CareFirst Union Blue

Michigan Glass & Glazing Welfare Fund (Michigan Glaziers)

(group #s 109332-00/01/02/70)

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network	Out-of-Network
General Provisions		
Effective Date	1/1/2026	
Benefit Period (1)	Calendar Year	
Deductible (per benefit period) Individual Family	 $1,000 $2,000	 $2,000 $4,000
Plan Pays – payment based on the plan allowance	80% after deductible	60% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 $2,500 $5,000	 $5,000 $10,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copayments, prescription cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $8,700 $17,400	 N/A N/A
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $30 copayment	60% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after $30 copayment	60% after deductible
Specialist Office Visits & Virtual Visits	100% after $30 copayment	60% after deductible
Virtual Visit Provider Originating Site Fee	80% after deductible	60% after deductible
Urgent Care Center Visits	100% after $30 copayment - copayment does not apply to Urgent Care Center Visits prescribed for the treatment of Mental Health or Substance Abuse	60% after deductible
Telemedicine Services (3)	100% after $30 copayment	Not Covered
Preventive Care (4)		
Routine Adult		
Physical exams	100% (deductible does not apply)	60% after deductible
Adult immunizations	100% (deductible does not apply)	60% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	60% (deductible does not apply)
Breast Cancer Screenings	100% (deductible does not apply)	60% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)	60% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	60% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	60% after deductible
Pediatric immunizations	100% (deductible does not apply)	60% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Emergency Services		
Emergency Room Services (5)	100% after $150 copayment (waived if admitted)	
Ambulance – Emergency	80% after network deductible	
Ambulance – Non-Emergency (6)	80% after deductible	60% after deductible
Hospital and Medical/Surgical Expenses (including maternity) (5)		
Hospital Inpatient	80% after deductible	60% after deductible
Hospital Outpatient	80% after deductible	60% after deductible
Pre-Surgical Consultations	100% (deductible does not apply)	60% after deductible
Outpatient Surgery (facility)	80% after deductible	60% after deductible
Surgical Services (professional)	80% after deductible	60% after deductible
Maternity (non-preventive professional services) including dependent daughter	100% (deductible does not apply)	60% after deductible

Benefit	Network	Out-of-Network
Medical Care (including inpatient visits and consultations)	80% after deductible	60% after deductible
Therapy Services		
Physical Medicine, Occupational Therapy & Speech Therapy	80% after deductible	60% after deductible
	Benefit Limit: 30 combined visits per benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Infusion Therapy	80% after network deductible	
Respiratory Therapy	80% after deductible	60% after deductible
Spinal Manipulations	100% after $30 copayment	60% after deductible
	Benefit Limit: 12 visits per benefit period	
Other Therapy Services (Cardiac Rehab, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	60% after deductible
Mental Health/Substance Abuse		
Inpatient Mental Health Services	80% after deductible	60% after deductible
Inpatient Detoxification/Rehabilitation	80% after deductible	60% after deductible
Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits	80% after deductible	60% after deductible
Outpatient Substance Abuse	80% after deductible	60% after deductible
Other Services		
Allergy Extracts and Injections	80% after deductible	60% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	80% after deductible	60% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	Not Covered	Not Covered
Diabetes Treatment		
Equipment and Supplies	80% after deductible	60% after deductible
Diabetes Education Program	80% after deductible	60% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
Mammograms (medically necessary)	100% (deductible does not apply)	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after network deductible	
Home Health Care	80% after network deductible	
	Benefit Limit: Unlimited visits per benefit period, aggregate with Visiting Nurse	
Hospice	100% (deductible does not apply)	
Infertility Counseling, Testing and Treatment (8)	80% after deductible	60% after deductible
Private Duty Nursing	70% after deductible	50% after deductible
	Benefit Limit: unlimited hours per benefit period	
Skilled Nursing Facility Care	80% after network deductible	
	Benefit Limit: 120 days per benefit period	
Blue Distinction Specialty Care* *For Transplants and Bariatric Surgery* **@ Blue Distinction Centers + (BDC+)**	100% (deductible does not apply)	Not applicable
@ Non-BDC+	80% after deductible	60% after deductible
Precertification/Authorization Requirements (9)	Yes	

Prescription Drugs [10]	
Prescription Drug Deductible Individual Family	 none none
Prescription Drug Program [10] SensibleRx Choice Defined by the National Plus Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses Comprehensive Formulary with an Incentive Benefit Design **Select Specialty Drugs are Limited to a 31-Day Supply** **Rx for Health Diabetes: $5 retail/$10 Mail Order** (applies to insulin, needles, syringes and other diabetic drugs) **Rx for Health Asthma: $5 retail/$10 Mail Order** **Rx for Health Hypertension: $5 retail/$10 Mail Order**	**With the Smart90 CVS Network, after two fills at a retail pharmacy that is not CVS you must choose between a 90-day supply through CVS retail pharmacy stores or through Express Scripts Mail Order Pharmacy.** **Retail Drugs (31-day Supply)** Generic $10 copayment Formulary Brand $30 copayment Non-Formulary Brand $50 copayment **Maintenance Drugs through Mail Order (1-90-day Supply)** Generic $20 copayment Formulary Brand $75 copayment Non-Formulary Brand $125 copayment

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