



Blue Cross
Blue Shield
of Michigan

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

Grand Ledge Public Schools A1MBV8 000000000000 Simply BlueSM PPO LG Effective Date: On or after January 2024 Benefits-at-a-glance

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

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

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

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

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

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

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

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

Benefits	In-network	Out-of-network
Deductibles	\$2,000 for one member, \$4,000 for the family (when two or more members are covered under your contract) each calendar year	\$4,000 for one member, \$8,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	<ul style="list-style-type: none"> \$20 copay for office visits and office consultations \$20 copay for virtual primary care visits \$20 copay for medical online visits \$20 copay for chiropractic and osteopathic manipulative therapy \$150 copay for emergency room visits \$20 copay for urgent care visits 	<ul style="list-style-type: none"> \$150 copay for emergency room visits
Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.	<ul style="list-style-type: none"> 30% of approved amount for private duty nursing care 	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 20% of approved amount for most other covered services
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	\$8,150 for one member, \$16,300 for the family (when two or more members are covered under your contract) each calendar year	\$16,300 for one member, \$32,600 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), two per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered

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Benefits	In-network	Out-of-network
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization of female reproductive organs	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 Well-child 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
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) <p>Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance</p>	80% after out-of-network deductible <p>Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.</p>
		One per member per calendar year
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy <p>Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance</p>	80% after out-of-network deductible
		One per member per calendar year

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Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary Note: Virtual Primary Care visits by a non-BCBSM selected vendor are not covered.	<ul style="list-style-type: none"> \$20 copay for each office visit (in person or virtual) \$20 copay for each virtual primary care visit for members 18 years of age or older, by a BCBSM selected vendor <p>Note: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.</p>	80% after out-of-network deductible
Online visits - by physician must be medically necessary Note: Online visits by a non-BCBSM selected vendor are not covered. Not all services delivered virtually are considered an online visit, but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	\$20 copay per online visit	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations - must be medically necessary	\$20 copay for each office consultation Note: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	80% after out-of-network deductible

Urgent care visits

Benefits	In-network	Out-of-network
Urgent care visits	\$20 copay for each urgent care visit Note: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	80% 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)	\$150 copay per visit (copay waived if admitted)
Ambulance services - must be medically necessary	100% after in-network deductible	100% after in-network deductible

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Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% 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	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Delivery and nursery care	100% 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	100% after in-network deductible	80% after out-of-network deductible
Note: Nonemergency services must be rendered in a participating hospital.	Unlimited days	
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% 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	100% after in-network deductible	100% 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 	100% after in-network deductible	100% after in-network deductible

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Benefits	In-network	Out-of-network
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 	100% after in-network deductible	100% 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	100% 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 of male reproductive organs	100% after in-network deductible	80% after out-of-network deductible
Note: For voluntary sterilization of female reproductive organs, see " Preventive care services. "		
Elective abortions	100% after in-network deductible	80% after out-of-network deductible

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
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials	100% after in-network deductible	80% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
Cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

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

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance use disorder treatment	100% after in-network deductible	80% 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 	100% after in-network deductible	80% after out-of-network deductible

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Benefits	In-network	Out-of-network
Outpatient mental health care: <ul style="list-style-type: none"> Facility and clinic 	100% after in-network deductible	100% after in-network deductible in participating facilities only
<ul style="list-style-type: none"> Online visits Note: Online visits by a non-BCBSM selected vendor are not covered.	100% after in-network deductible	80% after out-of-network deductible
<ul style="list-style-type: none"> Physician's office 	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities only	100% 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 behavior analysis (ABA) treatment - when rendered by an approved licensed behavior analyst - subject to preauthorization	100% after in-network deductible	100% after in-network deductible
Note: Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).		
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible
	Physical, speech and occupational therapy with an autism diagnosis is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP)	<ul style="list-style-type: none"> 100% after in-network deductible for diabetes medical supplies 100% (no deductible or copay/coinsurance) for diabetes self-management training 	80% 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.		
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$20 copay per visit Note: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam	80% after out-of-network deductible
	Limited to a combined 12-visit maximum per member per calendar year	

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Benefits	In-network	Out-of-network
Outpatient physical, speech and occupational therapy - provided for rehabilitation	100% after in-network deductible	80% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
Limited to a combined 60-visit maximum per member per calendar year		
Durable medical equipment Note: Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers. 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.	100% after in-network deductible	80% after out-of-network deductible
Prosthetic and orthotic appliances Note: Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers.	100% after in-network deductible	80% after out-of-network deductible
Private duty nursing care	70% after in-network deductible	50% after out-of-network deductible

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Preferred Rx Program LG
Effective Date: On or after January 2024
Benefits-at-a-glance**

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Prescription Drug Discount Program - Prescription drug manufacturers provide coupon programs for certain medications. Your benefit plan requires you to take advantage of BCBSM-approved coupon programs for select medications. This benefit may lower the cost-sharing typically required for these drugs. Your out-of-pocket expense will be no more than your benefit cost-sharing. When a manufacturer coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum.

NOTE: Adjustments may be required to accurately reflect your annual out-of-pocket maximum to reflect your true out-of-pocket cost.

This program may be discontinued at any time if it is no longer supported by the vendor.

Specialty Pharmaceutical Drugs - The pharmacy for **specialty drugs** is AllianceRx Walgreens Pharmacy, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. You may also obtain specialty drugs through a Walgreens retail pharmacy as long as the drug is available at that location. You may want to call ahead to confirm availability at the location. **If you go to a non-AllianceRx Walgreens Pharmacy, you may be responsible for 100% of the cost of the specialty drug.** A list of specialty drugs is available on our Web site at bcbsm.com/pharmacy. If you have any questions, please call AllianceRx Walgreens Pharmacy customer service at 1-866-515-1355.

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

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

Member's responsibility (copays and coinsurance amounts)

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

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 select prescribed over-the-counter drugs	1 to 30-day period You pay \$10 copay	You pay \$10 copay	You pay \$10 copay	You pay \$10 copay 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
Preferred brand-name drugs	31 to 83-day period	No coverage	You pay \$20 copay	No coverage	No coverage
	84 to 90-day period	You pay \$20 copay	You pay \$20 copay	No coverage	No coverage
	1 to 30-day period	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay	You pay \$40 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$80 copay	No coverage	No coverage
Nonpreferred brand-name drugs	84 to 90-day period	You pay \$80 copay	You pay \$80 copay	No coverage	No coverage
	1 to 30-day period	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay	You pay \$80 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$160 copay	No coverage	No coverage
	84 to 90-day period	You pay \$160 copay	You pay \$160 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 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

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Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	No coverage	100% of approved amount	75% of approved amount
FDA-approved 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
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
Select diabetic supplies and devices (test strips, lancets and glucometers) For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy.	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

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

Features of your prescription drug plan

Custom Drug List	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> • Generic drug tier - This tier 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. • Preferred brand-name drug tier - This tier includes non-specialty preferred brand-name drugs. These drugs are more expensive than generic and members pay more for them. • Nonpreferred brand-name drug tier - This tier includes non-specialty brand-name drugs for which there's either a generic alternative or a more cost-effective preferred brand-name drug available. Members pay more for these nonpreferred brand-name drugs.
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Features of your prescription drug plan

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

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**Grand Ledge Public Schools
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Hearing Care Coverage
Effective Date: On or after January 2024
Benefits-at-a-glance**

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

Member's responsibility (deductible and copay)

Benefits	Participating provider	Nonparticipating provider
Deductible	None	Not applicable
Copay	None	Not applicable

Covered services

You **must** receive the following services from a **hearing participating provider**. Hearing care services are **not** covered when performed by nonparticipating providers unless the services are performed outside of Michigan **and** the local Blue Cross and Blue Shield plan does **not** contract with providers for hearing care services. In this case, BCBSM will pay the approved amount for hearing aids and related covered services obtained from a nonparticipating provider. You may be responsible for charges that exceed our approved amount.

Benefits	Participating provider	Nonparticipating provider
Audiometric exam - one every 36 months	100% of approved amount	Not covered
Hearing aid evaluation- one every 36 months	100% of approved amount	Not covered
Ordering and fitting the hearing aid (a monaural or binaural hearing aid)- one every 36 months	100% of approved amount	Not covered
Hearing aid conformity test- one every 36 months	100% of approved amount	Not covered

Note: You **must** obtain a medical evaluation (sometimes called a medical clearance exam) of the ear performed by a physician-specialist before you receive your hearing aid. If a physician-specialist is not accessible, your primary care doctor may perform the medical evaluation. **This evaluation is not covered under your hearing care coverage, so you must pay for this exam unless your medical coverage includes coverage for office visits.**

A physician-specialist is a licensed doctor of medicine or osteopathy who is also board certified or in the process of being board certified as an otolaryngologist. A physician-specialist determines whether a patient has a hearing loss and whether such loss can be offset by a hearing aid.

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