

CMU RESEARCH CORPORATION
AOA-0000356175
Simply Blue℠ PPO SG
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.

Prior authorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, receive prior authorization 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.

Prior authorization 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 prior authorization of the drugs. **If prior authorization 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.

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.
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. 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.

Eligibility Information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Dependent children**: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage until the end of the year in which they turn age 26

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	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year	$1,000 for one member, $2,000 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	• $30 copay for office visits and office consultations with a **primary care physician** • $30 copay for **virtual primary care** visits • $50 copay for office visits and office consultations with a **specialist** • $30 copay for chiropractic and osteopathic manipulative therapy • $250 copay for emergency room visits • $60 copay for urgent care visits	• $250 copay for emergency room visits
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 30% of approved amount for most other covered services • 50% of approved amount for bariatric surgery	• 50% of approved amount for most other covered services • 50% of approved amount for bariatric surgery
Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but **does not** apply to deductibles, flat-dollar copays and prescription drug cost-sharing amounts	$5,000 for one member, $10,000 for the family (when two or more members are covered under your contract) each calendar year	$10,000 for one member, $20,000 for the family (when two or more members are covered under your contract) each calendar year **Note**: Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.
Annual out-of-pocket maximums - applies to deductibles, flat-dollar copays and coinsurance amounts for all covered services - including prescription drugs cost-sharing amounts	$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

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Benefits	In-network	Out-of-network
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
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)	50% 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)	50% after out-of-network deductible
Well-baby and Well-child visits	100% (no deductible or copay/coinsurance) • 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

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Benefits	In-network	Out-of-network
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	50% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	50% after out-of-network deductible
	One per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary **Note:** This includes mental health and substance use disorder services equivalent to medical office visits. **Note**: **Virtual Primary Care** visits by a non-BCBSM selected vendor are not covered.	• $30 copay for each office visit with a **primary care physician** (in person or virtual) • $30 copay for each **virtual primary care** visit for members 18 years of age or older, by a BCBSM selected vendor • $50 copay for each office visit with a **specialist** **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.	50% after out-of-network deductible
Online visits - by physician or **BCBSM** selected vendor 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.	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	70% after in-network deductible	50% after out-of-network deductible

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Benefits	In-network	Out-of-network
Office consultations - must be medically necessary	• $30 copay for each office consultation with a **primary care physician** • $50 copay for each office consultation with a **specialist** **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.	50% after out-of-network deductible

Urgent care visits

Benefits	In-network	Out-of-network
Urgent care visits - must be medically necessary	$60 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.	50% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	$250 copay per visit (copay waived if admitted)	$250 copay per visit (copay waived if admitted)
Ambulance services - must be medically necessary	70% after in-network deductible	70% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	70% after in-network deductible	50% after out-of-network deductible
Diagnostic tests and x-rays	70% after in-network deductible	50% after out-of-network deductible
Therapeutic radiology	70% after in-network deductible	50% after out-of-network deductible

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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)	50% after out-of-network deductible
Postnatal care	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Delivery and nursery care **Note:** For facility services See "Hospital Care"	70% after in-network deductible	50% 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 **Note:** Nonemergency services must be rendered in a **participating** hospital.	70% after in-network deductible Unlimited days	50% after out-of-network deductible
Inpatient consultations	70% after in-network deductible	50% after out-of-network deductible
Chemotherapy	70% after in-network deductible	50% 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	70% after in-network deductible Limited to a maximum of 120 days per member per calendar year	70% after in-network deductible
Hospice care	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)	100% (no deductible or copay/coinsurance)
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	70% after in-network deductible	70% after in-network deductible
Infusion therapy: • 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 prior authorization-consult with your doctor	70% after in-network deductible	70% 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	70% after in-network deductible	50% after out-of-network deductible

Benefits	In-network	Out-of-network
Presurgical consultations	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Voluntary sterilization of male reproductive organs **Note:** For voluntary sterilization of female reproductive organs, see **"Preventive care services."**	70% after in-network deductible	50% after out-of-network deductible
Elective Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	70% after in-network deductible	50% after out-of-network deductible
Bariatric surgery	50% after in-network deductible	50% after out-of-network deductible
	Limited to a **lifetime** maximum of one bariatric procedure per member	

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)	70% after in-network deductible	50% after out-of-network deductible
Specified oncology clinical trials	70% after in-network deductible	50% after out-of-network deductible
Cornea and skin transplants	70% after in-network deductible	50% 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 equivalent to an office visit or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be equivalent to an office visit or medical online visit, we will process the claim under your Physician Office Services.

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder treatment **Note:** Facility services are covered in participating facilities only.	70% after in-network deductible	50% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment requires prior authorization • subject to medical criteria	70% after in-network deductible	50% after out-of-network deductible
Outpatient mental health care: • Facility and clinic **Note:** Facility services are covered in participating facilities only.	70% after in-network deductible	70% after in-network deductible
• Online visits - for services equivalent to a medical online visit **Note:** Online visits by a non-BCBSM selected vendor are not covered.	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
• Physician's office **Note:** For services equivalent to a medical office visit. See "**Physician Office Services**".	70% after in-network deductible	50% after out-of-network deductible

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Benefits	In-network	Out-of-network
Outpatient substance use disorder treatment - in approved facilities **only**	70% after in-network deductible	50% 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 - subject to prior authorization **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 for each office visit	50% after out-of-network deductible **Note:** Services rendered by an approved licensed behavior analyst (LBA) will apply the in-network cost-sharing.
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder	70% after in-network deductible	50% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including nutritional counseling and mental health services, for autism spectrum disorder	70% after in-network deductible	50% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **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.	• 70% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	50% after out-of-network deductible
Allergy testing and therapy	70% after in-network deductible	50% after out-of-network deductible
Rehabilitative care: • Outpatient physical and occupational therapy	70% after in-network deductible	50% after out-of-network deductible **Note**: Services at nonparticipating outpatient physical therapy facilities are not covered.
• Chiropractic and osteopathic manipulation	$30 copay per visit	50% after out-of-network deductible
	Limited to a 30-visit maximum per member per calendar year **Note: This 30-visit outpatient maximum is a <u>combined</u> maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy.**	
Outpatient speech therapy - when provided for rehabilitative care	70% after in-network deductible	50% after out-of-network deductible
	Limited to a 30-visit maximum per member per calendar year	

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Benefits	In-network	Out-of-network
Habilitative care: Outpatient physical and occupational therapy (excludes chiropractic and osteopathic manipulation)	70% after in-network deductible	50% after out-of-network deductible **Note**: Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a 30-visit maximum per member per calendar year **Note: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical and occupational therapy**	
Outpatient speech therapy - when provided for habilitative care	70% after in-network deductible	50% after out-of-network deductible
	Limited to a 30-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 preventive benefit 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 preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	70% after in-network deductible	50% 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.	70% after in-network deductible	50% after out-of-network deductible
Private duty nursing care	Not covered	Not covered

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CMU RESEARCH CORPORATION
AOA-0000356175
Preferred Rx Program SG
Effective Date: On or after December 2026
Benefits-at-a-glance

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 preferred pharmacy for specialty drugs is **Walgreens Specialty Pharmacy**. Specialty drugs are covered only when dispensed through the Walgreens Specialty Pharmacy or through a participating Walgreens retail pharmacy, as long as the drug is available at that location. You may want to call ahead to confirm availability. **If you don't use Walgreens Specialty Pharmacy or a participating Walgreens retail pharmacy, you may be responsible for the full cost of the medication.**

A list of specialty drugs is available on our website at **bcbsm.com/pharmacy**. Click What are specialty drugs, then click Specialty Drug Program Rx Benefit Member Guide. The guide is updated monthly.

If you have additional questions, you can call Walgreens Specialty 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 Blue Cross defines as a "specialty pharmaceutical". We may make exceptions if a member requires more than a 30-day supply. Blue Cross reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay or 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 copays and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The 25% member liability for covered drugs obtained from an out-of-network pharmacy will **not** contribute to your annual out-of-pocket maximum.

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 drugs	1 to 30-day period	You pay $20 copay	You pay $20 copay	You pay $20 copay	You pay $20 copay plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $40 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $50 copay	No coverage	No coverage

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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
	84 to 90-day period	You pay $50 copay	You pay $50 copay	No coverage	No coverage
Preferred brand-name drugs	1 to 30-day period	You pay $60 copay	You pay $60 copay	You pay $60 copay	You pay $60 copay plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $120 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $170 copay	No coverage	No coverage
	84 to 90-day period	You pay $170 copay	You pay $170 copay	No coverage	No coverage
Nonpreferred brand-name drugs	1 to 30-day period	You pay $100 copay	You pay $100 copay	You pay $100 copay	You pay $100 copay plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $200 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $290 copay	No coverage	No coverage
	84 to 90-day period	You pay $290 copay	You pay $290 copay	No coverage	No coverage
Generic and preferred brand-name specialty drugs	1 to 30-day period	**Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs** You pay 20% of the approved amount, but no more than $200 **Note:** No coverage for 31-90 day supply.			
Nonpreferred brand-name specialty drugs	1 to 30-day period	**Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs** You pay 25% of approved amount, but no more than $300 **Note:** No coverage for 31-90 day supply.			

* 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
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 PPACA.	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 and devices 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 and devices 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

BCBSM Custom Select Drug List	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. • **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 then 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. • **Generic and preferred specialty drug tier** - This tier includes generic and preferred brand-name specialty drugs that are used to treat difficult health conditions. These drugs are generally more cost-effective than nonpreferred specialty drugs. • **Nonpreferred specialty drug tier** - This tier includes nonpreferred brand-name specialty drugs that are used to treat difficult health conditions. Members pay more for nonpreferred specialty drugs because there are cost-effective generic or preferred drugs available.

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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 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**.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Exclusions	The following drugs are not covered: ● Over-the-counter drugs and drugs with comparable OTC counterparts (e.g., antihistamines, cough/cold and acne treatment) unless deemed an Essential Health Benefit or not considered a covered service ● State-controlled drugs ● Brand-name drugs that have a generic equivalent available ● Drugs to treat erectile dysfunction and weight loss ● Prenatal vitamins (prescribed and over-the-counter) ● Brand-name drugs used to treat heartburn ● Compounded drugs, with some exceptions ● Cosmetic drugs

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CMU RESEARCH CORPORATION
AOA-0000356175
Vision Coverage (Pediatric)
Effective Date: On or after December 2026
Benefits-at-a-glance

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 members up to age 19. 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	None	None
Prescription glasses (lenses and/or frames)	None	None
Medically necessary contact lenses	None	None

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.	100% of approved amount	Reimbursement up to $34 (member responsible for any difference)
	One eye exam per 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	100% of approved amount	Reimbursement up to approved amount based on lens type (member responsible for any difference)
	One pair of lenses, with or without frames, per calendar year	
Note: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.		
Standard frames from a "select" collection	100% of approved amount	Reimbursement up to $38.25 (member responsible for any difference)
	One frame per calendar year	

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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)	100% of approved amount	Reimbursement up to $210 (member responsible for any difference)
	Covered - annual supply	
Standard (one pair annually) • Monthly (six-month supply) • Bi-weekly (three-month supply) • Dailies (three-month supply)	100% of approved amount	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Covered according to quantities outlined in your certificate, per calendar year	

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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	

Blue Cross Blue Shield of Michigan

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CMU RESEARCH CORPORATION
AOA-0000356175
Dental 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.

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