



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

MICHIGAN CARPENTERS' HEALTH CARE FUND

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Effective Date: 01/01/2017

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.

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 - 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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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. Cost-sharing may differ when you obtain covered services outside of Michigan. 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

Members	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 through the last day of the month the dependent turns age 26
No-fault automobile accidents, option 2	<p>Excludes BCBSM from responsibility for any services related to an injury that is a direct or indirect result of a motor vehicle accident. This applies whether or not a member has no - fault motor vehicle insurance.</p> <p>Note: Additional restrictions apply.</p>

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

Benefits	In-network	Out-of-network
Deductible	<p>\$1,000 for one member, \$2,000 for the family (when two or more members are covered under your contract) each calendar year (no 4th quarter carry-over)</p> <p>Note: Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance abuse services that are equivalent to an office visit and performed in an in-network physician's office.</p>	<p>\$2,000 for one member, \$4,000 for the family (when two or more members are covered under your contract) each calendar year (no 4th quarter carry-over)</p> <p>Note: Out-of-network deductible amounts also count toward the in-network deductible.</p>
Flat-dollar copays	<ul style="list-style-type: none"> \$40 copay for office visits and office consultations \$40 copay for online visits \$40 copay for chiropractic and osteopathic manipulative therapy \$250 copay for emergency room visits 	<ul style="list-style-type: none"> \$250 copay for emergency room visits
Coinsurance amounts (percent copays)	<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 abuse treatment 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office) 	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 40% of approved amount for mental health care and substance abuse treatment 40% of approved amount for most other covered services
<p>Note: Coinsurance amounts apply once the deductible has been met.</p> <p>Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but does not apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts</p>	<p>\$5,350 for one member, \$10,700 for the family (when two or more members are covered under your contract) each calendar year</p>	<p>\$10,700 for one member, \$21,400 for the family (when two or more members are covered under your contract) each calendar year</p> <p>Note: Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.</p>

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Benefits	In-network	Out-of-network
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	\$6,350 for one member, \$12,700 for the family (when two or more members are covered under your contract) each calendar year	\$12,700 for one member, \$25,400 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
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), one 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 for Females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and child care 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

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Benefits	In-network	Out-of-network
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.
One per member per calendar year		
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
One per member per calendar year		
Preventive endoscopic exams - one per member, per calendar year	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible

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 - must be medically necessary	\$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

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

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Benefits	In-network	Out-of-network
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 Unlimited days
Note: Nonemergency services must be rendered in a participating hospital.		
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a participating skilled nursing facility	80% after in-network deductible	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 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 	80% after in-network deductible	80% after in-network 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 	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	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
Note: For voluntary sterilizations for females, see " Preventive care services. "		
Voluntary Abortions	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

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Benefits	In-network	Out-of-network
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.		
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Mental health care and substance abuse treatment

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

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance abuse treatment	80% after in-network deductible	60% after out-of-network 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 	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> Facility and clinic 	80% after in-network deductible	80% after in-network deductible in participating facilities only
<ul style="list-style-type: none"> Physician's office 	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance abuse 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 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
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.		
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"> 80% after in-network deductible for diabetes medical supplies 100% (no deductible or copay/coinsurance) for diabetes self-management training 	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.		

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Benefits	In-network	Out-of-network
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 Limited to a combined 24-visit maximum per member per calendar year	60% after out-of-network deductible
Outpatient physical, speech and occupational therapy - provided for rehabilitation	80% after in-network deductible Limited to a combined 60-visit maximum per member per calendar year	60% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
Durable medical equipment Note: DME items 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. For a list of covered DME items required under PPACA, 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
Pediatric Ectodermal Dysplasias for qualified child dependents of eligible participants. Benefits will include up to two (2) sets of dentures for a twelve calendar month period for each qualified child dependent including related services necessary for fitting and adjustment to dentures. Restrictions apply.	90% after in-network deductible	70% after out-of-network deductible

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BCBSM Preferred RX Program

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 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. 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 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select 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 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 and the prescriber has not indicated "Dispensed as Written" (DAW) on the prescription, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic **plus** the applicable copay/coinsurance.

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 \$20 copay	You pay \$20 copay	You pay \$20 copay	You pay \$20 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$40 copay	No coverage	No coverage
	84 to 90-day period	You pay \$40 copay	You pay \$40 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay \$60 copay	You pay \$60 copay	You pay \$60 copay	You pay \$60 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$120 copay	No coverage	No coverage
	84 to 90-day period	You pay \$120 copay	You pay \$120 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay 50% of the approved amount, no more than \$300 copay per prescription drug	You pay 50% of the approved amount, no more than \$300	You pay 50% of the approved amount, no more than \$300	You pay 50% of the approved amount, no more than \$300 plus an additional 25% of BCBSM approved amount for the drug

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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
31 to 83-day period	No coverage	You pay 50% of the approved amount, no more than \$600	No coverage	No coverage
84 to 90-day period	You pay 50% of the approved amount, no more than \$600	You pay 50% of the approved amount, no more than \$600	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 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	Not covered	100% of approved amount	75% 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	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

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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
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	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
Elective drugs Note: Elective lifestyle drugs are lifestyle drugs that treat sexual impotency or infertility, or help in weight loss. They are not designed to treat acute or chronic illnesses. These medications are prescribed for medical conditions that have no demonstrable physical harm if not treated. (Smoking cessation drugs are not considered an elective lifestyle drug and are a payable benefit.) BCBSM determines when a drug is an elective drug.	50% of approved amount	50% of approved amount	50% of approved amount	50% of approved amount

* 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"> • Tier 1 (generic) - 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. • Tier 2 (preferred brand) - 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. • Tier 3 (nonpreferred brand) - 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.
Prior authorization/step therapy	<p>A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring preauthorization) 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 preauthorization. Details about which drugs require preauthorization or step therapy are available online site at bcbsm.com/pharmacy.</p>
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>

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 before 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 initial 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 bcbsm.com/pharmacy, along with the preferred medications.</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 all 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 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.</p>
<p>Quantity limits</p>	<p>To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.</p>

Vision Coverage

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Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com**.

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	Not applicable	Not applicable
Prescription glasses (lenses and/or frames)	Not applicable	Not applicable
Medically necessary contact lenses	Not applicable	Not applicable

Eye exam

Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	Not covered - 20% percent discount on eye exam	Not covered

Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
Standard lenses	Not covered - 20% percent discount applies to: <ul style="list-style-type: none">• complete pair of glasses• lens options• sunglasses	Not covered
Standard frames	Not covered - 20% discount on frames	Not covered

Contact lens evaluation and fitting

Benefits	VSP network doctor	Non-VSP provider
Contact lenses: <ul style="list-style-type: none">• Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)• Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	Not covered - 15% discount applies to contact lens exam only. Discount does not apply to contact lenses	Not covered

Value added discounts

Laser VisionCareSM - VSP has contracted with many of the nation's finest laser surgery facilities and doctors, offering you a discount off PRK and LASIK surgeries, available through contracted laser centers. Visit VSP's Web site at **vsp.com** to learn more about this exciting program.

Prescription glasses - Your plan provides unlimited use of the 20 percent discount on glasses as long as an eye exam has been performed in the last 12 months.

Contact lenses - VSP also offers valuable savings on annual supplies of certain brands of contacts. Visit **vsp.com** or ask your doctor for details .

Locating your VSP network doctor

When you obtain services from a VSP network doctor, you get the most value from your VSP benefit. VSP offers two convenient ways to locate a VSP doctor near your home or office, or to verify your doctor is a VSP network doctor:

- Visit the VSP Web site at **vsp.com**
- Call VSP Member Services at 1-800-877-7195

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MICHIGAN CARPENTERS HEALTH

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Effective Date: 01/01/2017

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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 - 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"> Subscriber's legal spouse 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
No-fault automobile accidents, option 2	<p>Excludes BCBSM from responsibility for any services related to an injury that is a direct or indirect result of a motor vehicle accident. This applies whether or not a member has no - fault motor vehicle insurance.</p> <p>Note: Additional restrictions apply.</p>

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

Benefits	In-network	Out-of-network
Deductible	<p>\$250 for one member, \$500 for the family (when two or more members are covered under your contract) each calendar year (no 4th quarter carry-over)</p> <p>Note: Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance abuse services that are equivalent to an office visit and performed in an in-network physician's office.</p>	<p>\$500 for one member, \$1,000 for the family (when two or more members are covered under your contract) each calendar year (no 4th quarter carry-over)</p> <p>Note: Out-of-network deductible amounts also count toward the in-network deductible.</p>
Flat-dollar copays	<ul style="list-style-type: none"> \$30 copay for office visits and office consultations \$30 copay for online visits \$30 copay for chiropractic and osteopathic manipulative therapy \$150 copay for emergency room visits 	<ul style="list-style-type: none"> \$150 copay for emergency room visits
Coinsurance amounts (percent copays)	<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 abuse treatment 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office) 	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 40% of approved amount for mental health care and substance abuse treatment 40% of approved amount for most other covered services
<p>Note: Coinsurance amounts apply once the deductible has been met.</p> <p>Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but does not apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts</p>	<p>\$5,350 for one member, \$10,700 for the family (when two or more members are covered under your contract) each calendar year</p>	<p>\$10,700 for one member, \$21,400 for the family (when two or more members are covered under your contract) each calendar year</p> <p>Note: Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.</p>

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Benefits	In-network	Out-of-network
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	\$6,350 for one member, \$12,700 for the family (when two or more members are covered under your contract) each calendar year	\$12,700 for one member, \$25,400 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
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), one 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 for Females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and child care 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

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Benefits	In-network	Out-of-network
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.
One per member per calendar year		
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
One per member per calendar year		
Preventive endoscopic exams - one per member, per calendar year	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	\$30 copay per office visit	60% after out-of-network deductible
Online visits - must be medically necessary	\$30 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	\$30 copay per office consultation	60% after out-of-network deductible
Urgent care visits - must be medically necessary	\$30 copay per urgent care visit	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	\$150 copay per visit (copay waived if admitted or for an accidental injury)	\$150 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

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

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Benefits	In-network	Out-of-network
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 Unlimited days
Note: Nonemergency services must be rendered in a participating hospital.		
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a participating skilled nursing facility	80% after in-network deductible	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 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 	80% after in-network deductible	80% after in-network 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 	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	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
Note: For voluntary sterilizations for females, see " Preventive care services. "		
Voluntary Abortions	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

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Benefits	In-network	Out-of-network
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.		
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Mental health care and substance abuse treatment

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

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance abuse treatment	80% after in-network deductible	60% after out-of-network 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 	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> Facility and clinic 	80% after in-network deductible	80% after in-network deductible in participating facilities only
<ul style="list-style-type: none"> Physician's office 	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance abuse 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 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
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.		
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"> 80% after in-network deductible for diabetes medical supplies 100% (no deductible or copay/coinsurance) for diabetes self-management training 	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.		

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Benefits	In-network	Out-of-network
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$30 copay per visit Limited to a combined 24-visit maximum per member per calendar year	60% after out-of-network deductible
Outpatient physical, speech and occupational therapy - provided for rehabilitation	80% after in-network deductible Limited to a combined 60-visit maximum per member per calendar year	60% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
Durable medical equipment Note: DME items 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. For a list of covered DME items required under PPACA, 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
Pediatric Ectodermal Dysplasias for qualified child dependents of eligible participants. Benefits will include up to two (2) sets of dentures for a twelve calendar month period for each qualified child dependent including related services necessary for fitting and adjustment to dentures. Restrictions apply.	90% after in-network deductible	70% after out-of-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. 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 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select 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 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 and the prescriber has not indicated "Dispensed as Written" (DAW) on the prescription, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic **plus** the applicable copay/coinsurance.

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 \$15 copay	You pay \$15 copay	You pay \$15 copay	You pay \$15 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$30 copay	No coverage	No coverage
	84 to 90-day period	You pay \$30 copay	You pay \$30 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay \$50 copay	You pay \$50 copay	You pay \$50 copay	You pay \$50 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$100 copay	No coverage	No coverage
	84 to 90-day period	You pay \$100 copay	You pay \$100 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay 50% of the approved amount, no more than \$100 copay per prescription drug	You pay 50% of the approved amount, no more than \$100 copay per prescription drug	You pay 50% of the approved amount, no more than \$100 copay per prescription drug	You pay 50% of the approved amount, no more than \$100 copay per prescription drug plus an additional 25% of BCBSM approved amount for the drug

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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
31 to 83-day period	No coverage	You pay 50% of the approved amount, no more than \$200 copay per prescription drug	No coverage	No coverage
84 to 90-day period	You pay 50% of the approved amount, no more than \$200 copay per prescription drug	You pay 50% of the approved amount, no more than \$200 copay per prescription 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 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	Not covered	100% of approved amount	75% 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	75% of approved amount

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 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 Note: Needles and syringes have no copay/ coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug
Elective drugs Note: Elective lifestyle drugs are lifestyle drugs that treat sexual impotency or infertility, or help in weight loss. They are not designed to treat acute or chronic illnesses. These medications are prescribed for medical conditions that have no demonstrable physical harm if not treated. (Smoking cessation drugs are not considered an elective lifestyle drug and are a payable benefit.) BCBSM determines when a drug is an elective drug.	50% of approved amount	50% of approved amount	50% of approved amount	50% of approved amount

* 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"> • Tier 1 (generic) - 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. • Tier 2 (preferred brand) - 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. • Tier 3 (nonpreferred brand) - 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.
Prior authorization/step therapy	<p>A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring preauthorization) 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 preauthorization. Details about which drugs require preauthorization or step therapy are available online site at bcbsm.com/pharmacy.</p>
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 before 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 initial 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 bcbsm.com/pharmacy, along with the preferred medications.</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 all 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 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.</p>
<p>Quantity limits</p>	<p>To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.</p>

Vision Coverage

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.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com**.

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	Not applicable	Not applicable
Prescription glasses (lenses and/or frames)	Not applicable	Not applicable
Medically necessary contact lenses	Not applicable	Not applicable

Eye exam

Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	Not covered - 20% percent discount on eye exam	Not covered

Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
Standard lenses	Not covered - 20% percent discount applies to: <ul style="list-style-type: none">complete pair of glasseslens optionssunglasses	Not covered
Standard frames	Not covered - 20% discount on frames	Not covered

Contact lens evaluation and fitting

Benefits	VSP network doctor	Non-VSP provider
Contact lenses: <ul style="list-style-type: none">Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	Not covered - 15% discount applies to contact lens exam only. Discount does not apply to contact lenses	Not covered

Value added discounts

Laser VisionCareSM - VSP has contracted with many of the nation's finest laser surgery facilities and doctors, offering you a discount off PRK and LASIK surgeries, available through contracted laser centers. Visit VSP's Web site at **vsp.com** to learn more about this exciting program.

Prescription glasses - Your plan provides unlimited use of the 20 percent discount on glasses as long as an eye exam has been performed in the last 12 months.

Contact lenses - VSP also offers valuable savings on annual supplies of certain brands of contacts. Visit **vsp.com** or ask your doctor for details .

Locating your VSP network doctor

When you obtain services from a VSP network doctor, you get the most value from your VSP benefit. VSP offers two convenient ways to locate a VSP doctor near your home or office, or to verify your doctor is a VSP network doctor:

- Visit the VSP Web site at **vsp.com**
- Call VSP Member Services at 1-800-877-7195

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Supplemental Care Coverage

This is not a Medicare document. It is intended as an easy-to-read summary of many important features of Blue Cross Blue Shield Supplemental health care 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 Cross Blue Shield certificates and riders. For more detailed information on Medicare benefits, please call or visit your local Social Security office or consult the Medicare handbook (available on the Medicare Web site at medicare.gov or at any Social Security office).

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

Note: Medicare deductible and coinsurance amounts are effective January 1, 2016 and are subject to change yearly.

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Deductible amounts	<ul style="list-style-type: none"> • Medicare Part A \$1,288 (for days 1-60) each benefit period • Medicare Part B \$166 per calendar year 	None
Coinsurance/fixed dollar copays	<ul style="list-style-type: none"> • Hospital stay \$322 per day (for days 61-90) and \$644 per each "lifetime reserve day" after day 90 (up to 60 days over your lifetime) • Skilled nursing facility stay (a limit of 100 days each benefit period) \$161 per day (for days 21-100) 	None
Coinsurance/percent copay amounts	<ul style="list-style-type: none"> • 20% of Medicare approved amount for most general services • 20% of Medicare approved amount for outpatient mental health care 	None

Preventive care services

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Health maintenance exam (yearly "Wellness" visit)	Covered at 100% of Medicare approved amount*, once every 12 months Note: Your first yearly "Wellness" visit can't take place within 12 months of your enrollment in Part B or your "Welcome to Medicare" preventive visit.	Covered in full by Medicare; no additional coverage by BCBSM
Gynecological exam	Covered at 100% of Medicare approved amount*, once every 24 months	When not covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Pap smear screening - laboratory services only	Covered at 100% of Medicare approved amount*, once every 24 months (more frequently if at high risk)	When not covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year
Voluntary sterilizations for females	Not covered Note: Medicare covers voluntary sterilization if it's necessary for the treatment of an illness or injury.	Covered at 100% of BCBSM approved amount
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	Not covered	Covered at 100% of BCBSM approved amount
Contraceptive injections - includes cost of medication when provided by the physician	Not covered	Covered at 100% of BCBSM approved amount
Screening fecal occult blood test	Covered at 100% of Medicare approved amount*, once every 12 months, if age 50 and older	When not covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening flexible sigmoidoscopy	Covered at 100% of Medicare approved amount*, once every 48 months, if age 50 and older, or every 120 months after a previous screening colonoscopy for those not at high risk	When not covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Prostate specific antigen (PSA) test	Covered at 100% of Medicare approved amount*, once every 12 months, if over age 50 Note: A digital rectal exam is covered at 80% of Medicare approved amount less Part B deductible	When not covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Flu shots	Covered at 100% of Medicare approved amount*, one flu shot per flu season	Covered in full by Medicare; no additional coverage by BCBSM
Hepatitis B shots - for those at medium or high risk for Hepatitis B	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Pneumococcal shot	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Mammography screening	Covered at 100% of Medicare approved amount*, once every 12 months at age 40 and older (one baseline mammogram for women between ages 35 and 39)	When not covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening colonoscopy	Covered at 100% of Medicare approved amount*, once every 120 months (high risk every 24 months) or every 48 months after a previous flexible sigmoidoscopy	When not covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year
Well-baby and child care visits	One health maintenance exam covered at 100% of Medicare approved amount* every 12 months, subsequent well-baby and child care visits not covered	Covered at 100% of BCBSM approved amount <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
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 and not covered by Medicare	Not covered	Covered at 100% of BCBSM approved amount

* Under Medicare coverage, you pay nothing for these services if the doctor or other qualified health care provider accepts assignment. You may be

required to pay 20 percent of the Medicare approved amount for the doctor's visit.

Physician office services		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Office visits	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare coinsurance
Outpatient and home visits	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare coinsurance
Office consultations	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare coinsurance

Emergency medical care		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Hospital emergency room (facility services) - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Ambulance services - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance

Clinical laboratory services		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Laboratory and pathology tests - used in the diagnosis and treatment of an illness or injury	Covered at 100% of Medicare approved amount for most diagnostic laboratory and pathology services (covered at 80% of approved amount for certain laboratory services)	Covered in full by Medicare

Hospital care		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies - does not include private duty nursing	Covered at 100% of Medicare approved amount less Part A deductible (also includes inpatient mental health and residential substance abuse)	Covers Medicare deductible
<ul style="list-style-type: none"> Days 1-60 of each benefit period 		
<ul style="list-style-type: none"> Days 61-90 of each benefit period 	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
<ul style="list-style-type: none"> Lifetime reserve days after day 90 of each benefit period (up to 60 days over your lifetime) 	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
<ul style="list-style-type: none"> Additional days 	Not covered	Covered at BCBSM approved amount, up to an additional 275 days
Chemotherapy	Covered at 80% of Medicare approved amount for administration and drugs, must meet Medicare criteria	Covers Medicare deductible and coinsurance

Alternatives to hospital care		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Skilled nursing facility care - subject to medical criteria	Covered at 100% of Medicare approved amount	Covered in full by Medicare
<ul style="list-style-type: none"> Days 1-20 of each benefit period 		
<ul style="list-style-type: none"> Days 21-100 of each benefit period 	Covered at 100% of Medicare approved amount less daily coinsurance	Covers Medicare coinsurance
<ul style="list-style-type: none"> Days 101 and after 	Not covered	Not covered

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Hospice care	Covered at Medicare approved amount less small copayment for outpatient prescription drugs and less small coinsurance for inpatient respite care	Covers limited costs not covered by Medicare
Home health care services - must be medically necessary and must be provided by a Medicare-certified home health agency	Covered at 100% of Medicare approved amount	Covered in full by Medicare

Surgical services provided by a physician		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Surgery - includes related surgical services	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance

Human organ transplants

Note: Payment is based on medical necessity and must be rendered in an approved facility.

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Heart and liver transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Lung and heart-lung transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Pancreas transplants	Not covered	Not covered
	Note: Pancreas transplants are covered under certain conditions. Please call Medicare for more information.	Note: Covers Medicare deductible and coinsurance when covered by Medicare
Bone marrow transplants - under certain conditions	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance
Kidney, cornea and skin transplants	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance

Mental health care		
Benefits	Original Medicare coverage	Medicare Supplemental coverage
Inpatient mental health care in psychiatric facility • Days 1-190 lifetime	See "Hospital care" benefits (Medicare pays the claim as part of your regular Part A hospital coverage, subject to Part A deductible and coinsurance) Note: In most cases, psychiatric care in general (as opposed to psychiatric) hospitals is not subject to the 190-day limit.	Covers Medicare deductible and daily coinsurance
• Additional days after 190 lifetime days are used	Not covered	Not covered
Outpatient mental health care	Covered at 80% of Medicare approved amount less Part B deductible Note: If you get your services in a hospital outpatient clinic, or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount to the hospital.	Covers Medicare deductible and coinsurance

Other covered services

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Allergy testing and therapy - with approved diagnosis	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance for testing. Injections are not covered.
Chiropractic services (limited coverage) - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance or set copayment
Outpatient physical, speech and occupational therapy	Covered at 80% of Medicare approved amount less Part B deductible Note: There may be a limit on the amount Medicare will pay for these services in a single year and there may be certain exceptions to these limits.	Covers Medicare deductible and coinsurance or set copayment
Durable medical equipment - must be obtained from a Medicare-approved supplier	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Prosthetic appliances	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Private duty nursing	Not covered	Not covered
Oral cancer drugs	Approved drugs are covered	Covered in full by Medicare

Foreign travel

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Hospital services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount, up to 30 days for covered services
Physician services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount

Vision Coverage

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Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com**.

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	20% discount off a thorough eye exam	No discount available
Prescription glasses (lenses and/or frames)	20% discount off unlimited complete pairs of prescription glasses and non-prescription sunglasses	No discount available
Medically necessary contact lenses Note: No copay is required for prescribed contact lenses that are not medically necessary.	15% discount off contact lens services, excluding materials	No discount available
Laser surgery including PRK, LASIK, and Custom Lasik	Discounts average 15% off or 5% off if the laser center is offering a promotional price.	No discount available

Eye exam

Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	20% discount off a thorough eye exam	No discount available

Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
Standard lenses and standard frames Note: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor	20% discount off unlimited complete pairs of prescription glasses and non-prescription sunglasses Note: The discounts are valid through any VSP doctor within 12 months of the last covered eye exam.	No discount available
Lens options Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	20% discount off all lens options	No discount available

Contact Lenses

Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	15% discount off contact lens services, excluding materials	No discount available