Blue Cross Blue Shield of Michigan

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

# EMERGING MARKETS NBU RETIREES PULL DIV
# 0070484900004 - 0CJHP
# Effective Date: 01/01/2027

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.

## Eligibility Information

| Member | Eligibility Criteria |
|---|---|
| **Dependents** | • Subscriber's legal spouse, same or opposite gender domestic partner eligible for coverage under the subscriber's contract<br>• **Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship, including eligible children of your same or opposite gender domestic partner; eligible for coverage through the end of the calendar year in which they turn age 26. |

## 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** | $500 for one member,<br>$1,000 for the family (when two or more members are covered under your contract) each calendar year | $1,000 for one member,<br>$2,000 for the family (when two or more members are covered under your contract) each calendar year<br><br>**Note**: Out-of-network deductible amounts also count toward the in-network deductible. |
| **Flat-dollar copays** | • $20 copay for office visits and office consultations with a **primary care physician**<br>• $40 copay for each office visits and office consultations with a **specialist**<br>• $20 copay for medical online visits<br>• $30 copay for chiropractic and osteopathic manipulative therapy<br>• $150 copay for emergency room visits<br>• $60 copay for urgent care visits | • $150 copay for emergency room visits |
| **Coinsurance amounts (percent copays)**<br><br>**Note**: Coinsurance amounts apply once the deductible has been met. | • 30% of approved amount for private duty nursing care<br>• 20% of approved amount for most other covered services | • 50% of approved amount for private duty nursing care<br>• 40% of approved amount for most other covered services |
| **Annual out-of-pocket maximums** - applies to deductibles, flat-dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable. | $2,000 for one member,<br>$4,000 for the family (when two or more members are covered under your contract) each calendar year | $4,000 for one member,<br>$8,000 for the family (when two or more members are covered under your contract) each calendar year<br><br>**Note**: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum. |
| **Lifetime dollar maximum** | None | |

## 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<br><br>**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<br><br>**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) | 100% 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),<br>• 8 visits, birth through 12 months<br>• 6 visits, 13 months through 23 months<br>• 6 visits, 24 months through 35 months<br>• 2 visits, 36 months through 47 months<br>• 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 |
| Routine mammogram and related reading | 100% (no deductible or copay/coinsurance)<br><br>**Note**: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance. | 60% after out-of-network deductible<br><br>**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 | |

| Benefits | In-network | Out-of-network |
|---|---|---|
| Colonoscopy - routine or medically necessary | 100% (no deductible or copay/coinsurance), for the first billed colonoscopy<br><br>**Note**: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance. | 60% after out-of-network deductible |
| | One per member per calendar year | |

## Physician office services

| Benefits | In-network | Out-of-network |
|---|---|---|
| Office visits-must be medically necessary | • $20 copay for each office visit with a **primary care physician**<br>• $40 copay for each office visit with a **specialist**<br><br>**Note**: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam.<br><br>Cost-sharing may not apply if preventive or immunization services are performed during the office visit. | 60% after out-of-network deductible |
| Online visits - by physician must be medically necessary<br><br>**Note:** Online visits by a 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. | $20 copay per online visit | 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 | • $20 copay for each office consultation with a **primary care physician**<br>• $40 copay for each office consultation with a **specialist**<br><br>**Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam.<br><br>Cost-sharing may not apply if preventive or immunization services are performed during the office visit. | 60% after out-of-network deductible |

## Urgent care visits

| Benefits | In-network | Out-of-network |
|---|---|---|
| Urgent care visits | $60 copay for each urgent care visit<br><br>**Note**: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam.<br><br>Cost-sharing may not apply if preventive or immunization services are performed during the office visit. | 60% after out-of-network deductible |

## Emergency medical care

| Benefits | In-network | Out-of-network |
|---|---|---|
| Hospital emergency room | $150 copay per visit (copay waived if admitted) | $150 copay per visit (copay waived if admitted) |
| Ambulance services-must be medically necessary | 80% after in-network deductible | 80% after in-network deductible |

## 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<br><br>**Note:** For facility services See "Hospital 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<br><br>**Note**: Nonemergency services must be rendered in a **participating** hospital. | 80% after in-network deductible<br><br>Unlimited days | 60% after out-of-network deductible |

| Benefits | In-network | Out-of-network |
|---|---|---|
| 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 | 80% after in-network deductible |
| | Limited to a maximum of 120 days per member per calendar year | |
| Hospice care | 100% (no deductible or copay/coinsurance) | 100% (no deductible or copay/coinsurance) |
| | 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) | |
| Home healthcare:<br>• must be medically necessary<br>• must be provided by a **participating** home healthcare agency | 80% after in-network deductible | 80% after in-network deductible |
| Infusion therapy:<br>• must be medically necessary<br>• must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC)<br>• 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 | 100% (no deductible or copay/coinsurance) | 60% after out-of-network deductible |
| Voluntary sterilization of male reproductive organs<br><br>**Note:** For voluntary sterilization of female reproductive organs, see **"Preventive care services."** | 80% after in-network deductible | 60% after out-of-network deductible |
| Elective Abortion Services<br><br>**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) | 100% (no deductible or copay/coinsurance) | 100% (no deductible or copay/coinsurance) - in designated facilities **only** |

| Benefits | In-network | Out-of-network |
|---|---|---|
| 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<br><br>**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 healthcare and **inpatient** substance use disorder treatment | 80% after in-network deductible | 60% after out-of-network deductible |
| **Note:** Facility services are covered in participating facilities only. | Unlimited days | |
| Residential psychiatric treatment facility:<br>• covered mental health services **must** be performed in a residential psychiatric treatment facility<br>• treatment requires prior authorization<br>• subject to medical criteria | 80% after in-network deductible | 60% after out-of-network deductible |
| Outpatient mental healthcare:<br>• Facility and clinic<br><br>**Note:** Facility services are covered in participating facilities only. | 80% after in-network deductible | 80% after in-network deductible |
| • Online visits<br><br>**Note:** Online visits by a 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<br><br>**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<br><br>**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)<br><br>**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.<br><br>**Note:** Continuous glucose monitors and related supplies are covered only when obtained from the BCBSM designated exclusive vendor. | • 80% after in-network deductible for diabetes medical supplies<br>• 100% (no deductible or copay/coinsurance) for diabetes self-management training | 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 | $30 copay per visit<br><br>**Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam | 60% after out-of-network deductible |
| | Limited to a **combined** 12-visit maximum per member per calendar year | |
| Outpatient physical, speech and occupational therapy-provided for rehabilitation | 80% after in-network deductible | 60% after out-of-network deductible<br><br>**Note**: Services at nonparticipating outpatient physical therapy facilities are not covered. |
| | Limited to a **combined** 30-visit maximum per member per calendar year | |
| Durable medical equipment<br><br>**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 | 70% after in-network deductible | 50% after out-of-network deductible |

## Preferred Rx Program ASC

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/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

**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 through a participating Walgreens retail pharmacy, as long as the drug is available at that location. You may want to call ahead to confirm availability. **If you don't use Walgreens Specialty Pharmacy or a participating Walgreens retail pharmacy, you may be responsible for the full cost of the medication.**

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)

**Note:** Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

| Benefits | | 90-day retail network pharmacy | In-network mail order pharmacy* | 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 | You pay $10 copay | You pay $10 copay | You pay $10 copay | You pay $10 copay plus an additional 25% of BCBSM approved amount for the drug |
| | 31 to 83-day period | No coverage | You pay $20 copay | No coverage | No coverage |
| | 84 to 90-day period | You pay $20 copay | You pay $20 copay | No coverage | No coverage |
| **Preferred brand-name drugs** | 1 to 30-day period | You pay $40 copay | You pay $40 copay | You pay $40 copay | You pay $40 copay plus an additional 25% of BCBSM approved amount for the drug |
| | 31 to 83-day period | No coverage | You pay $80 copay | No coverage | No coverage |
| | 84 to 90-day period | You pay $80 copay | You pay $80 copay | No coverage | No coverage |
| **Nonpreferred brand-name drugs** | 1 to 30-day period | You pay $80 copay | You pay $80 copay | You pay $80 copay | You pay $80 copay plus an additional 25% of BCBSM approved amount for the drug |
| | 31 to 83-day period | No coverage | You pay $160 copay | No coverage | No coverage |
| | 84 to 90-day period | You pay $160 copay | You pay $160 copay | No coverage | No coverage |

| Benefits | | 90-day retail network pharmacy | In-network mail order pharmacy* | In-network pharmacy (not part of the 90-day retail network) | Out-of-network pharmacy |
|---|---|---|---|---|---|
| **Generic specialty drugs** | 1 to 30-day period | **Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs**<br>You pay $10 copay<br><br>**Note:** No coverage for 31-90 day supply. | | | |
| **Preferred brand-name specialty drugs** | 1 to 30-day period | **Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs**<br>You pay $40 copay<br><br>**Note:** No coverage for 31-90 day supply. | | | |
| **Nonpreferred brand-name specialty drugs** | 1 to 30-day period | **Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs**<br>You pay $80 copay<br><br>**Note:** No coverage for 31-90 day supply. | | | |

**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 pharmacies, including Internet providers.

## Covered services

| Benefits | 90-day retail network pharmacy | In-network mail order pharmacy* | In-network pharmacy (not part of the 90-day retail network) | Out-of-network pharmacy |
|---|---|---|---|---|
| FDA-approved drugs | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 75% of approved amount less plan copay/coinsurance |
| Prescribed over-the-counter drugs - when covered by BCBSM | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 75% of approved amount less plan copay/coinsurance |
| State-controlled drugs | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 75% of approved amount less plan copay/coinsurance |
| 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 | 75% of approved amount |
| Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 75% of approved amount less plan copay/coinsurance |
| 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 | 75% of approved amount |

| Benefits | 90-day retail network pharmacy | In-network mail order pharmacy* | In-network pharmacy (not part of the 90-day retail network) | Out-of-network pharmacy |
|---|---|---|---|---|
| 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 | 75% of approved amount |
| Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs are not covered) | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 75% of approved amount less plan copay/coinsurance |
| Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs<br><br>**Note:** Needles and syringes have no copay/coinsurance. | 100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug | 100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug | 100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug | 75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug |
| Select diabetic supplies and devices (test strips, lancets and glucometers)<br><br>For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy.<br><br>**Note:** Continuous glucose monitors and related supplies are covered only when obtained from the BCBSM designated exclusive vendor. | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 75% of approved amount less plan copay/coinsurance |

* BCBSM will not pay for drugs obtained from out-of-network mail order pharmacies, 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.<br>• **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.<br>• **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.<br>• **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. |
| Prior authorization/step therapy | 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**. |

## Features of your prescription drug plan

| | |
|---|---|
| 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.<br><br>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 BCBSM approved amount for the brand name drug plus your copayment and/or deductible, if applicable.<br><br>**Note:** If your physician requests and receives authorization for a brand name drug from BCBSM's 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. |
| GLP-1 Products | GLP-1 products for conditions other than diabetes are not covered. |

# Hearing Care Coverage

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.

## Member's responsibility (deductible and copay)

| Benefits | Participating provider | Nonparticipating provider |
|---|---|---|
| Deductible | None | Not applicable |
| Copay | None | 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 | Not covered |
| Hearing aid evaluation- one every 36 months | Not covered | Not covered |
| Ordering and fitting the hearing aid (a monaural or binaural hearing aid) - one every 36 months | Not covered | Not covered |
| Hearing aid conformity test- one every 36 months | Not covered | 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.



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