



**Blue Care
Network**
of Michigan

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

Benefits-at-a-Glance

Classic

00601168 MORTGAGEPROS LLC

0001/0001

Effective Date: 11/01/2025

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 to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

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

Note: A list of services that require approval **before** they are provided is available online at <https://bcbsm.com/priorauth>.

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

Benefits	
Deductible (Coinsurance and select fixed dollar copays as defined by your plan documents, apply once the deductible has been met.)	\$3,000 per member/\$6,000 per family per calendar year
Fixed Dollar Copays	\$5 for allergy injections \$30 for office visits \$60 for urgent care visits \$250 for emergency room visits \$50 for referral physician visits \$150 for high tech imaging
Coinurance	50% for select services as noted below 20% for select services as noted below
Coinurance Maximum	\$2,500 per member/\$5,000 per family per calendar year Services that DO NOT apply to the ACM: Deductible, Flat Dollar Copays, Infertility, Male Mastectomy, Reduction Mammoplasty, Male Sterilization, Elective Abortion, TMJ, Orthognathic Surgery, Weight Reduction, DME, P&O, Diabetic Supplies, Prescription Drugs
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	\$8,150 per member/\$16,300 per family per calendar year

Preventive services

Benefits	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%

Preventive services (continued)

Benefits	
Pap Smear Screening - laboratory services only	100%
Well-Baby and Well-Child Visits	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening - laboratory services only	100%
Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Sterilization of Female Reproductive Organs	100%
Breast Pumps (DME guidelines apply.)	100%
Routine Maternity Prenatal and Postnatal Care	100%

Physician office services

Benefits	
PCP Office Visits	\$30 Copay
Note: Applicable cost sharing applies when other services are received in the office	
Medical Online Visits - when performed by a BCN participating provider or BCN designated online vendor	\$30 Copay
Note: 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.	
Referral Physician Visits - when referred for other than preventive services	\$50 Copay
Note: Applicable cost sharing applies when other services are received in the office	

Emergency medical care

Benefits	
Hospital Emergency Room - copay waived if admitted as inpatient	\$250 Copay after deductible
Urgent Care Center	\$60 Copay
Retail Health Clinic	\$60 Copay
Ambulance Services - medically necessary	80% after deductible

Diagnostic services

Benefits	
Laboratory and Pathology Tests	100%
Diagnostic Tests and X-rays	80% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	\$150 Copay after deductible
Radiation Therapy	80% after deductible

Maternity services provided by a physician

Benefits	
Routine Prenatal and Postnatal Care Visits	100%
Delivery and Nursery Care - professional services (see "Hospital Care" for facility charges)	100% after deductible

Hospital care

Benefits	
General Nursing Care, Hospital Services and Supplies	80% after deductible
Outpatient Surgery	80% after deductible

Alternatives to hospital care

Benefits	
Skilled Nursing Care	80% after deductible Up to 45 days per member per calendar year
Hospice Care	100% after deductible
Home Health Care	\$50 Copay after deductible

Surgical services

Benefits	
Surgery - includes all related surgical services and anesthesia.	80% after deductible
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	50% after deductible
Elective Abortion Services	Not covered
Human Organ Transplants (subject to medical criteria)	80% after deductible
Reduction Mammoplasty (subject to medical criteria)	50% after deductible
Male Mastectomy (subject to medical criteria)	50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	50% after deductible
Orthognathic Surgery (subject to medical criteria)	50% after deductible
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	50% after deductible

Behavioral health services (mental health and substance use disorder treatment)

Benefits	
Inpatient Mental Health Care	80% after deductible
Residential Substance Use Disorder	80% after deductible
Outpatient Mental Health Care includes online and telemedicine visits Note: For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	\$30 Copay
Outpatient Substance Use Disorder	\$30 Copay

Autism spectrum disorders, diagnoses and treatment

Benefits	
Applied behavioral analysis (ABA) treatment 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)	\$30 Copay
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	\$50 Copay after deductible
Other covered services, including mental health services, for autism spectrum disorder	See your outpatient mental health, medical office visit and preventive benefit.

Other services

Benefits	
Allergy Testing and Therapy	50% after deductible
Allergy Office Visits	50%
Allergy Injections	\$5 copay
Chiropractic Spinal Manipulation - when referred	\$50 Copay Limited to 30 visits per calendar year
Outpatient Physical, Speech and Occupational Therapy - Subject to meaningful improvement within 60 days	\$50 Copay after deductible Limited to 60 visits per calendar year for any combination of outpatient rehabilitation therapies
Infertility Counseling and Treatment	50% (excludes in-vitro fertilization) after deductible
Durable Medical Equipment	50%
Prosthetic and Orthotic Appliances	50%
Diabetic Supplies Note: Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable prescription drug cost-sharing will apply.	80%
Hearing Aid	Not Covered

Prescription drugs

Benefits	
Preferred Generic Tier	\$4 copay
Nonpreferred Generic Tier	\$15 copay
Preferred Brand Tier	\$40 copay
Nonpreferred Brand Tier	\$80 copay
Preferred Specialty Tier	20% coinsurance (Max \$200)
Nonpreferred Specialty Tier	20% coinsurance (Max \$300)
Contraceptives	Women's Contraceptives - Preferred Generic - 100%, Non-Preferred Generic - \$15 copay, Preferred Brand - \$40 copay, Non-Preferred Brand - \$80 copay
Drugs for the Treatment of Sexual Dysfunction	Not covered

Prescription drugs (continued)

Benefits	
Mail Order Prescription Drugs	30-day supply or less - applicable tiered copay / coinsurance; 31-90 day supply - 3x's the 30-day copay/coinsurance minus \$10. 90-day retail 84-90 day supply, 3X's the 30-day copay/coinsurance minus \$10.
Diabetic Supplies	Select diabetic supplies and equipment are covered, applicable cost sharing will apply. Cost sharing may not apply to certain preferred glucometers as defined on the drug list.
Specialty Drug Pharmacy	Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs
Variable Cost Share Coupon Program	Your plan includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum.
Prescription Drug Deductible	None
Custom Select Drug List	The list of prescription drugs that have been approved by the U.S. Food and Drug Administration and approved by the BCBSM/BCN Pharmacy and Therapeutics Committee. The list represents the clinical judgment of Michigan physicians, pharmacists and other experts in the diagnosis and treatment of disease and promotion of health. Medications are selected based on clinical effectiveness, safety and opportunity for cost savings. Some drugs included in the Custom Select Drug List require prior authorization and/or step therapy by BCN before they are covered. The Custom Select Drug List may be modified by BCN as needed to remove or add a covered drug or to modify the requirements for authorization of a covered drug. The list may be found at https://www.bcbsm.com/druglists

For Internal Purposes Only

Benefits Selected - CLSSLG : 25ECM,50RP,8150PM,90D3X,CI20%,CO30,D3000,DSR20%,ER250,IMG150,P415CS,UR60,WDRPOV



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Benefits-at-a-Glance

High Deductible Health Plan
00601168 MORTGAGEPROS LLC
0001/0002

Effective Date: 11/01/2025

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

Note: A list of services that require approval **before** they are provided is available online at <https://bcbsm.com/priorauth>.

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

Benefits	
Deductible Note: The Deductible will apply to all services except preventive services	\$6,350 per member/\$12,700 per family per calendar year (no 4th quarter carry-over)
The deductible is combined for both medical and prescription drug coverage.	The deductible is embedded. The deductible paid by all Members will be combined to satisfy the family deductible. However, one individual member cannot contribute more than the individual deductible amount toward the family deductible
Coinurance Note: Coinsurance applies once the deductible has been met	None
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	\$6,350 per member/\$12,700 per family per calendar year The out-of-pocket maximum is embedded. For members with more than one person on the contract, if the one member maximum is met even if the family maximum is not, that member does not pay any more cost-sharing for the rest of the year

Preventive services

Benefits	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening - laboratory services only	100%
Well-Baby and Well-Child Visits	100%

Preventive services (continued)

Benefits	
Immunizations	100%
Prostate Specific Antigen (PSA) Screening - laboratory services only	100%
Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Sterilization of Female Reproductive Organs	100%
Breast Pumps (DME guidelines apply.)	100%
Routine Maternity Prenatal and Postnatal Care	100%

Physician office services

Benefits	
PCP Office Visits	100% after deductible
Medical Online Visits - when performed by a BCN participating provider or BCN designated online vendor	100% after deductible
Note: 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.	
Referral Physician Visits	100% after deductible

Emergency medical care

Benefits	
Hospital Emergency Room	100% after deductible
Urgent Care Center	100% after deductible
Retail Health Clinic	100% after deductible
Ambulance Services - medically necessary	100% after deductible

Diagnostic services

Benefits	
Laboratory and Pathology Tests	100% after deductible
Diagnostic Tests and X-rays	100% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	100% after deductible
Radiation Therapy	100% after deductible

Maternity services provided by a physician

Benefits	
Routine Prenatal and Postnatal Care Visits	100%
Delivery and Nursery Care	100% after deductible

Hospital care

Benefits	
General Nursing Care, Hospital Services and Supplies	100% after deductible
Outpatient Surgery	100% after deductible

Alternatives to hospital care

Benefits	
Skilled Nursing Care	100% after deductible Up to 45 days per calendar year
Hospice Care	100% after deductible
Home Health Care	100% after deductible

Surgical services

Benefits	
Surgery - includes all related surgical services and anesthesia.	100% after deductible
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	100% after deductible
Elective Abortion Services	Not covered
Human Organ Transplants (subject to medical criteria)	100% after deductible
Reduction Mammoplasty (subject to medical criteria)	100% after deductible
Male Mastectomy (subject to medical criteria)	100% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	100% after deductible
Orthognathic Surgery (subject to medical criteria)	100% after deductible
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	100% after deductible

Behavioral health services (mental health and substance use disorder treatment)

Benefits	
Inpatient Mental Health Care	100% after deductible
Residential Substance Use Disorder	100% after deductible
Outpatient Mental Health Care includes online and telemedicine visits Note: For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	100% after deductible
Outpatient Substance Use Disorder	100% after deductible

Autism spectrum disorders, diagnoses and treatment

Benefits	
Applied behavioral analysis (ABA) treatment 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 deductible
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	100% after deductible
Other covered services, including mental health services, for autism spectrum disorder	See your outpatient mental health, medical office visit and preventive benefit.

Other services

Benefits	
Allergy Testing and Therapy	100% after deductible
Allergy Injections	100% after deductible
Chiropractic Spinal Manipulation - when referred	100% after deductible Limited to 30 visits per calendar year
Outpatient Physical, Speech and Occupational Therapy - subject to meaningful improvement within 60 days	100% after deductible Limited to 60 visits per calendar year for any combination of outpatient rehabilitation therapies.
Infertility Counseling and Treatment	100% after deductible
Durable Medical Equipment	100% after deductible
Prosthetic and Orthotic Appliances	100% after deductible
Diabetic Supplies Note: Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable prescription drug cost-sharing will apply.	100% after deductible
Hearing Aid	Not Covered

Prescription drugs

Benefits	
Generic Tier	Covered 100% after deductible
Preferred Brand Tier	Covered 100% after deductible
Nonpreferred Brand Tier	Covered 100% after deductible
Contraceptives	Women's Contraceptives - Generic - 100% after deductible, Preferred Brand - 100% after deductible , Non-Preferred Brand - 100% after deductible
Drugs for the Treatment of Sexual Dysfunction	Covered 100% after deductible
Mail Order Prescription Drugs	Covered 100% after deductible up to a 90 day supply. Specialty drugs are not covered through mail order pharmacies. after deductible.
Diabetic Supplies	Select diabetic supplies and equipment are covered, applicable cost sharing will apply. Cost sharing may not apply to certain preferred glucometers as defined on the drug list.

Prescription drugs (continued)

Benefits	
Specialty Drug Pharmacy	Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs
Prescription Drug Deductible	Prescription drug deductible is integrated with the medical deductible
Variable Cost Share Coupon Program	Your plan includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum.
Custom Drug List	The list of prescription drugs that have been approved by the U.S. Food and Drug Administration and approved by the BCBSM/BCN Pharmacy and Therapeutics Committee. The list represents the clinical judgment of Michigan physicians, pharmacists and other experts in the diagnosis and treatment of disease and promotion of health. Medications are selected based on clinical effectiveness, safety and opportunity for cost savings. Some drugs included in the Custom Drug List require prior authorization and/or step therapy by BCN before they are covered. The drug list may be modified by BCN as needed to remove or add a covered drug or to modify the requirements for authorization of a covered drug. The list may be found at https://www.bcbsm.com/druglists

For Internal Purposes Only

Benefits Selected - HDHPLG : 50CWHD,6350HD,630MHD,EDEPM,MOPD0,P0CHD



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MORTGAGEPROS LLC
0070487350004 - 0CG1B
Effective Date: 11/01/2025

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.

ADM PLANYR NOV;CB LG;CB-ET \$150 LG;CB-MTC \$20 LG;CB-OP IN 8150LG;CB-OV \$20 LG;CB-XC-IN LG;CB-XD-IN LG;CBC 20%-ON LG;CBOP ON 16300LG;CSRXP10/40/80LG;PDRX LG

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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	<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)

Benefits	In-network	Out-of-network
Deductibles	None	\$250 for one member, \$500 for the family (when two or more members are covered under your contract) each calendar year
Flat-dollar copays	<ul style="list-style-type: none"> \$20 copay for office visits and office consultations \$20 copay for virtual primary care visits \$20 copay for medical online visits \$20 copay for chiropractic and osteopathic manipulative therapy \$150 copay for emergency room visits \$20 copay for urgent care visits 	<ul style="list-style-type: none"> \$150 copay for emergency room visits
Coinurance amounts (percent copays)	<ul style="list-style-type: none"> 30% of approved amount for private duty nursing care 	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 20% of approved amount for mental health care and substance use disorder treatment 20% of approved amount for most other covered services
Note: Coinsurance amounts apply once the deductible has been met.		
Annual out-of-pocket maximums - applies to deductibles, flat-dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	\$8,150 for one member, \$16,300 for the family (when two or more members are covered under your contract) each calendar year	\$16,300 for one member, \$32,600 for the family (when two or more members are covered under your contract) each calendar year
		<p>Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.</p>
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	Not covered

Note: Additional well-women visits may be allowed based on medical necessity.

ADM PLAN YR NOV;CB LG;CB-ET \$150 LG;CB-MTC \$20 LG;CB-OP IN 8150LG;CB-OV \$20 LG;CB-XC-IN LG;CB-XD-IN LG;CBC 20%-ON LG;CBOP ON 16300LG;CSRXP10/40/80LG;PDRX LG

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
Gynecological exam	100% (no deductible or copay/coinsurance), two per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization of female reproductive organs	100% (no deductible or copay/coinsurance)	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)	100% 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 an in-network provider.

One per member per calendar year

ADM PLANYR NOV;CB LG;CB-ET \$150 LG;CB-MTC \$20 LG;CB-OP IN 8150LG;CB-OV \$20 LG;CB-XC-IN LG;CB-XD-IN LG;CBC 20%-ON LG;CBOP ON 16300LG;CSRXP10/40/80LG;PDRX LG

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Benefits	In-network	Out-of-network
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 per member per calendar year

Physician office services		
Benefits	In-network	Out-of-network
Office visits - must be medically necessary Note: This includes mental health and substance use disorder services equivalent to medical office visits. Note: Virtual Primary Care visits by a non-BCBSM selected vendor are not covered.	<ul style="list-style-type: none"> \$20 copay per office visit (in person or virtual) \$20 copay 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.	\$20 copay per online visit	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Office consultations - must be medically necessary	\$20 copay per office consultation	80% after out-of-network deductible
Urgent care visits - must be medically necessary	\$20 copay per urgent care visit	80% 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 or for an accidental injury)	\$150 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

Diagnostic services		
Benefits	In-network	Out-of-network
Laboratory and pathology services	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Diagnostic tests and x-rays	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Therapeutic radiology	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

ADM PLANYR NOV;CB LG;CB-ET \$150 LG;CB-MTC \$20 LG;CB-OP IN 8150LG;CB-OV \$20 LG;CB-XC-IN LG;CB-XD-IN LG;CBC 20%-ON LG;CBOP ON 16300LG;CSRXP10/40/80LG;PDRX LG

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Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Postnatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Delivery and nursery care	100% (no deductible or copay/coinsurance)	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	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible Unlimited days
Inpatient consultations	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Chemotherapy	100% (no deductible or copay/coinsurance)	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% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) Limited to a maximum of 120 days per member per calendar year
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a participating hospice program only ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)
Home health care: <ul style="list-style-type: none">• must be medically necessary• must be provided by a participating home health care agency	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Infusion therapy: <ul style="list-style-type: none">• must be medically necessary• must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC)• may use drugs that require prior authorization - consult with your doctor	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

ADM PLAN YR NOV;CB LG;CB-ET \$150 LG;CB-MTC \$20 LG;CB-OP IN 8150LG;CB-OV \$20 LG;CB-XC-IN LG;CB-XD-IN LG;CBC 20%-ON LG;CBOP ON 16300LG;CSRXP10/40/80LG;PDRX LG

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Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Voluntary sterilization of male reproductive organs	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Note: For voluntary sterilization of female reproductive organs, see "Preventive care services."		
Expanded Abortion Services	Not covered	Not covered

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities only
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Specified oncology clinical trials	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
Cornea and skin transplants	100% (no deductible or copay/coinsurance)	80% 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 health care and inpatient substance use disorder treatment	100% (no deductible or copay/coinsurance) Unlimited days	80% after out-of-network deductible
Residential psychiatric treatment facility: <ul style="list-style-type: none"> • covered mental health services must be performed in a residential psychiatric treatment facility • treatment requires prior authorization • subject to medical criteria 	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> • Facility and clinic • Online visits - for services equivalent to a medical online visit Note: Online visits by a non-BCBSM selected vendor are not covered.	100% (no deductible or copay/coinsurance) \$20 copay per online visit	100% (no deductible or copay/coinsurance) in participating facilities only 80% after out-of-network deductible
• Physician's office	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Note: For services equivalent to a medical office visit. See "Physician Office Services".		

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Benefits	In-network	Out-of-network
Outpatient substance use disorder treatment - in approved facilities only	100% (no deductible or copay/coinsurance)	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).	\$20 copay per office visit	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% (no deductible or copay/coinsurance) Physical, speech and occupational therapy with an autism diagnosis is unlimited	80% after out-of-network deductible
Other covered services, including nutritional counseling and mental health services, for autism spectrum disorder	100% (no deductible or copay/coinsurance)	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 an in-network provider. Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 100% (no deductible or copay/coinsurance) for diabetes medical supplies; • 100% (no deductible or copay/coinsurance) for diabetes self-management training	80% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$20 copay per visit Limited to a combined 24-visit maximum per member per calendar year	80% after out-of-network deductible
Outpatient physical, speech and occupational therapy - when provided for rehabilitation	100% (no deductible or copay/coinsurance) Limited to a combined 60-visit maximum per member per calendar year	80% 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: Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers.	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Note: DME items required under the preventive benefit provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of preventive DME items that PPACA requires to be covered at 100%, call BCBSM.		
Prosthetic and orthotic appliances Note: Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers.	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Private duty nursing care	70% (no deductible)	50% after out-of-network deductible

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Preferred Rx Program LG

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

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

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

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

Specialty Pharmaceutical Drugs - The preferred pharmacy for specialty drugs is **Walgreens Specialty Pharmacy**. Specialty drugs are covered only when dispensed through the Walgreens Specialty Pharmacy or through a participating Walgreens retail pharmacy, as long as the drug is available at that location. You may want to call ahead to confirm availability. **If you don't use Walgreens Specialty Pharmacy or a participating Walgreens retail pharmacy, you may be responsible for the full cost of the medication.**

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

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

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

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

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order 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 provider*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Generic drugs	1 to 30-day period	You pay \$10 copay	You pay \$10 copay	You pay \$10 copay	You pay \$10 copay plus an additional 25% of the BCBSM approved amount
	31 to 60-day period	No coverage	You pay \$20 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay \$20 copay	No coverage	No coverage
	84 to 90-day period	You pay \$20 copay	You pay \$20 copay	No coverage	No coverage
Preferred brand-name drugs	1 to 30-day period	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay plus an additional 25% of the BCBSM approved amount
	31 to 60-day period	No coverage	You pay \$80 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay \$110 copay	No coverage	No coverage
	84 to 90-day period	You pay \$110 copay	You pay \$110 copay	No coverage	No coverage

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Benefits		90-day retail network pharmacy	In-network mail order provider*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Nonpreferred brand-name drugs	1 to 30-day period	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay plus an additional 25% of the BCBSM approved amount
	31 to 60-day period	No coverage	You pay \$160 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay \$230 copay	No coverage	No coverage
	84 to 90-day period	You pay \$230 copay	You pay \$230 copay	No coverage	No coverage
Generic specialty drugs	1 to 30-day period	Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs You pay \$10 copay			
		Note: No coverage for 31-90 day supply.			
Preferred brand-name specialty drugs	1 to 30-day period	Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs You pay \$40 copay			
		Note: No coverage for 31-90 day supply.			
Nonpreferred brand-name specialty drugs	1 to 30-day period	Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs You pay \$80 copay			
		Note: No coverage for 31-90 day supply.			

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

Covered services					
Benefits	90-day retail network pharmacy	In-network mail order provider*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy	
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance	
FDA-approved generic and select brand-name prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount	
Other FDA-approved brand-name prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance	
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	No coverage	100% of approved amount	75% of approved amount	

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Benefits	90-day retail network pharmacy	In-network mail order provider*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved generic and select brand-name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved brand-name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug
Note: Needles and syringes have no copay/coinsurance.				
Select diabetic supplies and devices (test strips, lancets and glucometers)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy .				

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

Features of your prescription drug plan

Custom 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. <ul style="list-style-type: none"> ● Generic drug tier - This tier includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. ● Preferred brand-name drug tier - This tier includes non-specialty preferred brand-name drugs. These drugs are more expensive than generic and members pay more for them. ● Nonpreferred brand-name drug tier - This tier includes non-specialty brand-name drugs for which there's either a generic alternative or a more cost-effective preferred brand-name drug available. Members pay more for these nonpreferred brand-name drugs.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. Step Therapy , an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require prior authorization or step therapy are available online site at bcbsm.com/pharmacy .
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

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Features of your prescription drug plan

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

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MORTGAGEPROS LLC
0070487350003 - 0CG1C
Effective Date: 11/01/2025

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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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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	\$3,300 for one member or \$6,600 for the family (when two or more members are covered under your contract) each calendar year (no 4th quarter carry-over)	\$6,600 for one member or \$13,200 for the family (when two or more members are covered under your contract) each calendar year (no 4th quarter carry-over)
Note: Your deductible combines deductible amounts paid under your Simply Blue HSA medical coverage and your Simply Blue prescription drug coverage.		
Flat-dollar copays	See "Prescription Drugs" section	See "Prescription Drugs" section
Coinurance amounts (percent copays)	20% of approved amount for most covered services	40% of approved amount for most covered services
Note: Coinsurance amounts apply once the deductible has been met.		
Annual out-of-pocket maximums - applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts	\$6,900 for one member, \$13,800 for the family (when two or more members are covered under your contract) each calendar year	\$13,800 for one member, \$27,600 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
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

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Benefits	In-network	Out-of-network
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
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) <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.
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.	60% after out-of-network deductible

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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.	<ul style="list-style-type: none"> 80% after in-network deductible for each office visit (in person or virtual) 80% after in-network deductible for each virtual primary care visit for members 18 years of age or older, by a BCBSM-selected vendor 	60% 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.	80% after in-network deductible	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
Office consultations - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
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	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

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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 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

Note: Nonemergency services must be rendered in a **participating** hospital.

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a participating skilled nursing facility	80% after in-network deductible Limited to a maximum of 90 days per member per calendar year	80% after in-network deductible
Hospice care	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)	80% after in-network deductible
Home health care: • must be medically necessary • must be provided by a participating home health care agency	80% after in-network deductible	80% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • may use drugs that require prior authorization - consult with your doctor	80% after in-network deductible	80% after in-network deductible

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 of male reproductive organs	80% after in-network deductible	60% after out-of-network deductible
Note: For voluntary sterilization of female reproductive organs, see " Preventive care services. "		
Expanded Abortion Services	Not covered	Not covered

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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.		
Cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance use disorder treatment	80% after in-network deductible Unlimited days	60% after out-of-network deductible
Residential psychiatric treatment facility: <ul style="list-style-type: none"> covered mental health services must be performed in a residential psychiatric treatment facility treatment requires prior authorization subject to medical criteria 	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> Facility and clinic Online visits Note: Online visits by a non-BCBSM selected vendor are not covered	80% after in-network deductible 80% after in-network deductible	80% after in-network deductible in participating facilities only 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 behavior analysis (ABA) treatment - subject to prior authorization	80% after in-network deductible	60% after out-of-network deductible
Note: Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).		Note: Services rendered by an approved licensed behavior analyst (LBA) will apply the in-network cost-sharing.
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible

Physical, speech and occupational therapy **with an autism diagnosis** is unlimited

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Benefits	In-network	Out-of-network
Other covered services, including nutritional counseling and mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP)	80% after in-network deductible	60% after out-of-network deductible
Note: 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.		
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	60% after out-of-network deductible Limited to a combined 12-visit maximum per member per calendar year
Outpatient physical, speech and occupational therapy - provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered. Limited to a combined 30-visit maximum per member per calendar year
Durable medical equipment	80% after in-network deductible	60% after out-of-network deductible
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.		
Prosthetic and orthotic appliances	80% after in-network deductible	60% after out-of-network deductible
Note: Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers.		
Private duty nursing care	80% after in-network deductible	60% after out-of-network deductible

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Simply BlueSM HSA PPO with Rx Embedded Cost-Sharing LG

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 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. 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 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.

Benefits	90-day retail network pharmacy	In-network mail order provider*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Generic drugs	1 to 30-day period 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 BCBSM approved amount for the drug
	31 to 60-day period No coverage	After deductible is met, you pay \$30 copay	No coverage	No coverage
	61 to 83-day period No coverage	After deductible is met, you pay \$35 copay	No coverage	No coverage
	84 to 90-day period After deductible is met, you pay \$35 copay	After deductible is met, you pay \$35 copay	No coverage	No coverage
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 BCBSM approved amount for the drug
	31 to 60-day period No coverage	After deductible is met, you pay \$100 copay	No coverage	No coverage
	61 to 83-day period No coverage	After deductible is met, you pay \$140 copay	No coverage	No coverage
	84 to 90-day period After deductible is met, you pay \$140 copay	After deductible is met, you pay \$140 copay	No coverage	No coverage

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Benefits		90-day retail network pharmacy	In-network mail order provider*	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Nonpreferred brand-name drugs	1 to 30-day period	After deductible is met, you pay \$70 copay 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	After deductible is met, you pay \$70 copay 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 BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible is met, you pay \$140 copay or 50% of the approved amount (whichever is greater) but no more than \$200	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible is met, you pay \$200 copay or 50% of the approved amount (whichever is greater) but no more than \$290	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay \$200 copay or 50% of the approved amount (whichever is greater) but no more than \$290	After deductible is met, you pay \$200 copay or 50% of the approved amount (whichever is greater) but no more than \$290	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 is met, you pay 20% of the approved amount, but no more than \$200 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 is met, you pay 25% of the approved amount, but no more than \$300 Note: No coverage for 31-90 day supply.			

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
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

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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
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 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
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 .	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 providers, including Internet providers.

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Features of your prescription drug plan

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 than generic and members pay more for them.
- **Nonpreferred brand-name drug tier** - This tier includes non-specialty brand-name drugs for which there's either a generic alternative or a more cost-effective preferred brand-name drug available. Members pay more for these nonpreferred brand-name drugs.
- **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. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require prior authorization or step therapy are available online site at bcbsm.com/pharmacy.

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

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