What are specialty drugs, then click Specialty Drug Program Rx Benefit Member Guide. The guide is updated monthly.

If you have additional questions, you can 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 Blue Cross defines as a "specialty pharmaceutical". We may make exceptions if a member requires more than a 30-day supply. Blue Cross reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay or 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)

Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual out-of-pocket maximum required under your Simply Blue HSA medical coverage. Benefits are not payable until you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are require to pay applicable prescription drug copays and coinsurance amounts which are subject to your annual out-of-pocket maximums.

Note: The following prescription drug expenses will not apply to your Simply Blue HSA deductible or annual out-of-pocket maximum

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 20% member liability for covered drugs obtained from an out-of-network pharmacy

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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
Generic or select prescribed over-the-counter drugs	1 to 30-day period	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay plus an additional 20% of the BCBSM approved amount
	31 to 83-day period	No coverage	After deductible is met, you pay $10 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $10 copay	After deductible is met, you pay $10 copay	No coverage	No coverage
Preferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $20 copay	After deductible is met, you pay $20 copay	After deductible is met, you pay $20 copay	After deductible is met, you pay $20 copay ***plus*** an additional 20% prescription drug out-of-network copay from an out-of-network retail pharmacy provider
	31 to 83-day period	No coverage	After deductible is met, you pay $40 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $40 copay	After deductible is met, you pay $40 copay	No coverage	No coverage
Nonpreferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $40 copay	After deductible is met, you pay $40 copay	After deductible is met, you pay $40 copay	After deductible is met, you pay $40 copay ***plus*** an additional 20% prescription drug out-of-network copay from an out-of-network retail pharmacy provider
	31 to 83-day period	No coverage	After deductible is met, you pay $80 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $80 copay	After deductible is met, you pay $80 copay	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	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty

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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
Prescribed over-the-counter drugs - when covered by BCBSM	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
State-controlled drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
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	80% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
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	80% 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	80% of approved amount
Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance **plus** an additional 20% prescription drug out-of-network penalty
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty for insulin or other covered injectable legend drug

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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
Select diabetic supplies and devices (test strips, lancets and glucometers) For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty

* 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. • **Generic drug tier** - This tier 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. • **Preferred brand-name drug tier** - This tier includes non-specialty preferred brand-name drugs. These drugs are more expensive then generic and members pay more for them. • **Nonpreferred brand-name drug tier** - This tier includes non-specialty brand-name drugs for which there's either a generic alternative or a more cost-effective preferred brand-name drug available. Members pay more for these nonpreferred brand-name drugs.
Mandatory prior authorization	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) 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 prior authorization. Details about which drugs require prior authorization or step therapy are available online site at **bcbsm.com/pharmacy**.
Maximum allowable cost drugs	For maximum allowable cost (MAC) drugs, if you have a prescription filled by an in-network pharmacy, and the pharmacist fills it with a generic equivalent drug, you are required to pay only the copayment and/or deductible, if applicable. If you obtain a brand name drug when a generic equivalent drug is available, you must pay the difference between the maximum allowable cost and the Blue Cross approved amount for the brand name drug plus your copayment and/or deductible, if applicable. **Note:** If your physician requests and receives authorization for a brand name drug from Blue Cross Pharmacy Services Department and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your copayment and/or deductible, if applicable.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

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Blue Cross Blue Shield of Michigan

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0070002160136
Dental Coverage
Effective Date: On or after January 2025
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.

Coverage determination: Claims are subject to dental necessity verification and availability of dental benefits when they are processed, as well as the terms and conditions of the applicable BCBSM certificates and riders.

Dentist information
With Blue Dental EPO, you **must** choose a Tier 1 PPO (in-network) dentist.

You have outstanding access to thousands of Tier 1 PPO dentists across the United States through the Blue Dental PPO network. Tier 1 PPO dentists agree to accept our PPO approved amount as full payment for covered services, so you'll pay your applicable coinsurance and deductible amounts. To find a Tier 1 PPO dentist near you, log into your member account at **bcbsm.com** or call **1-888-826-8152.**

Note: If you go to a non-PPO (out-of-network) dentist, you are responsible for all costs for services rendered.

Eligibility information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • Dependent children: related to you by birth, marriage, legal adoption or legal guardianship; eligible for dental coverage through the end of the calendar year in which they turn age 26, provided all eligibility requirements are met.

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

Benefits	In-network	Out-of-network
Deductible	None	Not applicable
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services	None (covered at 100%)	Not covered
• Class II services	None (covered at 100%)	Not covered
• Class III services	15%	Not covered
• Class IV services	30%	Not covered
Dollar maximums • Annual maximum for Class I, II and III services	$2,600 per member per calendar year	Not applicable

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Benefits	In-network	Out-of-network
• Lifetime maximum for Class IV services	$2,400 per member	Not applicable

Class I services

Benefits	In-network	Out-of-network
Oral exams	100% of approved amount, twice per calendar year	Not covered
A set (up to 4 films) of bitewing x-rays	100% of approved amount, once per calendar year	Not covered
Panoramic or full-mouth x-rays	100% of approved amount, once every 60 months	Not covered
Prophylaxis (cleaning)	100% of approved amount, twice per calendar year	Not covered
Sealants - for members age 19 and younger	100% of approved amount, once per tooth in any 36 consecutive months when applied to the first and second permanent molars. This period begins on the date of the member's first treatment.	Not covered
Emergency palliative treatment	100% of approved amount	100% of approved amount
Fluoride treatments	100% of approved amount, two per calendar year	Not covered
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	100% of approved amount, once per quadrant per lifetime	Not covered
Periodontic maintenance	100% of approved amount, up to four periodontal maintenance cleanings per calendar year. **Note:** The patient must have a documented history of periodontal disease, prior to and during the treatment phase	Not covered
	Note: Twice per calendar year **Note:** Benefits are payable for up to four periodontal maintenance cleanings per calendar year during the first two years immediately following periodontal scaling and root planing or periodontal surgery.	

Class II services

Benefits	In-network	Out-of-network
Fillings - permanent (adult) teeth	100% of approved amount, replacement fillings covered after 12 months or more after initial filling	Not covered
Fillings - primary (child) teeth	100% of approved amount, replacement fillings covered after 12 months or more after initial filling	Not covered
Crowns, onlays, inlays, and veneer restorations - permanent teeth - for members age 12 and older **Note:** BCBSM will pay for replacement cast restorations (onlays, and veneers) once every 36 months per member. This period begins on the date the last restoration was cemented in place.	100% of approved amount, once every 60 months per tooth	Not covered
Recementation of crowns, veneers, inlays, onlays and bridges	100% of approved amount, three times per tooth per calendar year after six months from original restoration	Not covered
Oral surgery	100% of approved amount	Not covered

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Benefits	In-network	Out-of-network
Root canal treatment	100% of approved amount, once per tooth per lifetime; retreatment of previous root canal therapy once per tooth per lifetime	Not covered
Scaling and root planing	100% of approved amount, once every 24 months per quadrant	Not covered
Limited occlusal adjustments	100% of approved amount, **limited** occlusal adjustments covered up to five times in any 60 consecutive months	Not covered
Occlusal biteguards	100% of approved amount, once every 12 months	Not covered
General anesthesia or IV sedation	100% of approved amount, when medically necessary and performed with oral surgery	Not covered
Repairs and adjustments of a partial or complete denture	100% of approved amount, six months or more after denture is delivered	Not covered
Relining or rebasing of a partial or complete denture	100% of approved amount, once per arch in any 36 consecutive months	Not covered
Tissue conditioning	100% of approved amount, once per arch in any 36 consecutive months	Not covered

Class III services

Benefits	In-network	Out-of-network
Removable dentures (complete and partial)	85% of approved amount, once every 60 months	Not covered
Bridges (fixed partial dentures) - for members age 16 and older	85% of approved amount, once every 60 months	Not covered
Endosteal implants - for members age 16 and older who are covered at the time of the actual implant placement; subject to an annual benefit maximum of $1,200 per member, per calendar year	85% of approved amount, once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31	Not covered

Class IV services

Benefits	In-network	Out-of-network
Minor treatment for tooth guidance appliances	70% of approved amount	Not covered
Minor treatment to control harmful habits	70% of approved amount	Not covered
Interceptive and comprehensive orthodontic treatment	70% of approved amount	Not covered
Post-treatment stabilization	70% of approved amount	Not covered
Cephalometric film (skull) and diagnostic photos	70% of approved amount	Not covered

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins. **Services received outside the dental network are not covered.**

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Vision Coverage
Effective Date: On or after January 2025
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.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com.**

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	**Combined** $7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay
Medically necessary contact lenses **Note:** No copay is required for prescribed contact lenses that are not medically necessary.	$7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay

Eye exam

Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$5 copay	Reimbursement up to $50 less $5 copay (member responsible for any difference)
	One eye exam in any period of 12 **consecutive** months	

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Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. • Progressive Lenses - Covered when rendered by a VSP network doctor • Ultraviolet Coating - Covered when rendered by a VSP network doctor • Scratch Guard Coating - Covered when rendered by a VSP network doctor	$7.50 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $7.50 copay (member responsible for any difference)
	One pair of lenses, with or without frames, in any period of 12 **consecutive** months	
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	Covered up to $150 (member responsible for any cost exceeding approved amount) less less $7.50 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $70 less $7.50 copay (member responsible for any difference)
	One frame in any period of 12 **consecutive** months	

Contact Lenses

Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$7.50 copay	Reimbursement up to $210 less $7.50 copay (member responsible for any difference)
	Contact lenses up to the allowance in any period of 12 **consecutive** months	
Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	Covered up to a maximum payment of $200 (member responsible for any difference)	$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Contact lenses up to the allowance in any period of 12 **consecutive** months	

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Hearing Care Coverage
Effective Date: On or after January 2025
Benefits-at-a-glance

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Member's responsibility (deductible and copay/coinsurance)

Note: Limited to a benefit maximum of $2,707 for monaural hearing aids and binaural hearing aids every 36 months per member for participating providers

Benefits	Participating provider	Nonparticipating provider
Deductible **Note**: You are required to meet the annual calendar year deductible under your Simply Blue HSA coverage **before** using your hearing care benefits	**Your Simply Blue HSA hearing care benefits are subject to the same deductible required under your Simply Blue HSA medical coverage.** Hearing care benefits are **not** payable until after you have met the Simply Blue HSA annual deductible.	Not applicable
Copay/coinsurance	**Your Simply Blue HSA hearing care benefits are subject to the same coinsurance required under your Simply Blue HSA medical coverage.**	Not applicable

Covered services

You **must** receive the following services from **a hearing participating provider**. Hearing care services are **not** covered when performed by nonparticipating providers unless the services are performed outside of Michigan **and** the local Blue Cross and Blue Shield plan does **not** contract with providers for hearing care services. In this case, BCBSM will pay the approved amount for hearing aids and related covered services obtained from a nonparticipating provider. You may be responsible for charges that exceed our approved amount.

If you select a digitally controlled programmable hearing device, you may be responsible for charges that exceed the cost of a covered hearing aid.

Benefits	Participating provider	Nonparticipating provider
Audiometric exam - one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered
Hearing aid evaluation- one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered

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Benefits	Participating provider	Nonparticipating provider
Ordering and fitting the hearing aid (a monaural or binaural hearing aid) - one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered
Hearing aid conformity test- one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered

Note: You **must** obtain a medical evaluation (sometimes called a medical clearance exam) of the ear performed by a physician-specialist before you receive your hearing aid. If a physician-specialist is not accessible, your primary care doctor may perform the medical evaluation. **This evaluation is not covered under your hearing care coverage, so you must pay for this exam unless your medical coverage includes coverage for office visits.**
A physician-specialist is a licensed doctor of medicine or osteopathy who is also board certified or in the process of being board certified as an otolaryngologist. A physician-specialist determines whether a patient has a hearing loss and whether such loss can be offset by a hearing aid.

ADM PLANYR JAN;ADM SPA-HEQ-DEN;ADM SPA-HEQ-VIS;ASCMOD 11058MED;ASCMOD 6352 VIS;ASCMOD 6916;ASCMOD 7831 DRG;BK26;BLUE DENTAL;BLUE VISION;BV-PL;BV-SGC;BV-UVC;BVC-$7.50;BVFL;CDH DCFSA AO VC;CDH DCFSAAO DEN;CDH-HSA-DC-FSA;DO-DI;DO-PC4X;DO-PPO-XNP;DO-RCR;HEQ;L DORAF;PRX-MM ASC;RX-90-2X ASC;RX-VCP ASC;RXGLP-1 EXCLUS;RXP ASC;SB-HSA-AMB ASC;SB-HSA-HC(A)ASC;SBD HSA ASC;SBD HSA OLV ASC;SBHSA$1650ASC;SBHSA$3300ASC;SBHSAD-ECMP ASC;SD ASC;TTCMO2X52550ASC