Blue Care Network of Michigan

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

Benefits-at-a-Glance
2026 BCN Fixed Cost Gold Option 1 W/Elective Abortion
CMU RESEARCH CORPORATION
Effective Date: 12/01/2026

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 to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan. Services must be provided or arranged by the member's primary care physician or health plan.

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

Note: A list of services that require approval **before** they are provided is available online at **https://bcbsm.com/priorauth**.

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

Benefits	
Deductible (Coinsurance and select fixed dollar copays as defined by your plan documents, apply once the deductible has been met.)	None
Fixed Dollar Copays - the cost share will be the defined copayment or the approved amount, whichever is less	$5 for allergy injections $30 for PCP office visits $50 for specialist, outpatient therapy, home visits, urgent care and retail health visits $50 for allergy evaluation and serum, and skilled nursing facility per day $50 for DME and P&O purchase $20 copay for DME rental $100 for ambulance services and standard x-rays $150 for injectable drugs $200 for high tech imaging $200 for infertility drugs $350 for emergency room visits $500 for surgery in an ambulatory surgical center $1000 per day up to $3000 per inpatient facility admission and per outpatient facility visit $1000 per visit for outpatient facility
Annual Out of Pocket Maximum - applies to all covered services with a copay including prescription drug copays	$10,150 per member/$20,300 per family per calendar year

Preventive services

Benefits	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%

Preventive services (continued)

Benefits	
Pap Smear Screening - laboratory services only	100%
Well-Baby and Well-Child Visits	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening	100%
Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Sterilization of Female Organs	100%
Breast Pumps (DME guidelines apply.)	100%
Routine Maternity Prenatal and Postnatal Care	100%

Physician office services

Benefits	
PCP Office Visits **Note:** copay includes other services received in the office by the same visit and practitioner with the exception of injectable drugs	$30 copay
Medical Online Visits - when performed by a BCN participating provider or BCN designated online vendor **Note:** 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.	100%
Consulting Specialist Care - when referred for other than preventive services **Note:** copay includes other services received in the office by the same visit and practitioner with the exception of injectable drugs	$50 copay

Emergency medical care

Benefits	
Hospital Emergency Room - copay waived if admitted as inpatient	$350 copay
Urgent Care Center	$50 copay
Retail Health Clinic	$50 copay
Ambulance Services - medically necessary	$100 copay

Diagnostic services

Benefits	
Laboratory and Pathology Tests	100%
Diagnostic Tests	100% when performed in a physician's office 100% for professional fees When performed inpatient or in an outpatient facility setting, inpatient and outpatient facility copays apply.

Diagnostic services (continued)

Benefits	
Standard X-Rays	100% when performed in a physician's office 100% for professional fees $100 copay when performed in a free-standing imaging center or outpatient facility. If performed in an outpatient facility in coordination with other services, you are only responsible for the maximum outpatient facility copay per visit Copay waived when the service is performed in an inpatient setting or emergency room. Inpatient and ER copays will apply.
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	100% when performed in a physician's office 100% for professional fees $200 copay when performed in a free-standing imaging center or outpatient facility. If performed in an outpatient facility in coordination with other services, you are only responsible for the maximum outpatient facility copay Copay waived when the service is performed in an inpatient setting or emergency room. Inpatient and ER copays will apply.
Radiation Therapy	100% when performed in a physician's office 100% for professional fees When performed inpatient or in an outpatient facility setting, inpatient and outpatient facility copays apply.

Maternity services provided by a physician

Benefits	
Routine Prenatal and Postnatal Care Visits	100%
Delivery and Nursery Care	$1,000 copay per day, up to $3,000 per admission for facility charges 100% for professional services

Hospital care

Benefits	
Inpatient Hospital Services including Rehabilitation Care Facility	$1000 copay per day, up to $3000 per admission for facility charges 100% for professional services.
Outpatient Surgery- facility and professional services	$1000 copay per visit for facility charges 100% for professional services
Ambulatory Surgery	$500 copay per visit for facility charges 100% for professional services

Alternatives to hospital care

Benefits	
Skilled Nursing Care	$50 copay per day; Includes facility and professional Limited to 45 days per calendar year
Hospice Care	100%
Home Health Care	$50 copay per day
Home Infusion	100%

Surgical services

Benefits	
Surgery - includes all related surgical services and anesthesia.	100% when performed in a physician's office When performed inpatient, outpatient, or in an ambulatory surgical center, the applicable facility copays apply
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	100% when performed in a physician's office When performed inpatient, outpatient, or in an ambulatory surgical center, the applicable facility copays apply
Elective Abortion Services	Cost dependent on the location you receive the service, such as office visit, Outpatient facility or Inpatient facility.
Human Organ Transplants (subject to medical criteria)	100% when performed in a physician's office When performed inpatient, outpatient, or in an ambulatory surgical center, the applicable facility copays apply
Reduction Mammoplasty (subject to medical criteria)	100% when performed in a physician's office When performed inpatient, outpatient, or in an ambulatory surgical center, the applicable facility copays apply
Male Mastectomy (subject to medical criteria)	100% when performed in a physician's office When performed inpatient, outpatient, or in an ambulatory surgical center, the applicable facility copays apply
Temporomandibular Joint Syndrome (subject to medical criteria)	100% when performed in a physician's office When performed inpatient, outpatient, or in an ambulatory surgical center, the applicable facility copays apply
Orthognathic Surgery (subject to medical criteria)	100% when performed in a physician's office When performed inpatient, outpatient, or in an ambulatory surgical center, the applicable facility copays apply
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	100% when performed in a physician's office When performed inpatient, outpatient, or in an ambulatory surgical center, the applicable facility copays apply

Behavioral health services (mental health and substance use disorder treatment)

Benefits	
Inpatient Mental Health Care and Residential Substance Use Disorder	$1000 copay per day up to $3000 per admission for facility charges 100% for professional services.
Residential Substance Use Disorder	$1000 copay per day up to $3000 per admission for facility charges 100% for professional services.
Outpatient Mental Health Care includes online and telemedicine visits **Note:** For diagnostic and therapeutic services, the medical benefit applies.	$30 copay
Outpatient Substance Use Disorder	$30 copay

Autism spectrum disorders, diagnoses and treatment

Benefits	
Applied behavioral analysis (ABA) treatment **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)	$30 copay
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	$50 copay
Other covered services, including mental health services, for autism spectrum disorder	See your outpatient mental health, medical office visits and preventive benefit

Other services

Benefits	
Allergy Testing and Therapy	$50 copay; if billed with office visit, one copay applies per provider, per visit. The highest copay will apply.
Allergy Office Visits	$30 copay if performed by PCP; $50 copay if performed by specialist
Allergy Injections	$5 copay
Chiropractic Spinal Manipulation - when referred	$50 copay; up to 30 visits per calendar year
Rehabilitative Services -subject to meaningful improvement within 90 days	$50 copay Outpatient Physical and Occupational Therapy - limited to a combined benefit maximum of 30 visits per calendar year. Outpatient Speech Therapy - limited to 30 visits per calendar year
Habilitative Services	$50 copay Outpatient Physical and Occupational Therapy limited to a combined benefit maximum of 30 visits per calendar year Outpatient Speech Therapy limited to 30 visits per calendar year
Outpatient Cardiac and Pulmonary Rehabilitation	$50 copay Limited to 30 combined visits per calendar year
Infertility Counseling and Treatment	Copay based on site of care $200 copay for infertility drugs

Other services (continued)

Benefits	
Durable Medical Equipment	$50 copay for purchase $20 copay per item, per month for rental 100% for medical supplies
Prosthetic and Orthotic Appliances	$50 copay for each item
Diabetic Supplies Note: -Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable prescription drug cost-sharing will apply.	100%
Injectable Drugs	$150 copay per injection when administered in an office setting, home, or outpatient facility
Cancer Therapy Drugs	100% Outpatient facility copay applies to the administration
Pediatric Vision - Eye exam and prescription glasses (chosen from a select collection) limited to once per calendar year through the last day of the year in which an individual turns 19.	100% Eye Exam, Frames and Lenses - Limited to once per calendar year through the last day of the year in which an individual turns age 19.

Prescription drugs

Benefits	
Preferred Generic Tier	$15 copay
Nonpreferred Generic Tier	$40 copay
Preferred Brand Tier	$80 copay
Nonpreferred Brand Tier	$100 copay
Preferred Specialty Tier	$200 copay
Nonpreferred Specialty Tier	$300 copay
Contraceptives	Women's Contraceptives - Preferred Generic - 100%, Non-Preferred Generic - Copayment above applies, Preferred Brand - Copayment above applies, Non-Preferred Brand - Copayment above applies
Drugs for the Treatment of Sexual Dysfunction, Weight Loss, Cough & Cold	Not covered
Mail Order Prescription Drugs	30-day supply or less - applicable tiered copay / coinsurance; 31-90 day supply - 3x's the 30-day copay/coinsurance minus $10. 90-day retail 84-90 day supply, 3X's the 30-day copay/coinsurance minus $10.
Diabetic Supplies	Select diabetic supplies and equipment are covered, applicable cost sharing will apply. Cost sharing may not apply to certain preferred glucometers as defined on the drug list.
Specialty Drug Pharmacy	Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs

Prescription drugs (continued)

Benefits	
Variable Cost Share Coupon Program	Your plan includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum.
Prescription Drug Deductible	None
Custom Select Drug List	The list of prescription drugs that have been approved by the U.S. Food and Drug Administration and approved by the BCBSM/BCN Pharmacy and Therapeutics Committee. The list represents the clinical judgment of Michigan physicians, pharmacists and other experts in the diagnosis and treatment of disease and promotion of health. Medications are selected based on clinical effectiveness, safety and opportunity for cost savings. Some drugs included in the Custom Select Drug List require prior authorization and/or step therapy by BCN before they are covered. The Custom Select Drug List may be modified by BCN as needed to remove or add a covered drug or to modify the requirements for authorization of a covered drug. The list may be found at https://www.bcbsm.com/druglists

For Internal Purposes Only
Benefits Selected - FCSM : 10150M,1481CS,90D3X,FCBRG,ONVCW,PVSN,RXVAR,VAFCR

Blue Cross Blue Shield of Michigan

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CMU RESEARCH CORPORATION
AOA-0000356175
Vision Coverage
Effective Date: On or after December 2026
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.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com.**

Note: Vision benefits are only available to covered members (subscribers, spouses and dependent children) age 19 and older. Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

Member's responsibility (copays)

Benefits	In-network	Out-of-network
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	**Combined** $10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay
Medically necessary contact lenses	$10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay

Eye exam

Benefits	In-network	Out-of-network
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$5 copay	Reimbursement up to $34 less $5 copay (member responsible for any difference)
	One eye exam every calendar year	

Lenses and Frames

Benefits	In-network	Out-of-network
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. **Note:** Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	$10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $10 copay (member responsible for any difference)
	One pair of lenses, with or without frames, once every calendar year	

BV AO FRAME 200;BV-ADULT;BVFL SG

Benefits	In-network	Out-of-network
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$200 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to $38.25 less $10 copay (member responsible for any difference)
	One frame every calendar year	

Contact Lenses

Benefits	In-network	Out-of-network
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$10 copay	Reimbursement up to $210 less $10 copay (member responsible for any difference)
	One pair of contact lenses once every calendar year	
Elective contact lenses that **improve** vision (prescribed, but does not meet criteria of medically necessary)	$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Contact lenses are covered up to allowance once every calendar year	

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CMU RESEARCH CORPORATION
AOA-0000356175
Dental Coverage
Effective Date: On or after December 2026
Benefits-at-a-glance

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Note: Pediatric members are members who are 18 years of age or younger on the group's renewal date. They will receive pediatric dental benefits up to the group's renewal date after they turn age 19.

Dentist information
With Blue Dental PPO, you can choose any licensed dentist anywhere. However, you'll get the best coverage and save the most money when you choose a Tier 1 PPO (in-network) dentist.

You have outstanding access to thousands of Tier 1 PPO dentists across the country through the Blue Dental PPO network. Tier 1 PPO dentists agree to accept our PPO approved amount as full payment for covered services, so you'll pay your applicable coinsurance and deductible amounts. To find a Tier 1 PPO dentist near you, log into your member account at **bcbsm.com** or call **1-888-826-8152.**

If you go to a non-PPO dentist, you can still save money by choosing a Tier 2 participating non-PPO (out-of-network) dentist. Tier 2 dentists participate with us on a "per claim" basis through our Blue Par Select (BPS) arrangement. They accept our BPS approved amount as full payment for covered services, so you'll pay your applicable coinsurance and deductible amounts. To find a Tier 2 participating non-PPO dentist near you, log into your member account at **bcbsm.com**. You should ask your dentist if they participate with BCBSM before every treatment.

Note: If you go to a nonparticipating dentist, you are responsible for any difference between our approved amount and the dentist's charge.

Member's responsibility (deductible, coinsurance and dollar maximums)

Benefits	Coverage
Deductibles • Applies to Class II and Class III services only	$25 per member, $50 for two members, $75 per family per calendar year
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services	None (covered at 100%)
• Class II services	20%
• Class III services	50%
• Class IV services	Not covered
Dollar maximums • Annual maximum for Class I, II and III services	$1,000 per non-pediatric member per calendar year. The annual benefit maximum **does not** apply to pediatric members.
• Lifetime maximum for Class IV services	Not applicable

Benefits	Coverage
Out-of-pocket maximum • The maximum out-of-pocket expense pediatric members will pay in a calendar year for deductible and coinsurance amounts applied to most covered in-network dental services. The out-of-pocket maximum **does not** apply to charges that exceed our approved PPO fee, services provided by non-PPO dentists, non-covered services, or orthodontic services.	$450 for one pediatric member or $900 for two or more pediatric members per calendar year. There is no out-of-pocket maximum for non-pediatric members. **Note:** This out-of-pocket maximum is separate from the annual out-of-pocket maximum that applies under your hospital and medical coverage (if any).

Plan's responsibility

The plan's responsibility is subject to a review of the reported diagnosis, dental necessity verification and the availability of dental benefits at the time the claim is processed, as well as the conditions, exclusions and limitations, and deductible and coinsurance requirements under the applicable BCBSM certificates and riders.

Class I services

Benefits	Coverage
Most diagnostic and preventive services: • Periodic oral examinations/evaluations - twice per calendar year	100% of approved amount
• Prophylaxes (cleanings) three times per calendar year for pediatric members; two times per calendar year for all other members	100% of approved amount
• Fluoride treatments or topical fluoride varnishes- twice every calendar year for members to the end of the month of their 19th birthday. For members under age three, topical fluoride varnishes four times every calendar year.	100% of approved amount
• Sealants - once per fully erupted first and second permanent molar every 36 months for members to the end of the month of their 16th birthday	100% of approved amount
Bitewing X-rays - one set (up to four films) per calendar year	100% of approved amount
Oral brush biopsy sample collection - twice per calendar year	100% of approved amount

Class II services

Benefits	Coverage
Other diagnostic and preventive services: • Diagnostic tests and laboratory examinations	80% of approved amount after deductible
• Space maintainers - for missing posterior primary teeth for members to the end of the month of their 15th birthday	80% of approved amount after deductible
Panoramic or full-mouth X-rays - once per 60 months	80% of approved amount after deductible
Emergency palliative treatment	80% of approved amount after deductible
Minor restorative services: • Amalgam and resin-based composite fillings and fillings of similar materials - once per tooth and surface per 48 months for permanent teeth; once per tooth and surface per 24 months for primary teeth	80% of approved amount after deductible
• Recementation or repair of posts, crowns, veneers, inlays and onlays - three times per tooth per calendar year	80% of approved amount after deductible
Simple and surgical extractions of non-impacted teeth	80% of approved amount after deductible
Non-surgical endodontic services: • Root canal treatments - once per tooth per lifetime (retreatment of a root canal is payable once per tooth per lifetime)	80% of approved amount after deductible
• Therapeutic pulpotomies or pulpal debridement	80% of approved amount after deductible
• Vital pulpotomies on primary teeth	80% of approved amount after deductible

Benefits	Coverage
• Apexification	80% of approved amount after deductible
Non-surgical periodontic services: • Periodontal maintenance - three times per calendar year in place of routine dental prophylaxis for pediatric members; two times per calendar year in place of routine dental prophylaxis for all other members	80% of approved amount after deductible
• Periodontal scaling and root planing - once per quadrant per 24 months for pediatric members and once per quadrant per 36 months for all other members	80% of approved amount after deductible
• Localized delivery of antimicrobial agents - one surface per tooth and three teeth per quadrant with a maximum of 12 teeth per year **for non-pediatric members only**	80% of approved amount after deductible
Basic prosthodontic services for removable prosthetic appliances: • Adjustments and repairs	80% of approved amount after deductible
• Relines or rebases of partial dentures or complete denture - once per 36 months per arch	80% of approved amount after deductible
• Tissue conditioning - once per 36 months per arch	80% of approved amount after deductible
Adjunctive general services: • General anesthesia or IV sedation	80% of approved amount after deductible
• Office visits for observation (during regularly scheduled hours) **for non-pediatric members only**	80% of approved amount after deductible
• Office visits after regularly scheduled hours	80% of approved amount after deductible
• House and hospital calls **for non-pediatric members only**	80% of approved amount after deductible
• Antibiotic injections **for non-pediatric members only**	80% of approved amount after deductible
• Limited occlusal adjustments - up to five times per 60 months **for non-pediatric members only**	80% of approved amount after deductible
• Occlusal biteguards (and relines and repairs to occlusal biteguards) - once per 60 months **for non-pediatric members only**	80% of approved amount after deductible

Class III services

Benefits	Coverage
Major restorative services: • Onlays, crowns and veneers - once per permanent tooth per 60 months	50% of approved amount after deductible
• Substructures, including cores and posts - once per permanent tooth every 60 months	50% of approved amount after deductible
Oral surgery services: • Surgical exposure and facilitation of eruption of unerupted teeth	50% of approved amount after deductible
• Extractions of impacted teeth	50% of approved amount after deductible
• Incision and drainage of cellulitis or fascial space abscesses of intraoral soft tissue	50% of approved amount after deductible
• Removal of exostoses (excess bony growths of the upper and lower jaw)	50% of approved amount after deductible
• Excision of hyperplastic tissue per arch	50% of approved amount after deductible
• Frenulectomies	50% of approved amount after deductible
Surgical endodontic services: • Apical surgery on permanent teeth	50% of approved amount after deductible
Surgical periodontic services: • Gingivectomy and gingivoplasty	50% of approved amount after deductible
• Osseous surgery for **non-pediatric members only**	50% of approved amount after deductible
• Gingival flap procedures	50% of approved amount after deductible

Benefits	Coverage
• Soft tissue grafts	50% of approved amount after deductible
• Bone replacement grafts - **for non-pediatric members only**	50% of approved amount after deductible
Prosthodontic services: • Complete dentures - once per 84 months	50% of approved amount after deductible
• Removable partial dentures and fixed partial dentures (bridges), including abutment crowns and pontics - once per 84 months **for members age 16 and older only**	50% of approved amount after deductible
• Recementation and repairs of bridges	50% of approved amount after deductible
• Stayplates to replace recently extracted permanent anterior (front) teeth	50% of approved amount after deductible
• Endosteal implants and implant-related services - once per tooth per lifetime for teeth numbered 2 through 15 and 18 through 31 **for non-pediatric members only**	50% of approved amount after deductible

Class IV services

Benefits	Coverage
Orthodontics and related services	Not covered