Blue Cross Blue Shield of Michigan

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

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

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

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

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

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

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

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

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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 or other eligible persons who meet all eligibility requirements and is eligible for coverage under the subscriber's contract • **Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26
Principally supported (grand)children	Principally supported children are also covered when specific requirements are met.

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

Note: 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	Coverage
Deductibles	$100 for one member, $200 for a family (when two or more members are covered under your contract) each calendar year
Flat-dollar copays	None
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing • 10% of approved amount for most other covered services
Annual coinsurance maximum - does not apply to deductibles, copays and coinsurances for private duty nursing, and cost-sharing amounts for prescription drugs, if applicable	$500 for one member, $,1000 for a family (when two or more members are covered under your contract) each calendar year
Lifetime dollar maximum	None

Preventive care services

Benefits	Coverage
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	Not covered
Gynecological exam	Not covered
Pap smear screening-laboratory and pathology services	Not covered
Well-baby and child care visits	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunization Practices or other sources as recognized by BCBSM	Not covered
Fecal occult blood screening	Not covered
Flexible sigmoidoscopy exam	Not covered
Prostate specific antigen (PSA) screening	Not covered

Mammography

Benefits	Coverage
Mammography screening	Not covered

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Physician office services

Benefits	Coverage
Office visits	90% after deductible
Online visits - by physician or **BCBSM** selected vendor must be medically necessary	90% after deductible
Outpatient and home medical care visits	90% after deductible
Office consultations	90% after deductible

Emergency medical care

Benefits	Coverage
Hospital emergency room	90% after deductible
Ambulance services-must be medically necessary	90% after deductible

Diagnostic services

Benefits	Coverage
Laboratory and pathology services	90% after deductible
Diagnostic tests and x-rays	90% after deductible
Therapeutic radiology	90% after deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	Coverage
Prenatal care visits	90% after deductible
Postnatal care	90% after deductible
Delivery and nursery care	90% after deductible

Hospital care

Benefits	Coverage
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	90% after deductible, unlimited days
Inpatient consultations	90% after deductible
Chemotherapy	90% after deductible

Alternatives to hospital care

Benefits	Coverage
Skilled nursing care-must be in a **participating** skilled nursing facility	Not covered

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Benefits	Coverage
Hospice care	100% (no deductible or copay/coinsurance), up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods-provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	90% after 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 preauthorization-consult with your doctor	90% after deductible

Surgical services

Benefits	Coverage
Surgery-includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	90% after deductible
Presurgical consultations	• 100% (no deductible or copay/coinsurance) when obtained from a participating provider, • 90% after deductible when obtained from a nonparticipating provider
Voluntary sterilization for males	Not covered
Voluntary sterilization for females	Not covered
Voluntary abortions	90% after deductible
Routine screening colonoscopy	90% after deductible, limited to once per member per calendar year **Note:** Medically necessary colonoscopies are not limited to once per calendar year.

Human organ transplants

Benefits	Coverage
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)
Bone marrow transplants-must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	90% after deductible
Specified oncology clinical trials - **excludes** coverage for routine patient costs related to clinical trials	90% after deductible
Kidney, cornea and skin transplants	90% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	Coverage
Inpatient mental health care and **inpatient** substance use disorder treatment	90% after deductible, unlimited days
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment **must** be preauthorized • subject to medical criteria	90% after deductible
Outpatient mental health care	90% after deductible

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Benefits	Coverage
Online visits - by physician or **BCBSM** selected vendor	90% after deductible
Outpatient substance use disorder treatment-in approved facilities **only**	90% after deductible

Autism spectrum disorders, diagnoses and treatment

Benefits	Coverage
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	90% after deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	90% after deductible
Other covered services, including mental health services, for autism spectrum disorder	90% after deductible

Other covered services

Benefits	Coverage
Outpatient Diabetes Management Program (ODMP) **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	90% after deductible
Allergy testing and therapy	90% after deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	90% after deductible, limited to a **combined** 38-visit maximum per member per calendar year
Outpatient physical, speech and occupational therapy- provided for rehabilitation	90% after deductible, unlimited treatment
Durable medical equipment	90% after deductible
Prosthetic and orthotic appliances	90% after deductible
Private duty nursing	50% after deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	Not covered
Contraceptive Injections	Not covered

BCBSM Preferred RX Program

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Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. AllianceRx Walgreens Prime will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to the OptumRx home delivery pharmacy. (OptumRx is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call AllianceRx Walgreens Prime customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

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

Member's responsibility (copays and coinsurance amounts)

Benefits	In-network pharmacy	Out-of-network pharmacy
Generic drugs	You pay $10 copay	You pay $10 copay plus an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	**Copay for up to a 90 day supply:** • You pay $10 copay for generic drugs	Not covered

Covered services

Benefits	In-network pharmacy	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	No coverage	No coverage
Prescription contraceptive medication	Not covered	Not covered
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **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	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) For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy.	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

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Features of your prescription drug plan

Over-the-counter drugs	Excludes benefits for certain over-the-counter drugs.
Quantity of drugs	Your prescription drug coverage has eliminated authorization requirements for select prescription drugs, and quantities of drugs.
Clinical 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.
Mandatory maximum allowable cost drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

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