Blue Cross Blue Shield of Michigan

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

# Henniges Automotive
# Group Number: 71325  Package Code(s): 180, 190
# Division Code(s): 4050, 4150, 4202
# PPO - Iowa Choice PPO with Health Savings (IA Hourly), Rx10
# Effective Date: 01/01/2027
# 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. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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

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

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

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| **Deductibles** - per calendar year<br>The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract. | $1,750 per member<br>$3,500 per family | $3,000 per member<br>$6,000 per family |
| **Copays**<br>• Fixed Dollar Copays | No Copay | No Copay |
| **Coinsurance**<br>• Percent Coinsurance | 20% | 40%<br>**Note:** Services without a network are covered at the in-network level. |
| **Annual out-of-pocket maximums**<br>The full family out of pocket maximum must be met before it is considered satisfied. | $2,500 per member<br>$5,000 per family<br>Includes Deductible, Coinsurance and Copays | $5,000 per member<br>$10,000 per family<br>Includes Deductible and Coinsurance |
| **Lifetime dollar maximum** | Unlimited | |

## Preventive Care Services

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Health Maintenance Exam - 1 per benefit period | Covered - 100% | Not Covered |
| Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam | Covered - 100% | Not Covered |
| Annual Gynecological Exam - 1 per calendar year, in addition to health maintenance exam | Covered - 100% | Not Covered |
| Pap Smear Screening - 1 per calendar year | Covered - 100% | Not Covered |

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|---|---|---|
| Mammography Screening - 1 per calendar year<br>includes 3D Mammography | Covered - 100% | Not Covered |
| Contraceptive Methods and Counseling | Covered - 100% | Not Covered |
| Prostate Specific Antigen (PSA) screening - 1 per calendar year | Covered - 100% | Not Covered |
| Endoscopic Exams - 1 per calendar year | Covered - 100% | Not Covered |
| Well Child Care<br>• 8 visits, birth through 12 months<br>• 6 visits, 13 months through 23 months<br>• 6 visits, 24 months through 35 months<br>• 2 visits, 36 months through 47 months<br><br>Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit | Covered - 100% | Not Covered |
| Immunizations - pediatric and adult | Covered - 100% | Not Covered |

## Physician Office Services

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Office Visits | Covered - 80% after deductible | Covered - 60% after deductible |
| Telemedicine Visits | Covered - 80% after deductible | Covered - 60% after deductible |
| Virtual Care - Online Medical Visits<br>Note: Online Medical visits by a non-BCBSM selected vendor are not covered. | Covered - $15 copay after deductible, then covered at 100% | Not Covered |
| Office Consultations | Covered - 80% after deductible | Covered - 60% after deductible |
| Pre-Surgical Consultations | Covered - 80% after deductible | Covered - 60% after deductible |

## Emergency Medical Care

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Hospital Emergency Room<br>Qualified medical emergency | Covered - 80% after deductible | Covered - 80% after deductible |
| Non-Emergency use of the Emergency Room | Not Covered | Not Covered |
| Facility Urgent Care Services | Covered - 80% after deductible | Covered - 60% after deductible |
| Physician Urgent Care Services | Covered - 80% after deductible | Not Covered |
| Ambulance Services - Medically Necessary Transport | Covered - 80% after deductible | Covered - 80% after deductible |

## Diagnostic Services

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| MRI, MRA, PET and CAT Scans and Nuclear Medicine | Covered - 80% after deductible | Covered - 60% after deductible |
| Diagnostic Tests, X-rays, Laboratory & Pathology | Covered - 80% after deductible | Covered - 60% after deductible |
| Radiation Therapy and Chemotherapy | Covered - 80% after deductible | Covered - 60% after deductible |

## Maternity Services Provided by a Physician

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Prenatal and Postnatal Care Visits | Covered - 100% | Covered - 60% after deductible |

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|---|---|---|
| Delivery and Nursery Care<br>Note: For facility services See "Hospital Care" | Covered - 80% after deductible | Covered - 60% after deductible |

## Hospital Care * You have Blue Distinction Specialty Care Benefits (BDSC), please refer to the BDSC page for specific cost share information

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies | Covered - 80% after deductible | Covered - 60% after deductible |
| Inpatient Medical Care | Covered - 80% after deductible | Covered - 60% after deductible |

## Alternatives to Hospital Care

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Hospice Care | Covered - 80% after deductible | Covered - 80% after deductible |
| Home Health Care<br>Limited to a maximum of 120 visits per calendar year | Covered - 80% after deductible | Covered - 60% after deductible |
| Skilled Nursing<br>Limited to 90 days per calendar year | Covered - 80% after deductible | Covered - 60% after deductible |

## Surgical Services * You have Blue Distinction Specialty Care Benefits (BDSC), please refer to the BDSC page for specific cost share information

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Surgery (includes related surgical services) | Covered - 80% after deductible | Covered - 60% after deductible |
| Sterilization - male reproductive organs<br>excludes reversal sterilization | Covered - 80% after deductible | Covered - 60% after deductible |
| Sterilization - female reproductive organs<br>excludes reversal sterilization | Covered - 100% | Covered - 60% after deductible |
| Elective Abortion Services<br><br>**Note:** Abortions are not covered if rendered in a location where abortions are not legal. | Not Covered | Not Covered |

## Human Organ Transplants

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Specified Organ Transplants<br>In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504) | Covered - 80% after deductible | Not covered except in designated facilities |
| Kidney, Cornea, Bone Marrow and Skin | Covered - 80% after deductible | Covered - 60% after deductible |

## Behavioral Health Services (Mental Health and Substance Use Disorder)

| Benefits | In-Network | Out-of-Network |
|---|---|---|

| | | |
|---|---|---|
| Inpatient Mental Health Care and Substance Use Disorder Treatment | Covered - 80% after deductible | Covered - 60% after deductible |
| Outpatient Mental Health Care and Substance Use Disorder Treatment | Covered - 80% after deductible | Covered - 60% after deductible |
| Telemedicine Mental Health Care | Covered - 80% after deductible | Covered - 60% after deductible |
| Virtual Care - Online Mental Health Visits<br>Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered. | Covered - $15 copay after deductible, then covered at 100% | Not Covered |

## Other Covered Services

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Cardiac Rehabilitation | Covered - 80% after deductible | Covered - 60% after deductible |
| Chiropractic Spinal Manipulation Services<br>Limited to a maximum of 24 visits per calendar year | Covered - 80% after deductible | Covered - 60% after deductible |
| Durable Medical Equipment | Covered - 80% after deductible | Covered - 60% after deductible |
| Prosthetic and Orthotic Devices | Covered - 80% after deductible | Covered - 60% after deductible |
| Private Duty Nursing Care | Covered - 80% after deductible | Covered - 60% after deductible |
| Allergy Testing and Therapy | Covered - 80% after deductible | Covered - 60% after deductible |
| Facility Clinic Visit | Covered - 80% after deductible | Covered - 60% after deductible |

## Therapy Services

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Physical, Occupational and Speech Therapy<br>Limited to a combined maximum of 60 visits per calendar year | Covered - 80% after deductible | Covered - 60% after deductible |

## Blue Distinction Specialty Care

**Blue Distinction Centers** identifies facilities that demonstrate proven expertise in delivering safe, effective, high-quality care for select specialty procedures.

**Blue Distinction Centers+** are Blue Distinction Centers that are also recognized for their expertise and cost-efficiency in delivering safe, effective, high-quality specialty care.

| Specialty | BDC Plus Center | BDC Center | In-Network | Out-of-Network |
|---|---|---|---|---|
| Bariatric Surgery | Covered - 80% after deductible | Covered - 80% after deductible | Covered - 80% | Not Covered |

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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.

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# Henniges Automotive
# Group Number: 71325  Package Code(s): 180, 190
# Division Code(s): 4050, 4150, 4202
# Prescription Drugs
# Effective Date: 01/01/2027
# Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

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

| Benefits | Coverage |
|---|---|
| Deductible | $1,750 per member<br>$3,500 per family |
| Retail - 30-day supply | 10% coinsurance after deductible - Generic drugs $5 minimum, $20 maximum<br>25% coinsurance after deductible - Preferred brand drugs $20 minimum, $80 maximum<br>40% coinsurance after deductible - Non-Preferred brand drugs $40 minimum, $200 maximum<br><br>Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay. |
| Retail and Mail Order - 90-day supply | 10% coinsurance after deductible - Generic drugs $10 minimum, $40 maximum<br>25% coinsurance after deductible - Preferred brand drugs $40 minimum, $160 maximum<br>40% coinsurance after deductible - Non-Preferred brand drugs $80 minimum, $400 maximum |
| Specialty Drugs<br><br>**Exclusive Specialty Network**: We only cover specialty drugs when obtained from our exclusive specialty pharmacy network. Covered drugs will be subject to the member's cost-share requirements. If a member obtains specialty drugs from any other provider, they may be responsible for the total cost. | Retail 30-day:<br>10% coinsurance after deductible - Generic drugs $5 minimum, $20 maximum<br>25% coinsurance after deductible - Preferred brand drugs $20 minimum, $80 maximum<br>40% coinsurance after deductible - Non-Preferred brand drugs $40 minimum, $200 maximum<br><br>Members are restricted to a 30-day supply and certain specialty drugs are limited to only a 15-day supply for each fill. |
| 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 PPACA | Covered - 100% |

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| **Oral and Injectable Contraceptives**<br>Retail and Mail Order | Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance |
| **Additional Services** | |
| Smoking Cessation Drugs | Covered |
| Weight Loss Drugs | Not Covered |
| Impotency Drugs | Covered |
| Infertility Drugs | Not Covered |
| **Diabetic Supplies** | Includes:<br>Needles/Syringes - Covered at 100% if an injectable prescription drug was filled within the last 120 days under the BCBSM Rx benefit<br><br>Retail Test Strips and Lancets:<br>25% coinsurance after deductible $20 minimum, $80 maximum<br><br>Mail Order Test Strips and Lancets:<br>25% coinsurance after deductible $40 minimum, $160 maximum |

## Features of your prescription drug plan

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|---|---|
| Preferred Therapy Program | 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. 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.<br>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. |
| Mandatory maximum allowable cost drugs | If your prescription is filled by a 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 non-preferred 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.<br>**Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum. |

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