



Blue Cross
Blue Shield
of Michigan

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

ROCHESTER COMMUNITY SCHOOLS

0070048180007 - 0CN22

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

| Members | 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 through the last day of the month the dependent turns age 26 |

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

| Benefits | In-network | Out-of-network |
|---|---|--|
| Deductible | \$1,000 for one member, \$2,000 for the family (when two or more members are covered under your contract) each calendar year Note: Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office. | \$2,000 for one member, \$4,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network deductible amounts also count toward the in-network deductible. |
| Flat-dollar copays | <ul style="list-style-type: none"> \$20 copay for office visits and office consultations \$20 copay for medical online visits \$250 copay for emergency room visits \$20 copay for urgent care visits | <ul style="list-style-type: none"> \$250 copay for emergency room visits |
| Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met. | <ul style="list-style-type: none"> 30% of approved amount for private duty nursing care 10% of approved amount for mental health care and substance use disorder treatment 10% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office) | <ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 30% of approved amount for mental health care and substance use disorder treatment 30% of approved amount for most other covered services |
| Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but does not apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts | \$1,500 for one member, \$3,000 for the family (when two or more members are covered under your contract) each calendar year | \$3,000 for one member, \$6,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum. |

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| Benefits | In-network | Out-of-network |
|---|---|--|
| 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 | \$6,350 for one member, \$12,700 for the family (when two or more members are covered under your contract) each calendar year | \$12,700 for one member, \$25,400 for the family (when two or more members are covered under your contract) each calendar year 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 Note: Additional well-women visits may be allowed based on medical necessity. | Not covered |
| Gynecological exam | 100% (no deductible or copay/coinsurance), two per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity. | Not covered |
| Pap smear screening - laboratory and pathology services | 100% (no deductible or copay/coinsurance), one per member per calendar year | Not covered |
| Voluntary sterilization of female reproductive organs | 100% (no deductible or copay/coinsurance) | 70% 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) | 70% 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 |

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| Benefits | In-network | Out-of-network |
|--|---|--|
| 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. | 70% 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. | 70% after out-of-network deductible |
| One 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 Note: This includes mental health and substance use disorder services equivalent to medical office visits. | \$20 copay per office visit | 70% 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. | \$20 copay per online visit | 70% after out-of-network deductible |
| Outpatient and home medical care visits - must be medically necessary | 90% after in-network deductible | 70% after out-of-network deductible |
| Office consultations - must be medically necessary | \$20 copay per office consultation | 70% after out-of-network deductible |
| Urgent care visits - must be medically necessary | \$20 copay per urgent care visit | 70% after out-of-network deductible |

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Emergency medical care

| Benefits | In-network | Out-of-network |
|--|--|--|
| Hospital emergency room | \$250 copay per visit (copay waived if admitted or for an accidental injury) | \$250 copay per visit (copay waived if admitted or for an accidental injury) |
| Ambulance services - must be medically necessary | 90% after in-network deductible | 90% after in-network deductible |

Diagnostic services

| Benefits | In-network | Out-of-network |
|-----------------------------------|---------------------------------|-------------------------------------|
| Laboratory and pathology services | 90% after in-network deductible | 70% after out-of-network deductible |
| Diagnostic tests and x-rays | 90% after in-network deductible | 70% after out-of-network deductible |
| Therapeutic radiology | 90% after in-network deductible | 70% 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) | 70% after out-of-network deductible |
| Postnatal care visit | 100% (no deductible or copay/coinsurance) | 70% after out-of-network deductible |
| Delivery and nursery care | 90% after in-network deductible | 70% after out-of-network deductible |
| Note: For facility services See "Hospital Care" | | |

Hospital care

| Benefits | In-network | Out-of-network |
|--|---------------------------------|-------------------------------------|
| Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies | 90% after in-network deductible | 70% after out-of-network deductible |
| Note: Nonemergency services must be rendered in a participating hospital. | Unlimited days | |
| Inpatient consultations | 90% after in-network deductible | 70% after out-of-network deductible |
| Chemotherapy | 90% after in-network deductible | 70% 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 | 90% after in-network deductible | 90% after in-network deductible |
| | Limited to a maximum of 120 days per member per calendar year | |

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| Benefits | In-network | Out-of-network |
|--|--|---|
| Hospice care | 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) | 100% (no deductible or copay/coinsurance) |
| Home health care: <ul style="list-style-type: none"> must be medically necessary must be provided by a participating home health care agency | 90% after in-network deductible | 90% 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 | 90% after in-network deductible | 90% 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 | 90% after in-network deductible | 70% after out-of-network deductible |
| Presurgical consultations | 100% (no deductible or copay/coinsurance) | 70% after out-of-network deductible |
| Voluntary sterilization of male reproductive organs | 90% after in-network deductible | 70% after out-of-network deductible |
| Note: For voluntary sterilization of female reproductive organs, see "Preventive care services." | | |
| Elective Abortion Services | 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% (no deductible or copay/coinsurance) | 100% (no deductible or copay/coinsurance) - in designated facilities only |
| Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) | 90% after in-network deductible | 70% after out-of-network deductible |
| Specified oncology clinical trials | 90% after in-network deductible | 70% after out-of-network deductible |
| Note: BCBSM covers clinical trials in compliance with PPACA. | | |
| Kidney, cornea and skin transplants | 90% after in-network deductible | 70% after out-of-network deductible |

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Behavioral Health Services (Mental Health and Substance Use Disorder)

Note: Some mental health and substance use disorder services are considered by BCBSM to be equivalent to an office visit or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be equivalent to an office visit or medical online visit, we will process the claim under your Physician Office Services.

| Benefits | In-network | Out-of-network |
|---|---------------------------------|---|
| Inpatient mental health care and inpatient substance use disorder treatment | 90% after in-network deductible | 70% after out-of-network deductible |
| Unlimited days | | |
| <p>Note: Facility services are covered in participating facilities only.</p> <p>Residential psychiatric treatment facility:</p> <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 | 90% after in-network deductible | 70% after out-of-network deductible |
| <p>Outpatient mental health care:</p> <ul style="list-style-type: none"> Facility and clinic <p>Note: Facility services are covered in participating facilities only.</p> <ul style="list-style-type: none"> Online visits - for services equivalent to a medical online visit <p>Note: Online visits by a non-BCBSM selected vendor are not covered.</p> <ul style="list-style-type: none"> Physician's office <p>Note: For services equivalent to a medical office visit. See "Physician Office Services".</p> | 90% after in-network deductible | 90% after in-network deductible |
| Outpatient substance use disorder treatment - in approved facilities only | 90% after in-network deductible | 70% 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 | \$20 copay per office visit | 70% after out-of-network deductible |
| <p>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).</p> | | <p>Note: Services rendered by an approved licensed behavior analyst (LBA) will apply the in-network cost-sharing.</p> |
| Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder | 90% after in-network deductible | 70% 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 | 90% after in-network deductible | 70% after out-of-network deductible |

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Other covered services

| Benefits | In-network | Out-of-network |
|---|--|---|
| <p>Outpatient Diabetes Management Program (ODMP)</p> <p>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.</p> <p>Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.</p> | <ul style="list-style-type: none"> 90% after in-network deductible for diabetes medical supplies 100% (no deductible or copay/coinsurance) for diabetes self-management training | 70% after out-of-network deductible |
| Allergy testing and therapy | 100% (no deductible or copay/coinsurance) | 70% after out-of-network deductible |
| Chiropractic spinal manipulation and osteopathic manipulative therapy | 100% (no deductible or copay/coinsurance) | 70% 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 | 90% after in-network deductible | 70% 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 | 90% after in-network deductible | 90% 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 | 90% after in-network deductible | 90% after in-network deductible |
| Private duty nursing care | 70% after in-network deductible | 50% after out-of-network deductible |

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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.

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

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

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

Specialty Pharmaceutical Drugs - The preferred pharmacy for specialty drugs is **Walgreens Specialty Pharmacy**. Specialty drugs are covered only when dispensed through the Walgreens Specialty Pharmacy or 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 provider* | In-network pharmacy (not part of the 90-day retail network) | Out-of-network pharmacy |
|----------------------------|---------------------|--------------------------------|---------------------------------|---|--|
| Generic drugs | 1 to 30-day period | You pay \$5 copay | You pay \$5 copay | You pay \$5 copay | You pay \$5 copay plus an additional 25% of BCBSM approved amount for the drug |
| | 31 to 83-day period | No coverage | You pay \$5 copay | No coverage | No coverage |
| | 84 to 90-day period | You pay \$5 copay | You pay \$5 copay | No coverage | No coverage |
| Preferred brand-name drugs | 1 to 30-day period | You pay \$35 copay | You pay \$35 copay | You pay \$35 copay | You pay \$35 copay plus an additional 25% of BCBSM approved amount for the drug |
| | 31 to 83-day period | No coverage | You pay \$35 copay | No coverage | No coverage |
| | 84 to 90-day period | You pay \$35 copay | You pay \$35 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 | You pay \$50 copay | You pay \$50 copay | You pay \$50 copay | You pay \$50 copay plus an additional 25% of BCBSM approved amount for the drug |
| | 31 to 83-day period | No coverage | You pay \$50 copay | No coverage | No coverage |
| | 84 to 90-day period | You pay \$50 copay | You pay \$50 copay | No coverage | No coverage |
| Generic specialty drugs | 1 to 30-day period | Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs You pay \$5 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 You pay \$35 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 You pay \$50 copay Note: No coverage for 31-90 day supply. | | | |

* 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 | 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 |

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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 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 | 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 |
| Note: Needles and syringes have no copay/coinsurance. | | | | |
| Select diabetic supplies and devices (test strips, lancets and glucometers) | 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 |
| For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy . | | | | |

* 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. |
| 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 Blue Cross 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 Blue Cross Pharmacy Services Department and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your copayment and/or deductible, if applicable.</p> |
| Over-the-counter drugs | Excludes benefits for certain over-the-counter drugs. |

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Features of your prescription drug plan

| | |
|-------------------|---|
| Quantity of drugs | Your prescription drug coverage has eliminated authorization requirements for select prescription drugs, and quantities of drugs. |
| 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 | 40% |
| <ul style="list-style-type: none"> Class III services | 40% |
| <ul style="list-style-type: none"> Class IV services | 40% |
| Dollar maximums | \$1,600 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 | \$1,600 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 | 60% of approved amount Note: Once per tooth per lifetime; retreatment of previous root canal therapy once per tooth per lifetime |
| Scaling and root planing | 60% of approved amount Note: Once every 24 months per quadrant |
| Limited occlusal adjustments | 60% of approved amount, Limited occlusal adjustments covered once every 36 months |
| Occlusal biteguards | 60% 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 | 60% 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

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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) |
| 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 | | |
| Contact lenses up to the allowance in any period of 12 consecutive months when services are rendered by a Heritage network provider. | | |

ADM DC26MEVIS;ADM PLANYR JAN;ASCMOD 2356;ASCMOD 5593 DEN;ASCMOD 6759;ASCMOD 9324 VIS;BLUE DENTAL;CB ASC;CB CNCR SUP ASC;CB-AMB ASC;CB-DPP-ASC;CB-ECM-IN\$1.5KA;CB-ECM-ON \$3K A;CB-ECMP-ASC;CB-ET \$250 ASC;CB-MTC \$0 ASC;CB-OPMIN 6350 A;CB-OV \$20 ASC;CBD \$1K-IN ASC;CBD \$2K-ON ASC;CBOLV 20 ASC;CBOPMON 12.7K A;CDC-DC 26-ME;DC 26-ME ASC;DO-PPO;ESS VIS;EVC \$7.50;EVFL;MOPD ASC;PD-ESN ASC;PDRX ASC;PDTTC 5/25/50 A;PK535;PRX-MM ASC;RX-90 ASC;RX-VCP ASC;RXGLP-1 EXCLUS;XBPPE ASC;XVA-2 ASC

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