



Blue Cross
Blue Shield
of Michigan

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

ROCHESTER COMMUNITY SCHOOL DISTRICT 0070048180044 - OCN81 Effective Date: 01/01/2026

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	<ul style="list-style-type: none"> 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.	\$1,700 for a one-person contract \$3,400 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.	\$3,400 for a one-person contract \$6,800 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)	None	<ul style="list-style-type: none"> 20% of approved amount for most covered services
Note: Coinsurance amounts apply once the deductible has been met.		
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

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Benefits	In-network	Out-of-network
Voluntary sterilization of female reproductive organs	100% (no deductible or copay/coinsurance)	80% 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)	80% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Well-baby and Well-child visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> • 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.	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
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	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)

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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 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.	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
Note: For facility services See "Hospital Care"		

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Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	100% after in-network deductible	80% after out-of-network deductible
Unlimited days		
Note: Nonemergency services must be rendered in a participating hospital.		
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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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 	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 of male reproductive organs	100% after in-network deductible	80% after out-of-network deductible
Note: For voluntary sterilization of female reproductive organs, see "Preventive care services."		
Elective Abortion Services	Not covered	Not covered

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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	100% after in-network deductible	80% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
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		
Note: Facility services are covered in participating facilities only.		
Residential psychiatric treatment facility: <ul style="list-style-type: none"> covered mental health services must be performed in a residential psychiatric treatment facility Treatment requires prior authorization subject to medical criteria 	100% after in-network deductible	80% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> Facility and clinic 	100% after in-network deductible	100% after in-network deductible
Note: Facility services are covered in participating facilities only.		
<ul style="list-style-type: none"> Online visits 	100% after in-network deductible	80% after out-of-network deductible
Note: Online visits by a non-BCBSM selected vendor are not covered.		
<ul style="list-style-type: none"> 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 - subject to prior authorization	100% after in-network deductible	80% after out-of-network deductible
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).		Note: Services rendered by an approved licensed behavior analyst (LBA) will apply the in-network cost-sharing.

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Benefits	In-network	Out-of-network
Outpatient physical therapy, speech therapy and occupational therapy 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 nutritional counseling and mental health services, for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP)	100% after in-network deductible	80% after out-of-network deductible
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.		
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	100% after in-network deductible	100% after in-network deductible
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.		
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 BlueSM HSA PPO with Rx ASC

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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)

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 required 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

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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
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
	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
Generic specialty drugs	1 to 30-day period	Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs After deductible is met, you pay \$10 copay 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 After deductible is met, you pay \$40 copay 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 After deductible is met, you pay \$80 copay 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 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

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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
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 service center for additional information and list of drugs.	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	<p>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.</p> <ul style="list-style-type: none"> • 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 than 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	<p>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.</p>
Maximum allowable cost drugs	<p>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.</p> <p>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.</p> <p>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.</p>
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.

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Dental 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.

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 PPO, you can choose any licensed dentist anywhere. However, you'll get the best coverage and save the most money when you choose a Tier 1 PPO (in-network) dentist.

You have outstanding access to thousands of Tier 1 PPO dentists across the country 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**.

If you go to a non-PPO dentist, you can still save money by choosing a Tier 2 participating non-PPO (out-of-network) dentist. Tier 2 dentists participate with us on a "per claim" basis through our Blue Par Select (BPS) arrangement. They accept our BPS approved amount as full payment for covered services, so you'll pay your applicable coinsurance and deductible amounts. To find a Tier 2 participating non-PPO dentist near you, log into your member account at bcbsm.com. You should ask your dentist if they participate with BCBSM before every treatment.

Note: If you go to a nonparticipating dentist, you are responsible for any difference between our approved amount and the dentist's charge.

Eligibility information

Member	Eligibility Criteria
Dependents	<ul style="list-style-type: none"> Subscriber's legal spouse Dependent children and disabled unmarried children: related to you by birth, marriage, legal adoption or legal guardianship; eligible for dental coverage through the end of the month in which they turn 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)	None (covered at 100%)
<ul style="list-style-type: none"> Class I services 	
<ul style="list-style-type: none"> Class II services 	20%
<ul style="list-style-type: none"> Class III services 	40%
<ul style="list-style-type: none"> Class IV services 	40%
Dollar maximums	\$1,800 per member
<ul style="list-style-type: none"> Annual maximum for Class I, II and III services 	
<ul style="list-style-type: none"> 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

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Benefits	Coverage
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. This period begins on the date of the member's first treatment.
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
Periodontic maintenance in combination with prophylaxes (cleanings)	100% of approved amount

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 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.

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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	\$7.50 copay	Member responsible for difference between approved amount and provider's charge, after \$7.50 copay

Note: No copay is required for prescribed contact lenses that are not medically necessary.

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.	\$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)
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.	One pair of lenses, with or without frames, in any period of 12 consecutive months	
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

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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.		

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