



Blue Cross
Blue Shield
of Michigan

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

COUNTY OF ST CLAIR PULL DIV 0070062610040 - 0C1D8 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 end of the calendar year in which they turn age 19. Your unmarried dependent children eligible for coverage through the end of the calendar year in which they turn age 25, provided they meet eligibility criteria
Sponsored dependents	<ul style="list-style-type: none"> Dependents of the subscriber related by blood, marriage or legal adoption, over age 19 and not eligible as a dependent under the provisions of the subscriber's contract, provided the dependent meets all eligibility requirements. The subscriber is responsible for paying the cost of this coverage.

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

Benefits	In-network	Out-of-network
Deductible	<p>\$1,000 for one member, \$2,000 for the family (when two or more members are covered under your contract) each calendar year (no 4th quarter carry-over)</p> <p>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.</p>	<p>\$2,000 for one member, \$4,000 for the family (when two or more members are covered under your contract) each calendar year (no 4th quarter carry-over)</p> <p>Note: Out-of-network deductible amounts also count toward the in-network deductible.</p>
Flat-dollar copays	<ul style="list-style-type: none"> \$25 copay for office visits and office consultations \$25 copay for medical online visits \$20 copay for chiropractic and osteopathic manipulative therapy \$75 copay for emergency room visits \$25 copay for urgent care visits 	<ul style="list-style-type: none"> \$75 copay for emergency room visits
Coinsurance amounts (percent copays)	<ul style="list-style-type: none"> 30% of approved amount for private duty nursing care 20% of approved amount for mental health care and substance use disorder treatment 20% 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 40% of approved amount for mental health care and substance use disorder treatment 40% of approved amount for most other covered services
Annual coinsurance Maximum - applies to coinsurance for all covered services - including mental health and substance use disorder services - but <u>does not</u> apply to flat-dollar copays and private duty nursing coinsurance.	<p>\$1,500 for one member, \$3,000 for the family (when two or more members are covered under your contract) each calendar year</p> <p>Note: In-Network Coinsurance does not apply toward the out-of-network coinsurance maximum.</p>	<p>\$3,000 for one member, \$6,000 for the family (when two or more members are covered under your contract) each calendar year</p> <p>Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.</p>

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Benefits	In-network	Out-of-network
Annual dollar maximum	<ul style="list-style-type: none"> • \$250 maximum for preventive care 	
Lifetime dollar maximum	None	

Preventive care services

*Payment for all preventive services is limited to a combined maximum of \$250 per member per calendar year

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), one 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
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
Childhood immunizations as recommended by the Advisory Committee on Immunizations Practices or other sources as recognized by BCBSM	100% (no deductible or copay/coinsurance)	Not covered
Note: Immunizations for travel to foreign countries are not covered.		
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

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Mammography

Benefits	In-network	Out-of-network
Mammogram and related reading - routine and medically necessary	80% after in-network deductible	60% after out-of-network deductible Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.

One routine mammogram per member, per calendar year

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	\$25 copay per office visit	60% after out-of-network deductible
Note: This includes mental health and substance use disorder services equivalent to medical office visits.		
Online visits - by physician must be medically necessary	\$25 copay per online visit	60% after out-of-network deductible
Note: Online visits by a vendor are not covered. Not all services delivered virtually are considered an online visit, but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.		
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	\$25 copay per office consultation	60% after out-of-network deductible
Urgent care visits - must be medically necessary	\$25 copay per urgent care visit	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	\$75 copay per visit (copay waived if admitted or for an accidental injury)	\$75 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

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Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible
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	80% after in-network deductible	60% after out-of-network deductible
Note: Nonemergency services must be rendered in a participating hospital.		Unlimited days
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a participating skilled nursing facility	80% after in-network deductible Limited to a maximum of 120 days per member per calendar year	80% after in-network deductible
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: • must be medically necessary • must be provided by a participating home health care agency	80% after in-network deductible	80% 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 prior authorization - consult with your doctor	80% after in-network deductible	80% after in-network deductible

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Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Sterilization	80% after in-network deductible	60% after out-of-network deductible
Elective Abortion Services	80% after in-network deductible	60% after out-of-network deductible
Note: Abortions are not covered if rendered in a location where abortions are not legal.		
Colonoscopy	80% after in-network deductible	60% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities only
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials - excludes coverage for routine patient costs related to clinical trials	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

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.

Note: BCBSM will cover mental health services performed - MD, DO, Fully Licensed Psychologists and Clinical Licensed Master's Social Workers (CLMSWs), Limited Licensed Psychologists (LLPs), Licensed Professional Counselor, Social Workers who have the following social work degrees/certifications: MSSW, MMSW.

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance use disorder treatment	80% after in-network deductible	60% after out-of-network deductible
Unlimited days		
Note: Facility services are covered in participating facilities only.		
Residential psychiatric treatment facility:	80% after in-network deductible	60% after out-of-network deductible
<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 		
Outpatient mental health care:	80% after in-network deductible	80% after in-network deductible
<ul style="list-style-type: none"> Facility and clinic 		
Note: Facility services are covered in participating facilities only.		

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Benefits	In-network	Out-of-network
<ul style="list-style-type: none"> Online visits - for services equivalent to a medical online visit <p>Note: Online visits by a vendor are not covered.</p>	\$25 copay per online visit	60% after out-of-network deductible
Physician's office	80% after in-network deductible	60% after out-of-network deductible
Note: For services equivalent to a medical office visit. See " Physician Office Services ".		
Outpatient substance use disorder treatment - in approved facilities only	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavior analysis (ABA) treatment - subject to prior authorization	\$25 copay per office visit	60% 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.
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible
	Physical, speech and occupational therapy with an autism diagnosis is unlimited	
Other covered services, including nutritional counseling and mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP)	80% after in-network deductible	60% after out-of-network deductible
Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.		
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$20 copay per visit	60% 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	80% after in-network deductible	60% 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	

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Benefits	In-network	Out-of-network
Durable medical equipment	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	70% after in-network deductible	50% after out-of-network deductible

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Preferred Rx Program ASC

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

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

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

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

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

If you have additional questions, you can call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that Blue Cross defines as a "specialty pharmaceutical". We may make exceptions if a member requires more than a 30-day supply. Blue Cross reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay or coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

- 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 or select prescribed over-the-counter drugs	1 to 30-day period	You pay \$15 copay	You pay \$15 copay	You pay \$15 copay	You pay \$15 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$30 copay	No coverage	No coverage
	84 to 90-day period	You pay \$30 copay	You pay \$30 copay	No coverage	No coverage
Preferred 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 \$100 copay	No coverage	No coverage
	84 to 90-day period	You pay \$100 copay	You pay \$100 copay	No coverage	No coverage
Nonpreferred brand-name drugs	1 to 30-day period	You pay \$100 copay	You pay \$100 copay	You pay \$100 copay	You pay \$100 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$200 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
84 to 90-day period	You pay \$200 copay	You pay \$200 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	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
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	No coverage	No coverage	No coverage	No coverage
Prescription contraceptive medication	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.

ADM HCR-EXEMPT;ADM PLANYR JAN;ASCMOD 10981MED;ASCMOD 11300DRG;ASCMOD 6605 MED;CB ASC;CB-AMB ASC;CB-DPP-ASC;CB-ECMP-ASC;CB-ET \$75 ASC;CB-MTC \$20 ASC;CB-OV \$25 ASC;CB-PCB-XHCR ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBCICSASC;CBCMIN 1500 ASC;CBCMON 3000 ASC;CBD \$1K-IN ASC;CBD \$2K-ON ASC;CBPCDCSASC;PD-HCR-X ASC;PD-XID-1 ASC;PDCM-CS-ASC;PDRX ASC;PDTTC104080RXCX;RX-VCP ASC;RXGLP-1 EXCLUS;SD ASC;SOCT-XHCR-ASC;XCD ASC

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Features of your prescription drug plan

Custom Drug List

A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.

- **Generic drug tier** - This tier includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment.
- **Preferred brand-name drug tier** - This tier includes non-specialty preferred brand-name drugs. These drugs are more expensive 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

A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require prior authorization or step therapy are available online site at bcbsm.com/pharmacy.

Maximum allowable cost drugs

For maximum allowable cost (MAC) Drugs, if you have a prescription filled by an in-network pharmacy, and the pharmacist fills it with a generic equivalent drug, you are required to pay only the copayment and/or deductible, if applicable.

If you obtain a brand name drug when a generic equivalent drug is available, you must pay the difference between the maximum allowable cost and the BCBSM approved amount for the brand name drug plus your copayment and/or deductible, if applicable.

Note: If your physician requests and receives authorization for a brand name drug from BCBSM's Pharmacy Services Department and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your copayment and/or deductible, if applicable.

Quantity limits

To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

Impotence drugs

Benefits are excluded for impotence drugs.

GLP-1 Products

GLP-1 products for conditions other than diabetes are not covered.

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