Blue Cross Blue Shield of Michigan

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

# Professional Emergency Care
# AOA-0000365155
# Simply Blue℠ PPO 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.



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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. 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<br>• **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** | $500 for one member,<br>$1,000 for the family (when two or more members are covered under your contract) each calendar year | $1,000 for one member,<br>$2,000 for the family (when two or more members are covered under your contract) each calendar year<br><br>**Note:** Out-of-network deductible amounts also count toward the in-network deductible. |
| **Flat-dollar copays** | • $20 copay for office visits and office consultations with a **primary care physician**<br>• $20 copay for **virtual primary care** visits<br>• $40 copay for office visits and office consultations with a **specialist**<br>• $20 copay for chiropractic and osteopathic manipulative therapy<br>• $150 copay for emergency room visits<br>• $60 copay for urgent care visits | • $150 copay for emergency room visits |
| **Coinsurance amounts (percent copays)**<br><br>**Note:** Coinsurance amounts apply once the deductible has been met. | • 20% of approved amount for most other covered services<br>• 50% of approved amount for bariatric surgery | • 40% of approved amount for most other covered services<br>• 50% of approved amount for bariatric surgery |
| **Annual coinsurance maximums** - applies to coinsurance amounts for all covered services - but **does not** apply to deductibles, flat-dollar copays and prescription drug cost-sharing amounts | $1,000 for one member,<br>$2,000 for the family (when two or more members are covered under your contract) each calendar year | $2,000 for one member,<br>$4,000 for the family (when two or more members are covered under your contract) each calendar year<br><br>**Note**: Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum. |
| **Annual out-of-pocket maximums** - applies to deductibles, flat-dollar copays and coinsurance amounts for all covered services - including prescription drugs cost-sharing amounts | $7,500 for one member,<br>$15,000 for the family (when two or more members are covered under your contract) each calendar year | $15,000 for one member,<br>$30,000 for the family (when two or more members are covered under your contract) each calendar year<br><br>**Note**: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum |

| Benefits | In-network | Out-of-network |
|---|---|---|
| **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<br><br>**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<br><br>**Note**: Additional well-women visits may be allowed based on medical necessity. | Not covered |
| Pap smear screening - laboratory and pathology services | 100% (no deductible or copay/coinsurance), one per member per calendar year | Not covered |
| Voluntary sterilization of female reproductive organs | 100% (no deductible or copay/coinsurance) | 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) | 100% after out-of-network deductible |
| Contraceptive injections | 100% (no deductible or copay/coinsurance) | 60% after out-of-network deductible |
| Well-baby and Well-child visits | 100% (no deductible or copay/coinsurance)<br>• 8 visits, birth through 12 months<br>• 6 visits, 13 months through 23 months<br>• 6 visits, 24 months through 35 months<br>• 2 visits, 36 months through 47 months<br>• 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 |

| Benefits | In-network | Out-of-network |
|---|---|---|
| Routine mammogram and related reading | 100% (no deductible or copay/coinsurance)<br><br>**Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance. | 60% after out-of-network deductible<br><br>**Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider. |
| | One per member per calendar year | |
| Colonoscopy - routine or medically necessary | 100% (no deductible or copay/coinsurance) for the first billed colonoscopy<br><br>**Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance. | 60% after out-of-network deductible |
| | One per member per calendar year | |

## Physician office services

| Benefits | In-network | Out-of-network |
|---|---|---|
| Office visits - must be medically necessary<br><br>**Note:** This includes mental health and substance use disorder services equivalent to medical office visits.<br><br>**Note**: **Virtual Primary Care** visits by a non-BCBSM selected vendor are not covered. | • $20 copay for each office visit with a **primary care physician** (in person or virtual)<br>• $20 copay for each **virtual primary care** visit for members 18 years of age or older, by a BCBSM selected vendor<br>• $40 copay for each office visit with a **specialist**<br><br>**Note**: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam.<br>Cost-sharing may not apply if preventive or immunization services are performed during the office visit. | 60% after out-of-network deductible |
| Online visits - by physician or **BCBSM** selected vendor must be medically necessary<br><br>**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% (no deductible or copay/coinsurance) | 60% after out-of-network deductible |
| Outpatient and home medical care visits - must be medically necessary | 80% after in-network deductible | 60% after out-of-network deductible |

| Benefits | In-network | Out-of-network |
|---|---|---|
| Office consultations - must be medically necessary | • $20 copay for each office consultation with a **primary care physician**<br>• $40 copay for each office consultation with a **specialist**<br><br>**Note**: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam.<br>Cost-sharing may not apply if preventive or immunization services are performed during the office visit. | 60% after out-of-network deductible |

## Urgent care visits

| Benefits | In-network | Out-of-network |
|---|---|---|
| Urgent care visits - must be medically necessary | $60 copay for each urgent care visit<br><br>**Note**: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam.<br>Cost-sharing may not apply if preventive or immunization services are performed during the office visit. | 60% after out-of-network deductible |

## Emergency medical care

| Benefits | In-network | Out-of-network |
|---|---|---|
| Hospital emergency room | $150 copay per visit (copay waived if admitted) | $150 copay per visit (copay waived if admitted) |
| 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 | 100% (no deductible or copay/coinsurance) | 60% after out-of-network deductible |
| Delivery and nursery care<br><br>**Note:** For facility services See "Hospital 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<br><br>**Note:** Nonemergency services must be rendered in a **participating** hospital. | 80% after in-network deductible<br>Unlimited days | 60% after out-of-network deductible |
| 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<br>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)<br>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 healthcare:<br>• must be medically necessary<br>• must be provided by a **participating** home healthcare agency | 80% after in-network deductible | 80% after in-network deductible |
| Infusion therapy:<br>• must be medically necessary<br>• must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC)<br>• may use drugs that require prior authorization-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 |

| Benefits | In-network | Out-of-network |
|---|---|---|
| Presurgical consultations | 100% (no deductible or copay/coinsurance) | 60% after out-of-network deductible |
| Voluntary sterilization of male reproductive organs<br><br>**Note:** For voluntary sterilization of female reproductive organs, see **"Preventive care services."** | 80% after in-network deductible | 60% 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 | |

## 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 | 80% after in-network deductible | 60% after out-of-network deductible |
| 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.

| Benefits | In-network | Out-of-network |
|---|---|---|
| **Inpatient** mental healthcare and **inpatient** substance use disorder treatment<br><br>**Note:** Facility services are covered in participating facilities only. | 80% after in-network deductible | 60% after out-of-network deductible |
| | Unlimited days | |
| Residential psychiatric treatment facility:<br>• covered mental health services **must** be performed in a residential psychiatric treatment facility<br>• treatment requires prior authorization<br>• subject to medical criteria | 80% after in-network deductible | 60% after out-of-network deductible |
| Outpatient mental healthcare:<br>• Facility and clinic<br><br>**Note:** Facility services are covered in participating facilities only. | 80% after in-network deductible | 80% after in-network deductible |
| • Online visits - for services equivalent to a medical online visit<br><br>**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<br><br>**Note:** For services equivalent to a medical office visit. See "**Physician Office Services**". | 80% after in-network deductible | 60% after out-of-network deductible |



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| Benefits | In-network | Out-of-network |
|---|---|---|
| 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<br><br>**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). | $20 copay for each office visit | 60% after out-of-network deductible<br><br>**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)<br><br>**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.<br><br>**Note:** Continuous glucose monitors and related supplies are covered only when obtained from the BCBSM designated exclusive vendor. | • 80% after in-network deductible for diabetes medical supplies<br>• 100% (no deductible or copay/coinsurance) for diabetes self-management training | 60% after out-of-network deductible |
| Allergy testing and therapy | 80% after in-network deductible | 60% after out-of-network deductible |
| Rehabilitative care:<br>• Outpatient physical and occupational therapy | 80% after in-network deductible | 60% after out-of-network deductible<br><br>**Note**: Services at nonparticipating outpatient physical therapy facilities are not covered. |
| • Chiropractic and osteopathic manipulation | $20 copay per visit | 60% after out-of-network deductible |
| | Limited to a 30-visit maximum per member per calendar year<br>**Note: This 30-visit outpatient maximum is a <u>combined</u> maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy.** | |
| Outpatient speech therapy - when provided for rehabilitative care | 80% after in-network deductible | 60% after out-of-network deductible |
| | Limited to a 30-visit maximum per member per calendar year | |



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| Benefits | In-network | Out-of-network |
|---|---|---|
| Habilitative care:<br>Outpatient physical and occupational therapy (excludes chiropractic and osteopathic manipulation) | 80% after in-network deductible | 60% after out-of-network deductible<br><br>**Note**: Services at nonparticipating outpatient physical therapy facilities are not covered. |
| | Limited to a 30-visit maximum per member per calendar year<br>**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 | 80% after in-network deductible | 60% after out-of-network deductible |
| | Limited to a 30-visit maximum per member per calendar year | |
| Durable medical equipment<br><br>**Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers.<br><br>**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. | 80% after in-network deductible | 60% after out-of-network deductible |
| Prosthetic and orthotic appliances<br><br>**Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers. | 80% after in-network deductible | 60% after out-of-network deductible |
| Private duty nursing care | Not covered | Not covered |



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# Professional Emergency Care
# AOA-0000365155
# Preferred Rx Program 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)

**Note:** Your prescription drug copays and coinsurance amounts, including mail order copays and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The 25% 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 | You pay $15 copay | You pay $15 copay | You pay $15 copay | You pay $15 copay plus an additional 25% of the BCBSM approved amount for the drug |
| | 31 to 60-day period | No coverage | You pay $30 copay | No coverage | No coverage |
| | 61 to 83-day period | No coverage | You pay $35 copay | No coverage | No coverage |



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| 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 |
|---|---|---|---|---|---|
| | 84 to 90-day period | You pay $35 copay | You pay $35 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 the BCBSM approved amount for the drug |
| | 31 to 60-day period | No coverage | You pay $100 copay | No coverage | No coverage |
| | 61 to 83-day period | No coverage | You pay $140 copay | No coverage | No coverage |
| | 84 to 90-day period | You pay $140 copay | You pay $140 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 the BCBSM approved amount for the drug |
| | 31 to 60-day period | No coverage | You pay $200 copay | No coverage | No coverage |
| | 61 to 83-day period | No coverage | You pay $290 copay | No coverage | No coverage |
| | 84 to 90-day period | You pay $290 copay | You pay $290 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**<br>Generic: You pay 20% of the approved amount, but no more than $200<br><br>Preferred Brand Name: After deductible, you pay 20% of the approved amount, but no more than $200<br><br>**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**<br>After deductible, you pay 25% of approved amount, but no more than $300<br><br>**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 | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 75% of approved amount less plan copay/coinsurance |
| FDA-approved **generic** and **select brand name** prescription preventive drugs, supplements and vitamins as required by PPACA | 100% of approved amount | 100% of approved amount | 100% of approved amount | 75% of approved amount |
| Other FDA-approved **brand name** prescription preventive drugs, supplements and vitamins as required by PPACA | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 75% of approved amount less plan copay/coinsurance |



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| 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 |
|---|---|---|---|---|
| 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 | 75% 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 | 75% of approved amount |
| Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs and devices are not covered) | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 100% of approved amount less plan copay/coinsurance | 75% of approved amount less plan copay/coinsurance |
| Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs<br><br>**Note:** Needles and syringes have no copay/coinsurance. | 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 |
| Select diabetic supplies and devices (test strips, lancets and glucometers)<br><br>For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy.<br><br>**Note:** Continuous glucose monitors and related supplies are covered only when obtained from the BCBSM designated exclusive vendor. | 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 |

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



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## 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.<br>• **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.<br>• **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<br>• **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.<br>• **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.<br>• **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:<br>• 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<br>• State-controlled drugs<br>• Brand-name drugs that have a generic equivalent available<br>• Drugs to treat erectile dysfunction and weight loss<br>• Prenatal vitamins (prescribed and over-the-counter)<br>• Brand-name drugs used to treat heartburn<br>• Compounded drugs, with some exceptions<br>• Cosmetic drugs |



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# 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 | |

**BV-PEDS;CBPPO PLAT27;PDRX SG;SB SG**

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## 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)<br>• Monthly (six-month supply)<br>• Bi-weekly (three-month supply)<br>• 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 | |



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