



**WASHTENAW COUNTY ROAD COMM D  
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Effective Date: 01/01/2020**

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

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

BCBSM provides administrative claims services only. Your employer is financially responsible for claims.

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. 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"> <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 until the end of the year in which they turn 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>

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

Benefits	In-network	Out-of-network
<b>Deductible</b>	<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 abuse 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>
<b>Flat-dollar copays</b>	<ul style="list-style-type: none"> <li>\$20 copay for office visits and office consultations</li> <li>\$20 copay for chiropractic and osteopathic manipulative therapy</li> <li>\$100 copay for emergency room visits</li> </ul>	<ul style="list-style-type: none"> <li>\$100 copay for emergency room visits</li> </ul>
<p><b>Coinsurance amounts (percent copays)</b></p> <p><b>Note:</b> Coinsurance amounts apply once the deductible has been met.</p>	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing care</li> <li>10% of approved amount for mental health care and substance abuse treatment</li> <li>10% 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>20% of approved amount for mental health care and substance abuse treatment</li> <li>20% of approved amount for most other covered services</li> </ul>
<p><b>Annual coinsurance maximums</b> - applies to coinsurance amounts for all covered services - including mental health and substance abuse services - but <b>does not</b> apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts</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>\$2,000 for one member \$4,000 for the family (when two or more members are covered under your contract) each calendar year</p> <p><b>Note:</b> Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.</p>
<p><b>Annual out-of-pocket maximums</b> - applies to deductibles, copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable</p>	<p>\$6,350 for one member \$12,700 for the family (when two or more members are covered under your contract) each calendar year</p>	<p>\$12,700 for one member \$25,400 for the family (when two or more members are covered under your contract) each calendar year</p> <p><b>Note:</b> Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.</p>
<b>Lifetime dollar maximum</b>	None	

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## 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  <b>Note:</b> 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  <b>Note:</b> Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services - one per member per calendar year	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary Sterilization for Females	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Well-baby and 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>	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance)  <b>Note:</b> Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	80% 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

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Benefits	In-network	Out-of-network
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy  <b>Note:</b> Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible
One per member per calendar year		

Physician office services		
Benefits	In-network	Out-of-network
Office visits - must be medically necessary	\$20 copay per office visit	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	90% after in-network deductible	80% after out-of-network deductible
Office consultations - must be medically necessary	\$20 copay per office consultation	80% after out-of-network deductible
Urgent care visits - must be medically necessary	\$20 copay per urgent care visit	80% after out-of-network deductible

Emergency medical care		
Benefits	In-network	Out-of-network
Hospital emergency room	\$100 copay per visit (copay waived if admitted or for an accidental injury)	\$100 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	90% after in-network deductible	90% after in-network deductible

Diagnostic services		
Benefits	In-network	Out-of-network
Laboratory and pathology services	90% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	90% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	90% after in-network deductible	80% 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)	80% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Delivery and nursery care	90% after in-network deductible	80% after out-of-network deductible

Hospital care		
Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	90% after in-network deductible	80% after out-of-network deductible
Unlimited days		
<b>Note:</b> Nonemergency services must be rendered in a <b>participating</b> hospital.		
Inpatient consultations	90% after in-network deductible	80% after out-of-network deductible
Chemotherapy	90% after in-network deductible	80% after out-of-network deductible

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## Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a <b>participating</b> skilled nursing facility	90% after in-network deductible Limited to a maximum of 120 days per member per calendar year.	90% after in-network deductible
Hospice care	100% (no deductible or copay/coinsurance) Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a <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)	100% (no deductible or copay/coinsurance)
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>	90% after in-network deductible	90% after in-network deductible
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>	90% after in-network deductible	90% 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	90% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Voluntary sterilization for males	90% after in-network deductible	80% after out-of-network deductible
<b>Note:</b> For voluntary sterilizations for females, see " <b>Preventive care services.</b> "		

## 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)	90% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials	90% after in-network deductible	80% after out-of-network deductible
<b>Note:</b> BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	90% after in-network deductible	80% 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
<b>Inpatient</b> mental health care and <b>inpatient</b> substance abuse treatment	90% after in-network deductible	80% after out-of-network deductible Unlimited days

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Benefits	In-network	Out-of-network
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>	90% after in-network deductible	80% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> <li>Facility and clinic</li> </ul>	90% after in-network deductible	90% after in-network deductible in participating facilities <b>only</b>
<ul style="list-style-type: none"> <li>Physician's office</li> </ul>	90% after in-network deductible	80% after out-of-network deductible
Outpatient substance abuse treatment - in approved facilities <b>only</b>	90% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

## Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied 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)  <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.	<ul style="list-style-type: none"> <li>90% after in-network deductible for diabetes medical supplies</li> <li>100% (no deductible or copay/coinsurance) for diabetes self-management training</li> </ul>	80% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$20 copay per visit  Limited to a <b>combined</b> 24-visit maximum per member per calendar year	80% after out-of-network deductible
Outpatient physical, speech and occupational therapy - provided for rehabilitation	90% after in-network deductible	80% 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
Durable medical equipment  <b>Note:</b> 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.	90% after in-network deductible	90% after in-network deductible

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Benefits	In-network	Out-of-network
Prosthetic and orthotic appliances	90% after in-network deductible	90% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible
Special foods and formulas for Metabolic diseases	Not covered	Not covered

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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](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 initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

### 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
Generic or prescribed over-the-counter prescription drugs	1 to 30-day period	You pay \$0 copay	You pay \$0 copay	You pay \$0 copay	You pay 25% prescription drug out-of-network copay from an out-of-network retail pharmacy provider
	31 to 83-day period	No coverage	You pay \$0 copay	No coverage	No coverage
	84 to 90-day period	You pay \$0 copay	You pay \$0 copay	No coverage	No coverage
Brand name prescription drugs	1 to 30-day period	You pay \$30 copay	You pay \$30 copay	You pay \$30 copay	You pay \$30 copay <b>plus</b> an additional 25% prescription drug out-of-network copay from an out-of-network retail pharmacy provider
	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

**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 (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 preventive drugs, supplements and vitamins as required by PPACA (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
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

Mandatory preauthorization	A process that requires a physician to obtain approval from BCBSM <b>before</b> select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. <b>Step Therapy</b> , 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 <a href="http://bcbsm.com/pharmacy">bcbsm.com/pharmacy</a> .
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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>
Clinical 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>
Elective lifestyle drugs	<p>Benefits are excluded for elective lifestyle drugs.</p> <p><b>Note:</b> 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.</p>
Quantity limits	<p>To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.</p>