



Blue Cross
Blue Shield
of Michigan

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

WAYNE STATE UNIVERSITY 0070027790004 - 09QG7 Effective Date: 01/01/2024

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	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 30% of approved amount for private duty nursing 10% of approved amount for most other covered services
Note: Coinsurance amounts apply once the deductible has been met.	
Annual coinsurance maximum - does not apply to deductibles, flat-dollar 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 Well-child 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	90% after deductible

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Physician office services

Benefits	Coverage
Office visits	90% after deductible
Online visits - by physician must be medically necessary	90% after deductible
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.	
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	100% (no deductible or copay/coinsurance)
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	90% after deductible, unlimited days
Note: Nonemergency services must be rendered in a participating hospital.	
Inpatient consultations	90% after deductible
Chemotherapy	90% after deductible

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Alternatives to hospital care

Benefits	Coverage
Skilled nursing care-must be in a participating skilled nursing facility	Not covered
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: <ul style="list-style-type: none"> • must be medically necessary • must be provided by a participating home health care agency 	90% after deductible
Infusion therapy: <ul style="list-style-type: none"> • must be medically necessary • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization-consult with your doctor 	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)
Sterilization	90% after deductible
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: <ul style="list-style-type: none"> • covered mental health services must be performed in a residential psychiatric treatment facility • treatment must be preauthorized • subject to medical criteria 	90% after deductible

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Benefits	Coverage
Outpatient mental health care	90% after deductible
Online visits	90% after deductible
Note: Online visits by a non-BCBSM selected vendor are not covered.	
Outpatient substance use disorder treatment-in approved facilities only	90% after deductible

Autism spectrum disorders, diagnoses and treatment

Benefits	Coverage
Applied behavior analysis (ABA) treatment - when rendered by an approved licensed behavior analyst, subject to preauthorization	90% after 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).	
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)	90% after deductible
Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	
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	70% after deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	Not covered
Contraceptive Injections	Not covered

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Preferred Rx Program ASC

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Specialty Pharmaceutical Drugs - The pharmacy for **specialty drugs** is AllianceRx Walgreens Pharmacy, 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. You may also obtain specialty drugs through a Walgreens retail pharmacy as long as the drug is available at that location. You may want to call ahead to confirm availability at the location. **If you go to a non-AllianceRx Walgreens Pharmacy, you may be responsible for 100% of the cost of the specialty drug.** A list of specialty drugs is available on our Web site at bcbsm.com/pharmacy. If you have any questions, please call AllianceRx Walgreens Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical". 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
Copay	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: <ul style="list-style-type: none"> 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	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	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 .		

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Features of your prescription drug plan

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.
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.
Maximum allowable cost drugs	<p>When you receive a generic maximum allowable cost (MAC) drug from an in-network pharmacy, you pay your cost share as noted in your coverage.</p> <p>However, if you request a brand-name drug and the prescriber did not write "Dispense as Written" or "DAW" on the prescription, you must pay the difference between the maximum allowable cost and the Blue Cross Blue Shield of Michigan approved amount for the brand-name drug, plus your copayment.</p> <p>If the prescriber wrote "Dispense as Written" or "DAW" on the prescription, we will pay the pharmacy the approved amount for the brand-name drug, after deduction of your copayment.</p>

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