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

ROCHESTER COMMUNITY SCHOOL DISTRICT
0070048180041 - 09PGR
Effective Date: 01/01/2023

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.

Preauthorization for Specialty Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized 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.

Preauthorization 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 preauthorization of the drugs. **If preauthorization 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 • **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

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.	$1,500 for a one-person contract $3,000 for a family contract (two or more members) each calendar year **(no 4th quarter carry-over)**	$3,000 for a one-person contract $6,000 for a family contract (two or more members) each calendar year **(no 4th quarter carry-over)**
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.	None	20% 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	$2,250 for a one-person contract $4,500 for a family contract (two or more members) each calendar year	$4,500 for a one-person contract $9,000 for a family contract (two or more members) each calendar year
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 **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 sterilizations for females	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

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Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Benefits	In-network	Out-of-network
Prescription contraceptive devices-includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Well-baby and child care 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
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.	80% 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	
Routine screening colonoscopy	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.	80% after out-of-network deductible
	One routine colonoscopy per member per calendar year	
CA-125 screening	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Online visits - by physician or **BCBSM** selected vendor must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	100% after in-network deductible	100% after in-network deductible
Ambulance services - must be medically necessary	100% after in-network deductible	100% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% 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)	80% after out-of-network deductible
Postnatal care	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Delivery and nursery care	100% after in-network deductible	80% 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.	100% after in-network deductible Unlimited days	80% after out-of-network deductible

ADM PLANYR JAN;ASCMOD 10270MED;ASCMOD 5592 DEN;ASCMOD 9324 VIS;BLUE DENTAL;CDC-DC 26-ME;CDH-HSA;DHSAD1.5IN3KONA;DO-PPO;ESS VIS;EVC $7.50;EVFL;HEQ;PDTTC104080RXCM;PK536;PREV-DM RX ASC;SB-HSA-AMB ASC;SB-HSA-OT ASC;SBD HSA ASC;SBD HSA OLV ASC;SBDHSAC0IN20ONA;SBDHSAOCSM24ASC;SBHSA-D-DPP-ASC;SBHSAD-ECMP ASC;XVA-2 ASC

Benefits	In-network	Out-of-network
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% 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	100% after in-network deductible	100% after in-network deductible
	Limited to a maximum of 120 days per member, per calendar year	
Hospice care	100% after in-network deductible	100% 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)	
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	100% after in-network deductible	100% after in-network deductible
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 preauthorization-consult with your doctor	100% after in-network deductible	100% 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	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see **"Preventive care services."**	100% after in-network deductible	80% after out-of-network deductible
Voluntary abortions	Not covered	Not covered

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% after in-network deductible	100% 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)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials **Note**: BCBSM covers clinical trials in compliance with PPACA.	100% after in-network deductible	80% after out-of-network deductible

Benefits	In-network	Out-of-network
Kidney, cornea and skin transplants	100% after in-network deductible	80% 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	100% after in-network deductible	80% 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 must be preauthorized • subject to medical criteria	100% after in-network deductible	80% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	100% after in-network deductible	100% after in-network deductible in participating facilities **only**
• Online visits - by physician or **BCBSM** selected vendor	100% after in-network deductible	80% after out-of-network deductible
• Physician's office	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance use disorder treatment-in approved facilities **only**	100% after in-network deductible	80% 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 - when rendered by an approved licensed behavior analyst - subject to preauthorization **Note**: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	100% after in-network deductible	100% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible

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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.	100% after in-network deductible	80% after out-of-network deductible
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% after in-network deductible	80% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy-provided for rehabilitation	100% after in-network deductible	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year	
Durable medical equipment **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.	100% after in-network deductible	100% after in-network deductible
Prosthetic and orthotic appliances	100% after in-network deductible	100% after in-network deductible
Private duty nursing care	100% after in-network deductible	80% after out-of-network deductible

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Simply Blue HSA with Prescription Drugs

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Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Pharmacy, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. AllianceRx Walgreens Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to the OptumRx home delivery pharmacy. (OptumRx is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call AllianceRx Walgreens 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 BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/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

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 $10 copay	After deductible is met, you pay $10 copay	After deductible is met, you pay $10 copay	After deductible is met, you pay $10 copay plus an additional 20% of the BCBSM approved amount
	31 to 83-day period	No coverage	After deductible is met, you pay $20 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $20 copay	After deductible is met, you pay $20 copay	No coverage	No coverage
Preferred 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% of the BCBSM approved amount
	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
Nonpreferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $80 copay	After deductible is met, you pay $80 copay	After deductible is met, you pay $80 copay	After deductible is met, you pay $80 copay plus an additional 20% of the BCBSM approved amount

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
	31 to 83-day period	No coverage	After deductible is met, you pay $160 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $160 copay	After deductible is met, you pay $160 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
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 **Note:** Your deductible is waived for certain preventive drugs including diabetic medications when dispensed by a BCBSM in-network pharmacy. Please contact the customer serivice center for additional information and list of drugs.	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount

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
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
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.

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Features of your prescription drug plan

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, 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.
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 preauthorization) 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 preauthorization. Details about which drugs require preauthorization or step therapy are available online site at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by an in-network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug plus your applicable copay/coinsurance regardless of whether you or your physician requests the brand-name drug. **Exception:** If your physician requests and receives authorization for a nonpreferred brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay/coinsurance. **Note:** This MAC difference will not be applied toward your annual in-network deductible, your annual coinsurance, or your annual out-of-pocket maximum, if applicable.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

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Dental Coverage

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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.

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

Blue Dental PPO network- Blue Dental members have unmatched access to PPO (in-network) dentists through the Blue Dental PPO network, which offers more than 535,000 dentist locations* nationwide. PPO dentists agree to accept our approved amount as full payment for covered services, and members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152.**

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

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

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

Eligibility information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Unmarried** dependent children: related to you by birth, marriage, legal adoption or legal guardianship, eligible for dental coverage through the last day of the month the dependent turns age 26, provided all eligibility requirements are met

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

Benefits	Coverage
Deductible	None
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services	None (covered at 100%)
• Class II services	20%
• Class III services	40%
• Class IV services	40%
Dollar maximums • Annual maximum for Class I, II and III services	$1,800 per member
• Lifetime maximum for Class IV services	$1,800 per member

Class I services

Benefits	Coverage
Oral exams	100% of approved amount **Note:** Twice per calendar year
A set (up to 4 films) of bitewing x-rays	100% of approved amount **Note:** Twice per calendar year
Panoramic or full-mouth x-rays	100% of approved amount **Note:** Once every 60 months
Prophylaxis (cleaning)	100% of approved amount **Note:** Twice per calendar year
Pit and fissure sealants - for members age 14 and younger	100% of approved amount **Note:** Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Emergency palliative treatment	100% of approved amount
Fluoride treatments	100% of approved amount **Note:** Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	100% of approved amount **Note:** Once per quadrant per lifetime

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	100% of approved amount, replacement fillings covered after 12 months or more after initial filling
Fillings - primary (child) teeth	100% of approved amount **Note:** Replacement fillings covered after 12 months or more after initial filling
Recementation of crowns, veneers, inlays, onlays and bridges	100% of approved amount **Note:** Three times per tooth per calendar year after six months from original restoration
Oral surgery	100% of approved amount
Root canal treatment	80% of approved amount **Note:** Once per tooth per lifetime; retreatment of previous root canal therapy (after 12 months from the date of the original therapy) once per tooth per lifetime.
Scaling and root planing	80% of approved amount **Note:** Once every 24 months per quadrant
Limited occlusal adjustments	80% of approved amount, **Limited** occlusal adjustments covered once every 36 months
Occlusal biteguards	80% of approved amount, **limited** occlusal adjustments covered once per lifetime
General anesthesia or IV sedation	100% of approved amount **Note:** When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	100% of approved amount **Note:** Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	100% of approved amount **Note:** Once per arch in any 36 consecutive months
Tissue conditioning	80% of approved amount **Note:** Once per arch in any 36 consecutive months

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	60% of approved amount **Note:** Once every 60 months

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Benefits	Coverage
Bridges (fixed partial dentures) - for members age 16 and older	60% of approved amount **Note:** Once every 60 months
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	60% of approved amount **Note:** Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31
Inlays, onlays, crowns and veneer fillings - permanent teeth - for members **under 19 years of age**	60% of approved amount, once every 36 months per tooth
Inlays, onlays, crowns and veneer fillings - permanent teeth - for members **age 19 and above**	60% of approved amount, once every 60 months per tooth

Class IV services

Benefits	Coverage
Minor treatment for tooth guidance appliances	60% of approved amount
Minor treatment to control harmful habits	60% of approved amount
Interceptive and comprehensive orthodontic treatment	60% of approved amount
Post-treatment stabilization	60% of approved amount
Cephalometric film (skull) and diagnostic photos	60% of approved amount

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.

Vision 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.

Essential Vision benefits are provided by Heritage Vision Plans. Heritage Vision Plans is an independent company providing vision benefit services for Blues members. To find a Heritage Vision Plans network provider, call **1-800-252-2053** or visit Heritage Vision Plans online at **heritagevisionplans.com**.

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

Member's responsibility (copays)

Benefits	Network doctor	Non-network 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	Network doctor	Non-network 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 $35 less $5 copay (member responsible for any difference)
	One eye exam in any period of 12 **consecutive** months	

Lenses and frames

Benefits	Network doctor	Non-network 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. **Note:** Preferred pricing discounts on noncovered lens options and upgrades, and on an additional prescription eyeglass or sunglass (second pair) purchase when obtained from a network provider.	$7.50 copay (one copay applies to **both** lenses and frames) One pair of lenses, with or without frames, in any period of 12 **consecutive** months	Reimbursement up to approved amount based on lens type less $7.50 copay (member responsible for any difference)
Standard frames	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $7.50 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $45 after a $7.50 copay (member responsible for any difference)
	One frame in any period of 12 **consecutive** months	

Contact lenses

Benefits	Network doctor	Non-network provider
Medically necessary contact lenses (requires prior authorization approval from Heritage and must meet criteria of medically necessary)	$7.50 copay	Reimbursement up to approved amount 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)	$35 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance	$35 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 when services are rendered by a Heritage network provider.	

ADM PLANYR JAN;ASCMOD 10270MED;ASCMOD 5592 DEN;ASCMOD 9324 VIS;BLUE DENTAL;CDC-DC 26-ME;CDH-HSA;DHSAD1.5IN3KONA;DO-PPO;ESS VIS;EVC $7.50;EVFL;HEQ;PDTTC104080RXCM;PK536;PREV-DM RX ASC;SB-HSA-AMB ASC;SB-HSA-OT ASC;SBD HSA ASC;SBD HSA OLV ASC;SBDHSAC0IN20ONA;SBDHSAOCSM24ASC;SBHSA-D-DPP-ASC;SBHSAD-ECMP ASC;XVA-2 ASC

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