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): 160, 170
Division Code(s): 4000, 4100
PPO - Basic PPO Plan HDHP, Rx9
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 The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract.	$3,500 per member $7,000 per family	$7,000 per member $14,000 per family
Copays • Fixed Dollar Copays	No Copay	No Copay
Coinsurance • Percent Coinsurance	25%	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.	$7,000 per member $14,000 per family Includes Deductible, Coinsurance and Copays	$12,900 per member $25,800 per family 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

Mammography Screening - 1 per calendar year 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 • 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%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 75% after deductible	Covered - 60% after deductible
Telemedicine Visits	Covered - 75% after deductible	Covered - 60% after deductible
Virtual Care - Online Medical Visits 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 - 75% after deductible	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 75% after deductible	Covered - 60% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 75% after deductible	Covered - 75% after deductible
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Facility Urgent Care Services	Covered - 75% after deductible	Covered - 60% after deductible
Physician Urgent Care Services	Covered - 75% after deductible	Not Covered
Ambulance Services - Medically Necessary Transport	Covered - 75% after deductible	Covered - 75% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 75% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 75% after deductible	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 75% 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
Delivery and Nursery Care Note: For facility services See "Hospital Care"	Covered - 75% 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 - 75% after deductible	Covered - 60% after deductible
Inpatient Medical Care	Covered - 75% after deductible	Covered - 60% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 75% after deductible	Covered - 75% after deductible
Home Health Care Limited to a maximum of 120 visits per calendar year	Covered - 75% after deductible	Covered - 60% after deductible
Skilled Nursing Limited to 90 days per calendar year	Covered - 75% 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 - 75% after deductible	Covered - 60% after deductible
Sterilization - male reproductive organs excludes reversal sterilization	Covered - 75% 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.	Not Covered	Not Covered

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 - 75% after deductible	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 75% 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 - 75% after deductible	Covered - 60% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 75% after deductible	Covered - 60% after deductible
Telemedicine Mental Health Care	Covered - 75% after deductible	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 - $15 copay after deductible, then covered at 100%	Not Covered

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out-of-Network
Applied Behavior Analysis (ABA) Prior authorization required **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).	Covered - 75% after deductible	Covered - 60% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 75% after deductible	Covered - 60% after deductible
Nutritional Counseling	Covered - 75% after deductible	Covered - 60% after deductible

Other Covered 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
Cardiac Rehabilitation*	Not Covered	Not Covered
Chiropractic Spinal Manipulation Services Limited to a maximum of 24 visits per calendar year	Covered - 75% after deductible	Covered - 60% after deductible
Durable Medical Equipment	Covered - 75% after deductible	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 75% after deductible	Covered - 60% after deductible
Private Duty Nursing Care	Covered - 75% after deductible	Covered - 60% after deductible
Allergy Testing and Therapy	Covered - 75% after deductible	Covered - 60% after deductible
Facility Clinic Visit	Covered - 75% after deductible	Covered - 60% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 75% 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
Knee and Hip Replacement	Covered - 85% after deductible	Covered - 85% after deductible	Covered - 75% after deductible	Covered - 60% after deductible
Spine Surgery	Covered - 85% after deductible	Covered - 85% after deductible	Covered - 75% after deductible	Covered - 60% after deductible
Cardiac Care	Covered - 85% after deductible	Covered - 85% after deductible	Covered - 75% after deductible	Covered - 60% after deductible
Bariatric Surgery	Covered - 85% after deductible	Covered - 85% after deductible	Covered - 75%	Not Covered



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

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	$3,500 per member $7,000 per family
Retail - 30-day supply	10% coinsurance after deductible - Generic drugs $10 minimum, $20 maximum 25% coinsurance after deductible - Preferred brand drugs $30 minimum, $80 maximum 40% coinsurance after deductible - Non-Preferred brand drugs $80 minimum, $200 maximum 25% coinsurance after deductible - Generic and Preferred Specialty drugs $100 minimum, $200 maximum 40% coinsurance after deductible - Non-Preferred Specialty drugs $200 minimum, $400 maximum 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 $20 minimum, $40 maximum 25% coinsurance after deductible - Preferred brand drugs $60 minimum, $160 maximum 40% coinsurance after deductible - Non-Preferred brand drugs $160 minimum, $400 maximum
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: 25% coinsurance after deductible - Generic and Preferred Specialty drugs $100 minimum, $200 maximum 40% coinsurance after deductible - Non-Preferred Specialty drugs $200 minimum, $400 maximum 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 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	Not 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: 25% coinsurance after deductible $30 minimum, $80 maximum Mail Order Test Strips and Lancets: 25% coinsurance after deductible $60 minimum, $160 maximum

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 prior authorization) 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. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
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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