



Blue Cross  
Blue Shield  
of Michigan

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

## PLUMBERS & PIPEFITTERS LOCAL

0070047180000 - 07701

Effective Date: 01/01/2019

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](http://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** - Select specialty pharmaceuticals do not require preauthorization.

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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## Eligibility Information

Members	Eligibility Criteria
Dependents	<ul style="list-style-type: none"> <li>Subscriber's legal spouse</li> <li><b>Dependent children:</b> 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</li> </ul>
Sponsored dependents	<ul style="list-style-type: none"> <li>Dependents of the subscriber related by blood, marriage or legal adoption, over age 19 and not eligible as a dependent under the provisions of the subscriber's contract, provided the dependent meets all eligibility requirements. The subscriber is responsible for paying the cost of this coverage.</li> </ul>
No-fault automobile accidents, option 3	<p>Clarifies how payment for medical services will be coordinated between BCBSM and a member's motor vehicle insurance carrier when a member is involved in a motor vehicle accident.</p> <p>In all instances:</p> <ul style="list-style-type: none"> <li>BCBSM will be the <b>secondary</b> plan when paying benefits for injuries that are a direct or indirect result of a motor vehicle accident, regardless of the provisions contained in a member's no-fault motor vehicle insurance policy, and</li> <li>BCBSM will not duplicate benefits available under a member's no-fault motor vehicle insurance policy.</li> </ul> <p><b>Note:</b> The BCBSM payment, when combined with any payment a member receives under their no-fault motor vehicle insurance policy, will not be more than 100 percent of the BCBSM approved amount for covered services.</p>

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

Benefits	In-network	Out-of-network
Deductible	<p>\$500 for one member, \$1,000 for the family (when two or more members are covered under your contract) each calendar year</p> <p><b>Note:</b> Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.</p>	<p>\$1,000 for one member, \$2,000 for the family (when two or more members are covered under your contract) each calendar year</p> <p><b>Note:</b> Out-of-network deductible amounts also count toward the in-network deductible.</p>
Flat-dollar copays	<ul style="list-style-type: none"> <li>\$40 copay for office visits and office consultations</li> <li>\$40 copay for medical online visits</li> <li>\$40 copay for chiropractic and osteopathic manipulative therapy</li> <li>\$250 copay for emergency room visits</li> <li>\$40 copay for urgent care visits</li> </ul>	<ul style="list-style-type: none"> <li>\$250 copay for emergency room visits</li> </ul>
Coinsurance amounts (percent copays)	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing care</li> <li>20% of approved amount for mental health care and substance use disorder treatment</li> <li>20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)</li> </ul>	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing care</li> <li>40% of approved amount for mental health care and substance use disorder treatment</li> <li>40% of approved amount for most other covered services</li> </ul>
<p><b>Note:</b> Coinsurance amounts apply once the deductible has been met.</p>		

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Benefits	In-network	Out-of-network
<b>Annual coinsurance maximums</b> - applies to coinsurance amounts for all covered services - but <b>does not</b> apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	\$1,500 for one member, \$3,000 for the family (when two or more members are covered under your contract) each calendar year	\$3,000 for one member, \$6,000 for the family (when two or more members are covered under your contract) each calendar year  <b>Note:</b> Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.
<b>Annual out-of-pocket maximums</b> - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	\$7,900 for one member, \$15,800 for the family (when two or more members are covered under your contract) each calendar year	None
<b>Lifetime dollar maximum</b>	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  <b>Note:</b> Limited to one per member per calendar year.	100% (no deductible or copay/coinsurance),  <b>Note:</b> Additional well-women visits may be allowed based on medical necessity.	70% after out-of-network deductible
Gynecological exam  <b>Note:</b> Limited to one per member per calendar year.	100% (no deductible or copay/coinsurance),  <b>Note:</b> Additional well-women visits may be allowed based on medical necessity.	70% after out-of-network deductible
Pap smear screening - laboratory and pathology services  <b>Note:</b> Limited to one per member per calendar year.	100% (no deductible or copay/coinsurance),	70% after out-of-network deductible
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	70% 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)	70% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> <li>• 8 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 6 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> <li>• Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</li> </ul>	70% after out-of-network deductible
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)	70% after out-of-network deductible

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Benefits	In-network	Out-of-network
Fecal occult blood screening <b>Note:</b> limited to one per member per calendar year	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Flexible sigmoidoscopy exam <b>Note:</b> limited to one per member per calendar year	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Prostate specific antigen (PSA) screening <b>Note:</b> limited to one per member per calendar year	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) <b>Note:</b> Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	60% after out-of-network deductible <b>Note:</b> Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy <b>Note:</b> Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	60% after out-of-network deductible
	One per member per calendar year	

Physician office services		
Benefits	In-network	Out-of-network
Office visits - must be medically necessary	\$40 copay per office visit	60% after out-of-network deductible
Online visits - by physician must be medically necessary <b>Note:</b> Online visits by a vendor are not covered.	\$40 copay per online visit	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	\$40 copay per office consultation	60% after out-of-network deductible
Urgent care visits - must be medically necessary	\$40 copay per urgent care visit	60% after out-of-network deductible

Emergency medical care		
Benefits	In-network	Out-of-network
Hospital emergency room	\$250 copay per visit (copay waived if admitted or for an accidental injury)	\$250 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

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## 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 visit	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

## 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	60% after out-of-network deductible
<b>Note:</b> Nonemergency services must be rendered in a <b>participating</b> hospital.	Unlimited days	
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

## Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a <b>participating</b> skilled nursing facility	80% after in-network deductible	80% after in-network deductible
	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 <b>participating</b> hospice program <b>only</b> ; 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"> <li>• must be medically necessary</li> <li>• must be provided by a <b>participating</b> home health care agency</li> </ul>	80% after in-network deductible	80% after in-network deductible

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Benefits	In-network	Out-of-network
Infusion therapy: <ul style="list-style-type: none"> <li>• must be medically necessary</li> <li>• must be given by a <b>participating</b> Home Infusion Therapy (HIT) provider or in a <b>participating</b> freestanding Ambulatory Infusion Center (AIC)</li> <li>• may use drugs that require preauthorization - consult with your doctor</li> </ul>	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 <b>participating</b> ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males	80% after in-network deductible	60% after out-of-network deductible
<b>Note:</b> For voluntary sterilizations for females, see " <b>Preventive care services.</b> "		
Voluntary abortions	Not covered	Not covered
Refractive keratoplasties, including but not limited to LASIK and PRK services - subject to age and medical criteria	80% after in-network deductible	60% after out-of-network deductible

Human organ transplants		
Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a <b>designated</b> 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 <b>only</b>
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
<b>Note:</b> BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

## Mental health care and substance use disorder treatment

**Note:** Some mental health and substance use disorder services are considered by BCBSM to be comparable to an office visit or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit or medical online visit, we will process the claim under your office visit or medical online visit benefit.

Benefits	In-network	Out-of-network
<b>Inpatient</b> mental health care and <b>inpatient</b> substance use disorder treatment	80% after in-network deductible	60% after out-of-network deductible
		Unlimited days
Residential psychiatric treatment facility: <ul style="list-style-type: none"> <li>• covered mental health services <b>must</b> be performed in a residential psychiatric treatment facility</li> <li>• treatment <b>must</b> be preauthorized</li> <li>• subject to medical criteria</li> </ul>	80% after in-network deductible	60% after out-of-network deductible

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Benefits	In-network	Out-of-network
Outpatient mental health care:		
• Facility and clinic	80% after in-network deductible	80% after in-network deductible in participating facilities <b>only</b>
• Online visits	\$40 copay per online visit	60% after out-of-network deductible
<b>Note:</b> Online visits by a vendor are not covered.		
• Physician's office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities <b>only</b>	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 behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization	Not covered	Not covered
<b>Note:</b> 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.		
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not covered	Not covered
Other covered services, including mental health services, for autism spectrum disorder	Not covered	Not covered

## Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP)	<ul style="list-style-type: none"> <li>80% after in-network deductible for diabetes medical supplies</li> <li>100% (no deductible or copay/coinsurance) for diabetes self-management training</li> </ul>	60% after out-of-network deductible
<b>Note:</b> 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.		
<b>Note:</b> When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.		
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$40 copay per visit	60% after out-of-network deductible
	Limited to a <b>combined</b> 24-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
		<b>Note:</b> Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a <b>combined</b> 60-visit maximum per member per calendar year	

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Benefits	In-network	Out-of-network
Durable medical equipment  <b>Note:</b> DME items required under the preventive benefit provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

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## BCBSM Preferred RX Program

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**Specialty Pharmaceutical Drugs** - The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, 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. Walgreens Specialty Pharmacy 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 Express Scripts. (Express Scripts 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](http://bcbsm.com/pharmacy). If you have any questions, please 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 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](http://bcbsm.com/pharmacy).

## Member's responsibility (copays and coinsurance amounts)

**Note:** Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

**Note:** If your prescription is filled by any type of in-network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list, you do not need to pay the difference in cost between the maximum allowable cost and the BCBSM approved amount for the brand-name drug. You pay only your applicable copay.

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
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay 10% of approved amount, but not less than \$20 or more than \$200 for each covered drug	You pay 10% of approved amount, but not less than \$20 or more than \$200 for each covered drug	You pay 10% of approved amount, but not less than \$10 or more than \$100 for each covered drug	You pay \$5 copay <b>plus</b> an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay 10% of approved amount, but not less than \$20 or more than \$200 for each covered drug	No coverage	No coverage
	84 to 90-day period	You pay 10% of approved amount, but not less than \$20 or more than \$200 for each covered drug	You pay 10% of approved amount, but not less than \$20 or more than \$200 for each covered drug	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay 20% of approved amount, but not less than \$20 or more than \$200 for each covered drug	You pay 20% of approved amount, but not less than \$20 or more than \$200 for each covered drug	You pay 20% of approved amount, but not less than \$10 or more than \$100 for each covered drug	You pay \$10 copay <b>plus</b> an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay 20% of approved amount, but not less than \$20 or more than \$200 for each covered drug	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
Tier 3 - Nonpreferred brand-name drugs	84 to 90-day period	You pay 20% of approved amount, but not less than \$20 or more than \$200 for each covered drug	You pay 20% of approved amount, but not less than \$20 or more than \$200 for each covered drug	No coverage	No coverage
	1 to 30-day period	You pay 30% of approved amount, but not less than \$20 or more than \$200 for each covered drug	You pay 30% of approved amount, but not less than \$20 or more than \$200 for each covered drug	You pay 30% of approved amount, but not less than \$10 or more than \$100 for each covered drug	You pay \$25 copay <b>plus</b> an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay 30% of approved amount, but not less than \$20 or more than \$200 for each covered drug	No coverage	No coverage
	84 to 90-day period	You pay 30% of approved amount, but not less than \$20 or more than \$200 for each covered drug	You pay 30% of approved amount, but not less than \$20 or more than \$200 for each covered drug	No coverage	No coverage

**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	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
Prescribed over-the-counter drugs - when covered by BCBSM	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
State-controlled 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 <b>generic</b> and <b>select brand-name</b> 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 <b>brand-name</b> prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

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Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	No coverage	100% of approved amount	75% of approved amount
FDA-approved <b>generic</b> and <b>select brand-name</b> 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 <b>brand-name</b> 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
<b>Note:</b> Needles and syringes have no copay/coinsurance.				

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

## Features of your prescription drug plan

Custom Drug List	<p>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.</p> <ul style="list-style-type: none"> <li>• <b>Tier 1 (generic)</b> - Tier 1 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.</li> <li>• <b>Tier 2 (preferred brand)</b> - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance.</li> <li>• <b>Tier 3 (nonpreferred brand)</b> - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.</li> </ul>
Drug interchange and generic copay/coinsurance waiver	<p>BCBSM's drug interchange and generic copay/coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent.</p> <p>If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/coinsurance. In select cases BCBSM may waive the initial copay/coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.</p>

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## Features of your prescription drug plan

<p>Prescription drug preferred therapy</p>	<p>A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications <b>before</b> prescribing a more expensive brand-name drug. It applies only to prescriptions being filled for the first time of a targeted medication.</p> <p>Before filling your <b>initial</b> prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at <a href="http://bcbsm.com/pharmacy">bcbsm.com/pharmacy</a>, <b>along with the preferred medications.</b></p> <p>If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect <b>all</b> targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.</p>
<p>Mandatory maximum allowable cost drugs</p>	<p>If your prescription is filled by an in-network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you <b>MUST</b> pay the <b>difference</b> 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/coinsurance regardless of whether you or your physician requests the brand-name drug. <b>Exception:</b> If your physician requests and receives authorization for a nonpreferred 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/coinsurance.</p> <p><b>Note:</b> This MAC difference will not be applied toward your annual in-network deductible, your annual coinsurance, or your annual out-of-pocket maximum, if applicable.</p>
<p>Quantity limits</p>	<p>To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.</p>

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## Dental Coverage

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### Network access information

With Blue Dental PPO, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.<sup>1</sup>

**Blue Dental PPO network**- Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 438,000 dentist locations<sup>2</sup> nationwide. PPO dentists agree to accept our approved amount as full payment for covered services - members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit [mibluedentist.com](http://mibluedentist.com) or call **1-888-826-8152**.

<sup>1</sup>Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.

<sup>2</sup>A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.

**Blue Par Select<sup>SM</sup> arrangement**- Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services - members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit [mibluedentist.com](http://mibluedentist.com).

**Note:** Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

## Eligibility information

Member	Eligibility Criteria
Dependents	<ul style="list-style-type: none"> <li>Subscriber's legal spouse</li> <li><b>Unmarried</b> dependent children: related to you by birth, marriage, legal adoption or legal guardianship, eligible for dental coverage through the last day of the month the dependent turns age 26, provided all eligibility requirements are met</li> </ul>

## Member's responsibility (deductible, coinsurance and dollar maximums)

Benefits	Coverage
<b>Deductible</b>	None
<b>Coinsurance (percentage of BCBSM's approved amount for covered services)</b>	None (covered at 100%)
<ul style="list-style-type: none"> <li>Class I services</li> </ul>	
<ul style="list-style-type: none"> <li>Class II services</li> </ul>	50%
<ul style="list-style-type: none"> <li>Class III services</li> </ul>	50%
<ul style="list-style-type: none"> <li>Class IV services</li> </ul>	Not covered
<b>Dollar maximums</b>	\$1,000 per member
<ul style="list-style-type: none"> <li>Annual maximum for Class I, II and III services</li> </ul>	
<ul style="list-style-type: none"> <li>Lifetime maximum for Class IV services</li> </ul>	Not applicable

## Class I services

Benefits	Coverage
Oral exams	100% of approved amount <b>Note:</b> Twice per calendar year
A set (up to 4 films) of bitewing x-rays	100% of approved amount <b>Note:</b> Twice per calendar year

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Benefits	Coverage
Panoramic or full-mouth x-rays	100% of approved amount <b>Note:</b> Once every 60 months
Dental prophylaxis (teeth cleaning)	100% of approved amount <b>Note:</b> Twice per calendar year
Pit and fissure sealants - for members age 19 and younger	100% of approved amount <b>Note:</b> Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Palliative (emergency) treatment	100% of approved amount
Fluoride treatments	100% of approved amount <b>Note:</b> Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	100% of approved amount <b>Note:</b> Once per quadrant per lifetime

## Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	50% of approved amount <b>Note:</b> Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	50% of approved amount <b>Note:</b> Replacement fillings covered after 12 months or more after initial filling
Onlays, inlays, crowns and veneer restorations - permanent teeth - for members age 12 and older	50% of approved amount <b>Note:</b> Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	50% of approved amount <b>Note:</b> Three times per tooth per calendar year after six months from original restoration
Oral surgery	50% of approved amount
Root canal treatment	50% of approved amount <b>Note:</b> Once every 12 months
Scaling and root planing	50% of approved amount <b>Note:</b> Once every 24 months per quadrant
Limited occlusal adjustments	50% of approved amount <b>Note:</b> <b>Limited</b> occlusal adjustments covered up to five times in any 60 consecutive months
Occlusal biteguards	50% of approved amount <b>Note:</b> Once every 12 months
General anesthesia or IV sedation	50% of approved amount <b>Note:</b> When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	50% of approved amount <b>Note:</b> Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	50% of approved amount <b>Note:</b> Once per arch in any 36 consecutive months
Tissue conditioning	50% of approved amount <b>Note:</b> Once per arch in any 36 consecutive months

## Class III services

Benefits	Coverage
Removable dentures (complete and partial)	50% of approved amount <b>Note:</b> Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	50% of approved amount <b>Note:</b> Once every 60 months

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Benefits	Coverage
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount <b>Note:</b> Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

### Class IV services - Orthodontic services for dependents under age 19

Benefits	Coverage
Minor treatment for tooth guidance appliances	Not covered
Minor treatment to control harmful habits	Not covered
Interceptive and comprehensive orthodontic treatment	Not covered
Post-treatment stabilization	Not covered
Cephalometric film (skull) and diagnostic photos	Not covered

**Note:** For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination **before** treatment begins.

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