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): 040
Division Code(s): 1050, 1150, 1205
PPO - Iowa Plan B, Rx2
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.

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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 Note: Two or more members must meet the family deductible. If the one-member deductible has been met, but not the family deductible, we will pay for covered services only for that member who has met the deductible. Covered services for the remaining family members will be paid when the full family deductible has been met.	$700 per member $1,400 per family	$1,300 per member $2,600 per family
Copays • Fixed Dollar Copays	$25 copay for : • Professional Urgent care services • Primary Care Physician (PCP) office visits • Chiropractic spinal manipulations • Allergy testing • Allergy therapy $30 copay for : • Specialist office visits $35 copay for : • Facility Urgent care services $175 copay for : • Facility medical emergency	$175 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	20%	40% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums All members on the contract can contribute to the family out of pocket maximum; however, a single member will not exceed the individual out of pocket maximum.	$2,900 per member $5,800 per family Includes Deductible, Coinsurance and Copays	$6,000 per member $12,000 per family Includes Deductible and Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - 1 per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Covered - 60% after deductible
Annual Gynecological Exam - 2 per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - 1 per calendar year	Covered - 100%	Covered - 60% after deductible
Mammography Screening - 1 per calendar year includes 3D Mammography	Covered - 100%	Covered - 60% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - 1 per calendar year	Covered - 100%	Covered - 60% after deductible
Endoscopic Exams - 1 per calendar year	Covered - 100%	Covered - 60% after deductible
Well Child Care • 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	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Covered - 60% after deductible

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $25 pcp copay; $30 specialist copay	Covered - 60% after deductible
Telemedicine Visits	Covered - 100% after $25 pcp copay; $30 specialist copay	Covered - 60% after deductible
Virtual Care - Online Medical Visits Note: Online Medical visits by a non-BCBSM selected vendor are not covered.	Covered - 100%	Not Covered
Office Consultations	Covered - 100% after $25 pcp copay; $30 specialist copay	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 100% after $25 pcp copay; $30 specialist copay	Covered - 60% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $175 copay	Covered - 100% after $175 copay
Non-Emergency use of the Emergency Room	Covered - 80% after deductible	Covered - 60% after deductible
Facility Urgent Care Services	Covered - 100% after $35 copay	Covered - 60% after deductible
Physician Urgent Care Services	Covered - $25 copay then 80% after deductible	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

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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.

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	Covered - 80% after deductible	Covered - 60% after deductible
Chemotherapy	Covered - 80%	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
Delivery and Nursery Care 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 Limited to lifetime maximum of 30 days	Covered - 80% after deductible	Covered - 80% after deductible
Home Health Care	Covered - 80% after deductible	Covered - 60% after deductible
Skilled Nursing 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 excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - female reproductive organs excludes reversal sterilization	Covered - 100%	Covered - 60% after deductible
Elective Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	Covered - 80% after deductible	Covered - 60% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants 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 - 100% after $25 copay	Covered - 60% after deductible
Telemedicine Mental Health Care	Covered - 100% after $25 copay	Covered - 60% after deductible
Virtual Care - Online Mental Health Visits Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered.	Covered - 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	Covered - 100% after $25 copay	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 - 100% after $25 copay	Covered - 60% after deductible
Facility Clinic Visit	Covered - 100% after $25 copay	Covered - 60% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy	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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Henniges Automotive
Group Number: 71325 Package Code(s): 040
Division Code(s): 1050, 1150, 1205
Prescription Drugs
Effective Date: 01/01/2026
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
Retail - 30-day supply	$15 copay - Generic drugs $30 copay - Preferred brand drugs $50 copay - Non-Preferred brand drugs 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	$15 copay - Generic drugs $30 copay - Preferred brand drugs $50 copay - Non-Preferred brand drugs
Specialty Drugs **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: $75 copay 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%
Oral and Injectable Contraceptives 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: Needles/Syringes - Covered at 100% if an injectable prescription drug was filled within the last 120 days under the BCBSM Rx benefit Retail Test Strips and Lancets: $30 copay Mail Order Test Strips and Lancets: $30 copay

Features of your prescription drug plan

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. 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. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

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