



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

BRONZE PLAN WITH HIGH DENTAL

AUTO RETIREE VEBA TRUST 62628004 0070416420003 - 05NDG Effective Date: 01/01/2016

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at bcbsm.com/importantinfo. Select **Approving covered services**.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

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

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.	\$2,000 for a one-person contract \$4,000 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)	\$4,000 for a one-person contract \$8,000 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)
Flat-dollar copays	See "Prescription Drugs" section	See "Prescription Drugs" section
Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.	20% of approved amount for most covered services	40% of approved amount for most covered services
Annual out-of-pocket maximums - applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts	\$3,000 for a one-person contract \$6,000 for a family contract (2 or more members) each calendar year	\$6,000 for a one-person contract \$12,000 for a family contract (2 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), 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
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible

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Benefits	In-network	Out-of-network
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and child care 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.	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 per member per calendar year
Routine screening colonoscopy	100% (no deductible or copay/coinsurance) for routine colonoscopy Note: Medically necessary colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible
		One routine colonoscopy per member per calendar year

Physician office services		
Benefits	In-network	Out-of-network
Office visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Online visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Note: Online visits by a non-BCBSM selected vendor are not covered		
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	80% after in-network deductible	60% after out-of-network deductible

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Benefits	In-network	Out-of-network
Urgent care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible

Emergency medical care		
Benefits	In-network	Out-of-network
Hospital emergency room	80% after in-network deductible	80% after in-network deductible
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

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

Maternity services provided by a physician or certified nurse midwife		
Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care	80% after in-network deductible	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

Hospital care		
Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	80% after in-network deductible	60% after out-of-network deductible
		Unlimited days
Note: Nonemergency services must be rendered in a participating hospital.		
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care		
Benefits	In-network	Out-of-network
Skilled nursing care - must be in a participating skilled nursing facility	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	

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Benefits	In-network	Out-of-network
Hospice care	80% after in-network deductible	80% 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 	80% after in-network deductible	80% 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 preauthorization - consult with your doctor 	80% after in-network deductible	80% after in-network deductible

Surgical services		
Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	80% after in-network deductible	60% after out-of-network deductible
Voluntary sterilization for males	80% after in-network deductible	60% after out-of-network deductible
Note: For voluntary sterilizations for females, see " Preventive care services. "		
Elective abortions	Not covered	Not covered

Human organ transplants		
Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	80% 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)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Mental health care and substance use disorder treatment		
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	
Residential psychiatric treatment facility: <ul style="list-style-type: none"> covered mental health services must be performed in a residential psychiatric treatment facility treatment must be preauthorized subject to medical criteria 	80% after in-network deductible	60% after out-of-network deductible

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Benefits	In-network	Out-of-network
Outpatient mental health care: • Facility and clinic	80% after in-network deductible	80% after in-network deductible in participating facilities only
• Online visits Note: Online visits by a non-BCBSM selected vendor are not covered	80% after in-network deductible	60% after out-of-network deductible
• Physician's office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities only	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	80% after in-network deductible	80% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after in-network deductible Physical, speech and occupational therapy with an autism diagnosis is unlimited	60% after out-of-network deductible
Other covered services, including 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) 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.	80% after in-network deductible	60% after out-of-network deductible
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	80% after in-network deductible Limited to a combined 12-visit maximum per member per calendar year	60% after out-of-network deductible
Outpatient physical, speech and occupational therapy - provided for rehabilitation	80% after in-network deductible Limited to a combined 30-visit maximum per member per calendar year	60% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.

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Benefits	In-network	Out-of-network
Durable medical equipment Note: DME items 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. For a list of covered DME items required under PPACA, call BCBSM.	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	80% after in-network deductible	80% after in-network deductible

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Simply Blue HSA with Prescription Drugs

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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

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

Member's responsibility (copays and coinsurance amounts)

Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual out-of-pocket maximum required under your Simply Blue HSA medical coverage. Benefits are not payable until you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are 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
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	After deductible is met, you pay \$15 copay	After deductible is met, you pay \$15 copay	After deductible is met, you pay \$15 copay	After deductible is met, you pay \$15 copay plus an additional 20% of the BCBSM approved amount
	31 to 83-day period	No coverage	After deductible is met, you pay \$30 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay \$30 copay	After deductible is met, you pay \$30 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	After deductible is met, you pay \$50 copay	After deductible is met, you pay \$50 copay	After deductible is met, you pay \$50 copay	After deductible is met, you pay \$50 copay plus an additional 20% of the BCBSM approved amount
	31 to 83-day period	No coverage	After deductible is met, you pay \$100 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	84 to 90-day period	After deductible is met, you pay \$100 copay	After deductible is met, you pay \$100 copay	No coverage	No coverage
	1 to 30-day period	After deductible is met, you pay \$70 or 50% of the approved amount (whichever is greater), but no more than \$100	After deductible is met, you pay \$70 or 50% of the approved amount (whichever is greater), but no more than \$100	After deductible is met, you pay \$70 or 50% of the approved amount (whichever is greater), but no more than \$100	After deductible is met, you pay \$70 copay or 50% of the approved amount (whichever is greater), but no more than \$100 plus an additional 20% of the BCBSM 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
31 to 83-day period	No coverage	After deductible is met, you pay \$140 or 50% of the approved amount (whichever is greater), but no more than \$200	No coverage	No coverage
84 to 90-day period	After deductible is met, you pay \$140 or 50% of the approved amount (whichever is greater), but no more than \$200	After deductible is met, you pay \$140 or 50% of the approved amount (whichever is greater), but no more than \$200	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs * BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Covered services				
Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Prescribed over-the-counter drugs - when covered by BCBSM	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
State-controlled drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
FDA-approved generic and select brand-name prescription preventive drugs, supplements and vitamins as required by PPACA	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

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
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

* 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"> • Tier 1 (generic) - Tier 1 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. • Tier 2 (preferred brand) - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. • Tier 3 (nonpreferred brand) - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these 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 preauthorization) will be covered. Step Therapy, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at bcbsm.com/pharmacy.</p>
Drug interchange and generic copay/ coinsurance waiver	<p>BCBSM's drug interchange and generic copay/coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent.</p> <p>If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/ coinsurance. In select cases BCBSM may waive the initial copay/coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.</p>

Features of your prescription drug plan

Mandatory maximum allowable cost drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the difference in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug plus your applicable copay regardless of whether you or your physician requests the brand name drug. Exception: If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, You pay only your applicable copay. Note: This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

Vision Coverage

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Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com**.

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

Note: Discounts up to 20% for additional prescription glasses and any amount over the allowance **plus** savings on non-covered lens extras (up to 25%) when obtained from a VSP provider

Member's responsibility (copays)		
Benefits	VSP network doctor	Non-VSP provider
Eye exam	\$10 copay	\$10 copay applies to charge
Prescription glasses (lenses and/or frames)	Combined \$15 copay	Member responsible for difference between approved amount and provider's charge, after \$15 copay
Medically necessary contact lenses	\$15 copay	Member responsible for difference between approved amount and provider's charge, after \$15 copay
Note: No copay is required for prescribed contact lenses that are not medically necessary.		

Eye exam		
Benefits	VSP network doctor	Non-VSP 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.	\$10 copay	Reimbursement up to \$45 less \$10 copay (member responsible for any difference)
One eye exam in any period of 12 consecutive months		

Lenses and frames		
Benefits	VSP network doctor	Non-VSP 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.	\$15 copay (one copay applies to both lenses and frames)	Reimbursement up to approved amount based on lens type less \$15 copay (member responsible for any difference)
<ul style="list-style-type: none"> Progressive Lenses - Covered when rendered by a VSP network doctor 	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)	Reimbursement up to \$70 less \$15 copay (member responsible for any difference)
Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.		
One frame in any period of 24 consecutive months		

Contact Lenses		
Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	\$15 copay	Reimbursement up to \$210 less \$15 copay (member responsible for any difference)
Contact lenses up to the allowance in any period of 12 consecutive months		

Benefits	VSP network doctor	Non-VSP provider
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	\$130 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	\$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)



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Dental High Plan Dental Coverage Effective Date: On or after April 2020 Benefits-at-a-glance

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.

Network access information

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

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

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

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

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

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

Benefits	Coverage
Deductible <ul style="list-style-type: none"> Applies to Class II and Class III services only 	\$50 per member per calendar year
Coinsurance (percentage of BCBSM's approved amount for covered services) <ul style="list-style-type: none"> Class I services Class II services Class III services Class IV services 	None (covered at 100%) 20% 50% 50%
Dollar maximums <ul style="list-style-type: none"> Annual maximum for Class I, II and III services Lifetime maximum for Class IV services 	\$3,000 per member \$2,500 per member

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Class I services

Benefits	Coverage
Oral exams	100% of approved amount Note: Twice per calendar year
A set (up to 4 films) of bitewing x-rays	100% of approved amount Note: Twice per calendar year
Panoramic or full-mouth x-rays	100% of approved amount Note: Once every 60 months
Prophylaxis (cleaning)	100% of approved amount Note: Twice per calendar year
Sealants - for members age 19 and younger	100% of approved amount Note: Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Emergency palliative treatment	100% of approved amount
Fluoride treatments	100% of approved amount Note: Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	100% of approved amount Note: Once per quadrant per lifetime

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	80% of approved amount after deductible Note: Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	80% of approved amount after deductible Note: Replacement fillings covered after 12 months or more after initial filling
Crowns, onlays, inlays, and veneer restorations - permanent teeth - for members age 12 and older	80% of approved amount after deductible Note: Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	80% of approved amount after deductible Note: Three times per tooth per calendar year after six months from original restoration
Oral surgery	80% of approved amount after deductible
Root canal treatment	80% of approved amount after deductible Note: Once every 12 months
Scaling and root planing	80% of approved amount after deductible Note: Once every 24 months per quadrant
Limited occlusal adjustments	80% of approved amount after deductible Note: Limited occlusal adjustments covered up to five times in any 60 consecutive months
Occlusal biteguards	80% of approved amount after deductible Note: Once every 12 months
General anesthesia or IV sedation	80% of approved amount after deductible Note: When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	80% of approved amount after deductible Note: Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	80% of approved amount after deductible Note: Once per arch in any 36 consecutive months
Tissue conditioning	80% of approved amount after deductible Note: Once per arch in any 36 consecutive months

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Class III services

Benefits	Coverage
Removable dentures (complete and partial)	50% of approved amount after deductible Note: Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	50% of approved amount after deductible Note: Once every 60 months
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount after deductible Note: Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services - Orthodontic services for dependents under age 19

Benefits	Coverage
Minor treatment for tooth guidance appliances	50% of approved amount
Minor treatment to control harmful habits	50% of approved amount
Interceptive and comprehensive orthodontic treatment	50% of approved amount
Post-treatment stabilization	50% of approved amount
Cephalometric film (skull) and diagnostic photos	50% 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.