



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

Advance Employment Svcs

Simply BlueSM PPO Plan \$1500/20% LG

Effective Date: On or after July 2023

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/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized 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.

Preauthorization 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 preauthorization of the drugs. **If preauthorization 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

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 | \$1,500 for one member, \$3,000 for the family (when two or more members are covered under your contract) each calendar year | \$3,000 for one member, \$6,000 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 | <ul style="list-style-type: none"> \$30 copay for office visits and office consultations with a non-specialist provider \$30 copay for medical online visits \$30 copay for office visits and office consultations with a specialist provider \$30 copay for chiropractic and osteopathic manipulative therapy \$150 copay for emergency room visits \$30 copay for each urgent care visit | \$150 copay for emergency room visits |
| Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met. | <ul style="list-style-type: none"> 70% of approved amount for private duty nursing care 20% of approved amount for most other covered services | <ul style="list-style-type: none"> 70% of approved amount for private duty nursing care 40% of approved amount for most other covered services |
| Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but does not apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts | \$2,500 for one member, \$5,000 for the family (when two or more members are covered under your contract) each calendar year | \$5,000 for one member, \$10,000 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 cost-sharing amounts for prescription drugs, if applicable | \$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 |
| 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 |

| Benefits | In-network | Out-of-network |
|---|--|--|
| Gynecological exam | 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 |
| Pap smear screening -laboratory and pathology services | 100% (no deductible or copay/coinsurance), one per member per calendar year | Not covered |
| Voluntary sterilizations for females | 100% (no deductible or copay/coinsurance) | 60% 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) | 60% after out-of-network deductible |
| Well-baby and child care visits | 100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> • 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 |
| 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 | 60% 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 | 60% 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 | <ul style="list-style-type: none"> \$30 copay per office visit with a non-specialist provider \$30 copay per office visit with a specialist provider <p>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.</p> | 60% after out-of-network deductible |
| Outpatient and home medical care visits-must be medically necessary | 80% after in-network deductible | 60% after out-of-network deductible |
| Office consultations-must be medically necessary | <ul style="list-style-type: none"> \$30 copay for each office consultation with a non-specialist provider \$30 copay for each office consultation with a specialist provider <p>Note: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office consultation copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office consultation.</p> | 60% after out-of-network deductible |
| Online visits – must be medically necessary | \$30 copay for online visits | 60% after out-of-network deductible |
| Note: Online visits by a non-BCBSM selected vendor are not covered. | | |

Urgent care visits

| Benefits | In-network | Out-of-network |
|--------------------|---|-------------------------------------|
| Urgent care visits | \$30 copay for each urgent care visit <p>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.</p> | 60% after out-of-network deductible |

Emergency medical care

| Benefits | In-network | Out-of-network |
|--|--|--|
| Hospital emergency room | \$150 copay per visit (copay waived if admitted) | \$150 copay per visit (copay waived if admitted) |
| Ambulance services-must be medically necessary | 80% after in-network deductible | 80% after in-network deductible |

Diagnostic services

| Benefits | In-network | Out-of-network |
|-----------------------------------|---------------------------------|-------------------------------------|
| Laboratory and pathology services | 80% after in-network deductible | 60% after out-of-network deductible |
| Diagnostic tests and x-rays | 80% after in-network deductible | 60% after out-of-network deductible |
| Therapeutic radiology | 80% after in-network deductible | 60% after out-of-network deductible |

Maternity services provided by a physician or certified nurse midwife

| Benefits | In-network | Out-of-network |
|--|---|-------------------------------------|
| Routine Prenatal and Postnatal Care visits | 100% (no deductible or copay/coinsurance) | 60% after out-of-network deductible |
| Delivery and nursery care | 80% after in-network deductible | 60% 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 | 80% after in-network deductible | 60% after out-of-network deductible Unlimited days |

Note: Nonemergency services must be rendered in a **participating** hospital.

| | | |
|-------------------------|---------------------------------|-------------------------------------|
| Inpatient consultations | 80% after in-network deductible | 60% after out-of-network deductible |
| Chemotherapy | 80% after in-network deductible | 60% 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 | 80% after in-network deductible | 80% after in-network deductible Limited to a maximum of 120 days per member per calendar year |
| Hospice care | 100% (no deductible or copay/coinsurance) | 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) |
| Home health care: <ul style="list-style-type: none"> • must be medically necessary • must be provided by a participating home health care agency | 80% after in-network deductible | 80% after in-network deductible |
| Infusion therapy: <ul style="list-style-type: none"> • 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 preauthorization- consult with your doctor | 80% after in-network deductible | 80% 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 | 80% after in-network deductible | 60% after out-of-network deductible |
| Presurgical consultations | 100% (no deductible or copay/coinsurance) | 60% after out-of-network deductible |
| Voluntary sterilization for males | 80% after in-network deductible | 60% after out-of-network deductible |
| Note: For voluntary sterilizations for females, see " Preventive care services. " | | |
| Elective abortions | 80% after in-network deductible | 60% after out-of-network deductible |

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) | 80% after in-network deductible | 60% after out-of-network deductible |
| Specified oncology clinical trials | 80% after in-network deductible | 60% after out-of-network deductible |
| Note: BCBSM covers clinical trials in compliance with PPACA. | | |
| Kidney, cornea and skin transplants | 80% after in-network deductible | 60% 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 BSBCM to be comparable to an office visit or medical online visit. When a mental health or substance use disorder service is considered by BSBCM to be comparable to an office visit or medical online visit, we will process the claim under your office visit or medical online visit benefit.

| Benefits | In-network | Out-of-network |
|--|---------------------------------|---|
| Inpatient mental health care and inpatient substance use disorder treatment | 80% after in-network deductible | 60% after out-of-network deductible Unlimited days |
| Residential psychiatric treatment facility <ul style="list-style-type: none"> covered mental health services must be performed in a residential psychiatric treatment facility treatment must be preauthorized subject to medical criteria | 80% after in-network deductible | 60% after out-of-network deductible |
| Outpatient mental health care: <ul style="list-style-type: none"> Facility and clinic | 80% after in-network deductible | 80% after in-network deductible in participating facilities only |
| Note: Online visits by a non-BCBSM selected vendor are not covered. <ul style="list-style-type: none"> Physician's office | 80% after in-network deductible | 60% after out-of-network deductible |
| Outpatient substance use disorder treatment- in approved facilities only | 80% after in-network deductible | 60% 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 behavioral analysis (ABA) treatment-when rendered by an approved board-certified behavioral analyst, subject to preauthorization Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment. | 80% after in-network deductible | 80% after in-network deductible |
| Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder | 80% after in-network deductible Physical, speech and occupational therapy with an autism diagnosis is unlimited | 60% after out-of-network deductible |
| Other covered services, including mental health services, for autism spectrum disorder | 80% after in-network deductible | 60% 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. Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs. | <ul style="list-style-type: none"> 80% after in-network deductible for diabetes medical supplies 100% (no deductible or copay/coinsurance) for diabetes self-management training | 60% after out-of-network deductible |
| Allergy testing and therapy | 80% after in-network deductible | 60% after out-of-network deductible |
| Chiropractic spinal manipulation and osteopathic manipulative therapy | \$30 copay per 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. Limited to a combined 12-visit maximum per member per calendar year | 60% after out-of-network deductible |
| Outpatient physical, speech and occupational therapy-provided for rehabilitation | 80% after in-network deductible | 60% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered. Limited to a combined 30-visit maximum per member per calendar year |
| Durable medical equipment Note: DME items 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. For a list of covered DME items required under PPACA, call BCBSM. Note: Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers. | 80% after in-network deductible | 60% 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. | 80% after in-network deductible | 60% after out-of-network deductible |
| Private duty nursing care | 50% after in-network deductible | 50% after in-network deductible |



Blue Cross
Blue Shield
of Michigan

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Blue Preferred® Rx LG Prescription Drug Coverage Custom Select \$20/\$60/50%/20%/25% Benefits-at-a-glance Effective Date: On or after July 2023

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/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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 mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Pharmacy, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. AllianceRx Walgreens Pharmacy will handle mail order prescriptions only for specialty drugs. You may obtain specialty drugs through a Walgreens retail pharmacy as well as long as the drug is available at that location. You may want to call ahead to confirm availability at the location. **If you go to a non-AllianceRx Walgreens Pharmacy, you may be responsible for 100% of the cost of the specialty drug.** Other mail order prescriptions for non-specialty medications can continue to be sent to OptumRx home delivery pharmacy. (OptumRx is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at bcbsm.com/pharmacy. If you have any questions, please call AllianceRx Walgreens 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 BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/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 or select prescribed over-the-counter 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 BCBSM approved amount for the drug |

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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 |
|--|---------------------|--|--|---|---|
| | 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 |
| | 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 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 \$80 or 50% of the approved amount (whichever is greater), but no more than \$100 | You pay \$80 or 50% of the approved amount (whichever is greater), but no more than \$100 | You pay \$80 or 50% of the approved amount (whichever is greater), but no more than \$100 | You pay \$80 or 50% of the approved amount (whichever is greater), but no more than \$100 plus an additional 25% of BCBSM approved amount for the drug |
| | 31 to 60-day period | No coverage | You pay \$160 or 50% of the approved amount (whichever is greater), but no more than \$200 | No coverage | No coverage |
| | 61 to 83-day period | No coverage | You pay \$230 or 50% of the approved amount (whichever is greater), but no more than \$290 | No coverage | No coverage |
| | 84 to 90-day period | You pay \$230 or 50% of the approved amount (whichever is greater), but no more than \$290 | You pay \$230 or 50% of the approved amount (whichever is greater), but no more than \$290 | No coverage | No coverage |
| Generic and preferred brand-name specialty drugs | 1 to 30-day period | You pay 20% of approved amount, but no more than \$200 | You pay 20% of approved amount, but no more than \$200 | You pay 20% of approved amount, but no more than \$200 | You pay 20% of approved amount, but no more than \$200 plus an additional 25% of BCBSM approved amount for the drug |
| | 31 to 60-day period | No coverage | No coverage | No coverage | No coverage |
| | 61 to 83-day period | No coverage | No coverage | No coverage | No coverage |
| | 84 to 90-day period | No coverage | No coverage | No coverage | No coverage |
| Nonpreferred brand-name specialty drugs | 1 to 30-day period | You pay 25% of approved amount, but no more than \$300 | You pay 25% of approved amount, but no more than \$300 | You pay 25% of approved amount, but no more than \$300 | You pay 25% of approved amount, but no more than \$300 plus an additional 25% of BCBSM approved amount for the drug |
| | 31 to 60-day period | No coverage | No coverage | No coverage | No coverage |
| | 61 to 83-day period | No coverage | No coverage | No coverage | No coverage |
| | 84 to 90-day period | No coverage | No coverage | No coverage | No coverage |

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select

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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 |
|----------|--------------------------------|----------------------------------|---|-------------------------|
|----------|--------------------------------|----------------------------------|---|-------------------------|

prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs * 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 (non-self-administered drugs 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 preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs 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 |
| FDA-approved generic and select brand name prescription contraceptive medication (non-self-administered drugs 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 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 | 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 |
| Note: Needles and syringes have no copay/ coinsurance. | | | | |
| Select diabetic supplies and devices (test strips, lancets and glucometers) | 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 |
| For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy . | | | | |

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Features of your prescription drug plan

| | |
|----------------------------------|--|
| Custom Select Drug List | <p>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.</p> <ul style="list-style-type: none"> • 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. Select brand-name drugs may be included in the generic tier. • Preferred brand-name drug tier – This tier includes non-specialty preferred brand-name drugs. These drugs are more expensive than 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. |
| Prior authorization/step therapy | <p>A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring preauthorization) 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. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at bcbsm.com/pharmacy.</p> |
| Quantity limits | <p>To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.</p> |
| Exclusions | <p>The following drugs are not covered:</p> <ul style="list-style-type: none"> • 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 |