

Professional Emergency Care
AOA-0000365155
Simply Blue℠ HSA PPO with Rx Embedded Cost-Sharing SG
Effective Date: On or after January 2027
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.

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

Eligibility information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Dependent children**: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage until the end of the year in which they turn age 26

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

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

Benefits	In-network	Out-of-network
Deductibles **Note:** Your deductible **combines** deductible amounts paid under your Simply Blue HSA medical coverage **and** your Simply Blue prescription drug coverage. **Note:** Two or more members must meet the family deductible. If the one-member deductible has been met, but not the family deductible, we will pay for covered services only for that member who has met the deductible. Covered services for the remaining family members will be paid when the full family deductible has been met.	$5,500 per member, $11,000 for the family (when two or more members are covered under your contract) each calendar year **(no 4th quarter carry-over)**	$11,000 per member, $22,000 for the family (when two or more members are covered under your contract) 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.	• 50% of approved amount for bariatric surgery	• 20% of approved amount for most other covered services • 50% of approved amount for bariatric surgery
Annual out-of-pocket maximums - applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts	$8,000 per member, $16,000 for the family (when two or more members are covered under your contract) each calendar year	$16,000 per member, $32,000 for the family (when two or more members are covered under your contract) each calendar year
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), two per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered

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

Benefits	In-network	Out-of-network
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)	80% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Well-baby and Well-child visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
	One per member per calendar year	
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible
	One routine colonoscopy per member per calendar year	

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

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary **Note: Virtual Primary Care** visits by a non-BCBSM selected vendor are not covered.	• 100% after in-network deductible for each office visit (in person or virtual) • 100% after in-network deductible for each **virtual primary care** visit for members 18 years of age or older, by a BCBSM selected vendor	80% after out-of-network deductible
Online visits - by physician or **BCBSM** selected vendor must be medically necessary **Note:** Online visits by a non-BCBSM selected vendor are not covered. Not all services delivered virtually are considered an online visit, but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

Emergency medical care

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

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Postnatal care	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Delivery and nursery care **Note:** For facility services See "Hospital Care"	100% after in-network deductible	80% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a **participating** skilled nursing facility	100% after in-network deductible	100% after in-network deductible
	Limited to a maximum of 90 days per member per calendar year	
Hospice care	100% after in-network deductible	100% after in-network deductible
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home healthcare: • must be medically necessary • must be provided by a **participating** home healthcare agency	100% after in-network deductible	100% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require prior authorization - consult with your doctor	100% after in-network deductible	100% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization of male reproductive organs **Note:** For voluntary sterilization of female reproductive organs, see **"Preventive care services."**	100% after in-network deductible	80% after out-of-network deductible
Elective Abortion Services	Not covered	Not covered
Bariatric surgery	50% after in-network deductible	50% after out-of-network deductible
	Limited to a **lifetime** maximum of one bariatric procedure per member	

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

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	100% after in-network deductible
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	100% after in-network deductible	80% after out-of-network deductible
Cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-network	Out-of-network
Inpatient mental healthcare and **inpatient** substance use disorder treatment **Note:** Facility services are covered in participating facilities only.	100% after in-network deductible Unlimited days	80% after out-of-network deductible
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential treatment facility • treatment requires prior authorization • subject to medical criteria	100% after in-network deductible	80% after out-of-network deductible
Outpatient mental healthcare: • Facility and clinic **Note:** Facility services are covered in participating facilities only.	100% after in-network deductible	100% after in-network deductible
• Online visits **Note:** Online visits by a non-BCBSM selected vendor are not covered	100% after in-network deductible	80% after out-of-network deductible
• Physician's office	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	100% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavior analysis (ABA) treatment - subject to prior authorization **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).	100% after in-network deductible	80% after out-of-network deductible **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	100% after in-network deductible Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	80% after out-of-network deductible

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

Benefits	In-network	Out-of-network
Other covered services, including nutritional counseling and mental health services, for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **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 a network provider. **Note:** Continuous glucose monitors and related supplies are covered only when obtained from the BCBSM designated exclusive vendor.	100% after in-network deductible	80% after out-of-network deductible
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible
Rehabilitative care: • Outpatient physical and occupational therapy	100% after in-network deductible	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
• Chiropractic and osteopathic manipulation	100% after in-network deductible	80% after out-of-network deductible
	Limited to a 30-visit maximum per member per calendar year **Note: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy.**	
Outpatient speech therapy - when provided for rehabilitative care	100% after in-network deductible	80% after out-of-network deductible
	Limited to a 30-visit maximum per member per calendar year	
Habilitative care: Outpatient physical and occupational therapy (excludes chiropractic and osteopathic manipulation)	100% after in-network deductible	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a 30-visit maximum per member per calendar year **Note: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical and occupational therapy**	
Outpatient speech therapy - when provided for habilitative care	100% after in-network deductible	80% after out-of-network deductible
	Limited to a 30-visit maximum per member per calendar year	
Durable medical equipment **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers. **Note:** DME items required under the preventive benefit provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	100% after in-network deductible	80% after out-of-network deductible

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

Benefits	In-network	Out-of-network
Prosthetic and orthotic appliances **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers.	100% after in-network deductible	80% after out-of-network deductible
Private duty nursing care	Not covered	Not covered

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

Professional Emergency Care
AOA-0000365155
Simply Blue℠ HSA PPO with Rx Embedded Cost-Sharing SG
Effective Date: On or after January 2027
Benefits-at-a-glance

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)

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 after 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 20% member liability for covered drugs obtained from an out-of-network pharmacy will not contribute to your annual out-of-pocket maximum.

Benefits		90-day retail network pharmacy	In-network mail order pharmacy*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Generic drugs	1 to 30-day period	After deductible, you pay $20 copay	After deductible, you pay $20 copay	After deductible, you pay $20 copay	After deductible, you pay $20 copay plus an additional 20% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible, you pay $40 copay	No coverage	No coverage

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Benefits		90-day retail network pharmacy	In-network mail order pharmacy*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
	61 to 83-day period	No coverage	After deductible, you pay $50 copay	No coverage	No coverage
	84 to 90-day period	After deductible, you pay $50 copay	After deductible, you pay $50 copay	No coverage	No coverage
Preferred brand-name drugs	1 to 30-day period	After deductible, you pay $100 copay	After deductible, you pay $100 copay	After deductible, you pay $100 copay	After deductible, you pay $100 copay plus an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible, you pay $200 copay	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible, you pay $290 copay	No coverage	No coverage
	84 to 90-day period	After deductible, you pay $290 copay	After deductible, you pay $290 copay	No coverage	No coverage
Nonpreferred brand-name drugs	1 to 30-day period	After deductible, you pay $150 copay	After deductible, you pay $150 copay	After deductible, you pay $150 copay	After deductible, you pay $150 copay plus an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible, you pay $300 copay	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible, you pay $440 copay	No coverage	No coverage
	84 to 90-day period	After deductible, you pay $440 copay	After deductible, you pay $440 copay	No coverage	No coverage
Generic and preferred brand-name specialty drugs	1 to 30-day period	**Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs** After deductible, you pay 20% of approved amount, but no more than $300 **Note:** No coverage for 31-90 day supply.			
Nonpreferred brand-name specialty drugs	1 to 30-day period	**Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs** After deductible, you pay 25% of approved amount, but no more than $500 **Note:** No coverage for 31-90 day supply.			

* BCBSM will not pay for drugs obtained from out-of-network mail order pharmacies, including Internet providers

Covered services

Benefits	90-day retail network pharmacy	In-network mail order pharmacy*	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
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

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Benefits	90-day retail network pharmacy	In-network mail order pharmacy*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Other FDA-approved **brand name** prescription preventive drugs, supplements and vitamins as required by PPACA	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA.	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 and devices 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 and devices 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 for the insulin or other covered injectable legend drug plus an additional 20% prescription drug out-of-network penalty
Select diabetic supplies and devices (test strips, lancets and glucometers) For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy. **Note:** Continuous glucose monitors and related supplies are covered only when obtained from the BCBSM designated exclusive vendor.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty

* BCBSM will not pay for drugs obtained from out-of-network mail order pharmacies, including Internet providers

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Features of your prescription drug plan

BCBSM Custom Select 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 then generic and members pay more for them • **Nonpreferred brand-name drug tier** - This tier includes non-specialty brand-name drugs for which there's either a generic alternative or a more cost-effective preferred brand-name drug available. Members pay more for these nonpreferred brand-name drugs. • **Generic and preferred specialty drug tier** - This tier includes generic and preferred brand-name specialty drugs that are used to treat difficult health conditions. These drugs are generally more cost-effective than nonpreferred specialty drugs. • **Nonpreferred specialty drug tier** - This tier includes nonpreferred brand-name specialty drugs that are used to treat difficult health conditions. Members pay more for nonpreferred specialty drugs because there are cost-effective generic or preferred drugs available.
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. 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 at **bcbsm.com/pharmacy**.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Exclusions	The following drugs are not covered: • Over-the-counter drugs and drugs with comparable OTC counterparts (e.g., antihistamines, cough/cold and acne treatment) unless deemed an Essential Health Benefit or not considered a covered service • State-controlled drugs • Brand-name drugs that have a generic equivalent available • Drugs to treat erectile dysfunction and weight loss • Prenatal vitamins (prescribed and over-the-counter) • Brand-name drugs used to treat heartburn • Compounded drugs, with some exceptions • Cosmetic drugs

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.



Professional Emergency Care
AOA-0000365155
Vision Coverage (Pediatric)
Effective Date: On or after January 2027
Benefits-at-a-glance

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: Vision benefits are only available to members up to age 19. Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

Member's responsibility (copays)

Benefits	In-network	Out-of-network
Eye exam	None	None
Prescription glasses (lenses and/or frames)	None	None
Medically necessary contact lenses	None	None

Eye exam

Benefits	In-network	Out-of-network
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.	100% of approved amount	Reimbursement up to $34 (member responsible for any difference)
	One eye exam per calendar year	

Lenses and Frames

Benefits	In-network	Out-of-network
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	100% of approved amount	Reimbursement up to approved amount based on lens type (member responsible for any difference)
	One pair of lenses, with or without frames, per calendar year	
Note: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.		
Standard frames from a "select" collection	100% of approved amount	Reimbursement up to $38.25 (member responsible for any difference)
	One frame per calendar year	

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Contact Lenses

Benefits	In-network	Out-of-network
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	100% of approved amount	Reimbursement up to $210 (member responsible for any difference)
	Covered - annual supply	
Standard (one pair annually) • Monthly (six-month supply) • Bi-weekly (three-month supply) • Dailies (three-month supply)	100% of approved amount	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Covered according to quantities outlined in your certificate, per calendar year	

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.