



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

## WAYNE COUNTY COMMUNITY COLLEGE DISTRICT

### 0070119080005 - 09PN0

### Effective Date: 01/01/2024

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.

**Preauthorization for Specialty 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](https://www.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 provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

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## Eligibility Information

| Member               | Eligibility Criteria                                                                                                                                                                                                                                                                                                                                       |
|----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Dependents           | <ul style="list-style-type: none"> <li>Subscriber's legal spouse</li> <li><b>Dependent children:</b> 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</li> </ul>                                                                                         |
| Sponsored dependents | <ul style="list-style-type: none"> <li>Dependents of the subscriber related by blood, marriage or legal adoption, over age 19 and not eligible as a dependent under the provisions of the subscriber's contract, provided the dependent meets all eligibility requirements. The subscriber is responsible for paying the cost of this coverage.</li> </ul> |

## 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                                                                                                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Deductibles</b><br><br><b>Note:</b> Your deductible <b>combines</b> deductible amounts paid under your Simply Blue HSA medical coverage <b>and</b> your Simply Blue prescription drug coverage.<br><br><b>Note:</b> The full family deductible <b>must</b> be met under a two-person or family contract before benefits are paid for any person on the contract. | \$2,000 for a one-person contract<br>\$4,000 for a family contract (two or more members) each calendar year<br><b>(no 4th quarter carry-over)</b> | \$4,000 for a one-person contract<br>\$8,000 for a family contract (two or more members) each calendar year<br><b>(no 4th quarter carry-over)</b> |
| <b>Flat-dollar copays</b>                                                                                                                                                                                                                                                                                                                                           | See "Prescription Drugs" section                                                                                                                  | See "Prescription Drugs" section                                                                                                                  |
| <b>Coinsurance amounts (percent copays)</b><br><br><b>Note:</b> Coinsurance amounts apply once the deductible has been met.                                                                                                                                                                                                                                         | None                                                                                                                                              | 20% of approved amount for most covered services                                                                                                  |
| <b>Annual out-of-pocket maximums</b> -applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts                                                                                                                                                                                                    | \$4,000 for a one-person contract<br>\$8,000 for a family contract (two or more members) each calendar year                                       | \$8,000 for a one-person contract<br>\$16,000 for a family contract (two or more members) each calendar year                                      |
| <b>Lifetime dollar maximum</b>                                                                                                                                                                                                                                                                                                                                      | 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<br><br><b>Note:</b> 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<br><br><b>Note:</b> Additional well-women visits may be allowed based on medical necessity. | Not covered    |

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| Benefits                                                                                                                                                                                                                                | In-network                                                                                                                                                                                                                                                                                                                                                                                            | Out-of-network                                                                                                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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)                                                                                                                                                                                                                                                                                                                                                             | 80% 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)                                                                                                                                                                                                                                                                                                                                                             | 80% after out-of-network deductible                                                                                                                                                              |
| Contraceptive injections                                                                                                                                                                                                                | 100% (no deductible or copay/coinsurance)                                                                                                                                                                                                                                                                                                                                                             | 80% after out-of-network deductible                                                                                                                                                              |
| Well-baby and Well-child visits                                                                                                                                                                                                         | 100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> <li>8 visits, birth through 12 months</li> <li>6 visits, 13 months through 23 months</li> <li>6 visits, 24 months through 35 months</li> <li>2 visits, 36 months through 47 months</li> <li>Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</li> </ul> | 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) <p><b>Note:</b> Subsequent medically necessary mammograms performed during the <b>same</b> calendar year are subject to your deductible and coinsurance, if applicable.</p>                                                                                                                                                                                 | 80% after out-of-network deductible <p><b>Note:</b> Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.</p> |
| One per member per calendar year                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                  |
| Colonoscopy - routine or medically necessary                                                                                                                                                                                            | 100% (no deductible or copay/coinsurance) for routine colonoscopy <p><b>Note:</b> Medically necessary colonoscopies performed during the <b>same</b> calendar year are subject to your deductible and coinsurance, if applicable.</p>                                                                                                                                                                 | 80% after out-of-network deductible                                                                                                                                                              |
| One routine colonoscopy per member per calendar year                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                  |

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| Physician office services                                                                                                                                                                                                                                                                                                                 |                                  |                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------|
| Benefits                                                                                                                                                                                                                                                                                                                                  | In-network                       | Out-of-network                      |
| Office visits - must be medically necessary                                                                                                                                                                                                                                                                                               | 100% after in-network deductible | 80% after out-of-network deductible |
| Online visits - by physician must be medically necessary<br><br><b>Note:</b> Online visits by a 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% after in-network deductible | 80% after out-of-network deductible |
| Outpatient and home medical care visits - must be medically necessary                                                                                                                                                                                                                                                                     | 100% after in-network deductible | 80% after out-of-network deductible |
| Office consultations - must be medically necessary                                                                                                                                                                                                                                                                                        | 100% after in-network deductible | 80% after out-of-network deductible |
| Urgent care visits - must be medically necessary                                                                                                                                                                                                                                                                                          | 100% after in-network deductible | 80% after out-of-network deductible |

| Emergency medical care                           |                                  |                                  |
|--------------------------------------------------|----------------------------------|----------------------------------|
| Benefits                                         | In-network                       | Out-of-network                   |
| Hospital emergency room                          | 100% after in-network deductible | 100% after in-network deductible |
| Ambulance services - must be medically necessary | 100% after in-network deductible | 100% after in-network deductible |

| Diagnostic services               |                                  |                                     |
|-----------------------------------|----------------------------------|-------------------------------------|
| Benefits                          | In-network                       | Out-of-network                      |
| Laboratory and pathology services | 100% after in-network deductible | 80% after out-of-network deductible |
| Diagnostic tests and x-rays       | 100% after in-network deductible | 80% after out-of-network deductible |
| Therapeutic radiology             | 100% after in-network deductible | 80% after out-of-network deductible |

| 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) | 80% after out-of-network deductible |
| Postnatal care                                                        | 100% (no deductible or copay/coinsurance) | 80% after out-of-network deductible |
| Delivery and nursery care                                             | 100% after in-network deductible          | 80% after out-of-network deductible |

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## Hospital care

| Benefits                                                                                         | In-network                       | Out-of-network                      |
|--------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------|
| Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies | 100% after in-network deductible | 80% after out-of-network deductible |
| Unlimited days                                                                                   |                                  |                                     |
| <b>Note:</b> Nonemergency services must be rendered in a <b>participating</b> hospital.          |                                  |                                     |
| Inpatient consultations                                                                          | 100% after in-network deductible | 80% after out-of-network deductible |
| Chemotherapy                                                                                     | 100% after in-network deductible | 80% after out-of-network deductible |

## Alternatives to hospital care

| Benefits                                                                                                                                                                                                                                                                                                                                          | In-network                       | Out-of-network                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------|
| Skilled nursing care- must be in a <b>participating</b> skilled nursing facility                                                                                                                                                                                                                                                                  | 100% after in-network deductible | 100% after in-network deductible |
| Limited to a maximum of 90 days per member per calendar year                                                                                                                                                                                                                                                                                      |                                  |                                  |
| Hospice care                                                                                                                                                                                                                                                                                                                                      | 100% after in-network deductible | 100% after in-network deductible |
| Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods-provided through a <b>participating</b> hospice program <b>only</b> ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)         |                                  |                                  |
| Home health care:<br><ul style="list-style-type: none"> <li>must be medically necessary</li> <li>must be provided by a <b>participating</b> home health care agency</li> </ul>                                                                                                                                                                    | 100% after in-network deductible | 100% after in-network deductible |
| Infusion therapy:<br><ul style="list-style-type: none"> <li>must be medically necessary</li> <li>must be given by a <b>participating</b> Home Infusion Therapy (HIT) provider or in a <b>participating</b> freestanding Ambulatory Infusion Center (AIC)</li> <li>may use drugs that require preauthorization-consult with your doctor</li> </ul> | 100% after in-network deductible | 100% after in-network deductible |

## Surgical services

| Benefits                                                                                                                                   | In-network                       | Out-of-network                      |
|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------|
| Surgery-includes related surgical services and medically necessary facility services by a <b>participating</b> ambulatory surgery facility | 100% after in-network deductible | 80% after out-of-network deductible |
| Presurgical consultations                                                                                                                  | 100% after in-network deductible | 80% after out-of-network deductible |
| Voluntary sterilization of male reproductive organs                                                                                        | 100% after in-network deductible | 80% after out-of-network deductible |
| <b>Note:</b> For voluntary sterilization of female reproductive organs, see <b>"Preventive care services."</b>                             |                                  |                                     |
| Voluntary abortions                                                                                                                        | 100% after in-network deductible | 80% after out-of-network deductible |

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## Human organ transplants

| Benefits                                                                                                                                                      | In-network                       | Out-of-network                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|------------------------------------------------------------------------|
| Specified human organ transplants - must be in a <b>designated</b> facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) | 100% after in-network deductible | 100% after in-network deductible -in designated facilities <b>only</b> |
| Bone marrow transplants-must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)                                                 | 100% after in-network deductible | 80% after out-of-network deductible                                    |
| Specified oncology clinical trials                                                                                                                            | 100% after in-network deductible | 80% after out-of-network deductible                                    |
| <b>Note:</b> BCBSM covers clinical trials in compliance with PPACA.                                                                                           |                                  |                                                                        |
| Kidney, cornea and skin transplants                                                                                                                           | 100% after in-network deductible | 80% after out-of-network deductible                                    |

## Behavioral Health Services (Mental Health and Substance Use Disorder)

| Benefits                                                                                                                                                                                                                                                                            | In-network                       | Out-of-network                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-----------------------------------------------------------------------------------------------------|
| <b>Inpatient</b> mental health care and <b>inpatient</b> substance use disorder treatment                                                                                                                                                                                           | 100% after in-network deductible | 80% after out-of-network deductible                                                                 |
| Unlimited days                                                                                                                                                                                                                                                                      |                                  |                                                                                                     |
| Residential psychiatric treatment facility: <ul style="list-style-type: none"> <li>covered mental health services <b>must</b> be performed in a residential psychiatric treatment facility</li> <li>Treatment must be preauthorized</li> <li>subject to medical criteria</li> </ul> | 100% after in-network deductible | 80% after out-of-network deductible                                                                 |
| Outpatient mental health care: <ul style="list-style-type: none"> <li>Facility and clinic</li> </ul>                                                                                                                                                                                | 100% after in-network deductible | 100% after in-network deductible in participating facilities <b>only</b>                            |
| <ul style="list-style-type: none"> <li>Online visits</li> </ul>                                                                                                                                                                                                                     | 100% after in-network deductible | 80% after out-of-network deductible                                                                 |
| <b>Note:</b> Online visits by a vendor are not covered.                                                                                                                                                                                                                             |                                  |                                                                                                     |
| <ul style="list-style-type: none"> <li>Physician's office</li> </ul>                                                                                                                                                                                                                | 100% after in-network deductible | 80% after out-of-network deductible                                                                 |
| Outpatient substance use disorder treatment-in approved facilities <b>only</b>                                                                                                                                                                                                      | 100% after in-network deductible | 80% 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 - when rendered by an approved licensed behavior analyst - subject to preauthorization                                                                                                                                                                                                                            | 100% after in-network deductible | 100% after in-network deductible    |
| <b>Note:</b> 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). |                                  |                                     |
| Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder                                                                                                                                                                                                                                      | 100% after in-network deductible | 80% after out-of-network deductible |
| Physical, speech and occupational therapy <b>with an autism diagnosis</b> is unlimited                                                                                                                                                                                                                                                                      |                                  |                                     |

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| Benefits                                                                               | In-network                       | Out-of-network                      |
|----------------------------------------------------------------------------------------|----------------------------------|-------------------------------------|
| Other covered services, including mental health services, for autism spectrum disorder | 100% after in-network deductible | 80% after out-of-network deductible |

## Other covered services

| Benefits                                                                                                                                                                                                                                                                                                           | In-network                                                                 | Out-of-network                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| Outpatient Diabetes Management Program (ODMP)                                                                                                                                                                                                                                                                      | 100% after in-network deductible                                           | 80% after out-of-network deductible                                                                      |
| <p><b>Note:</b> 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.</p> <p><b>Note:</b> When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.</p> |                                                                            |                                                                                                          |
| Allergy testing and therapy                                                                                                                                                                                                                                                                                        | 100% after in-network deductible                                           | 80% after out-of-network deductible                                                                      |
| Chiropractic spinal manipulation and osteopathic manipulative therapy                                                                                                                                                                                                                                              | 100% after in-network deductible                                           | 80% after out-of-network deductible                                                                      |
|                                                                                                                                                                                                                                                                                                                    | Limited to a <b>combined</b> 12-visit maximum per member per calendar year |                                                                                                          |
| Outpatient physical, speech and occupational therapy-provided for rehabilitation                                                                                                                                                                                                                                   | 100% after in-network deductible                                           | 80% after out-of-network deductible                                                                      |
|                                                                                                                                                                                                                                                                                                                    |                                                                            | <p><b>Note:</b> Services at nonparticipating outpatient physical therapy facilities are not covered.</p> |
|                                                                                                                                                                                                                                                                                                                    | Limited to a <b>combined</b> 30-visit maximum per member per calendar year |                                                                                                          |
| Durable medical equipment                                                                                                                                                                                                                                                                                          | 100% after in-network deductible                                           | 100% after in-network deductible                                                                         |
| <p><b>Note:</b> 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.</p>                  |                                                                            |                                                                                                          |
| Prosthetic and orthotic appliances                                                                                                                                                                                                                                                                                 | 100% after in-network deductible                                           | 100% after in-network deductible                                                                         |
| Private duty nursing care                                                                                                                                                                                                                                                                                          | 100% after in-network deductible                                           | 80% after out-of-network deductible                                                                      |

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## Simply Blue<sup>SM</sup> HSA PPO with Rx ASC

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.

**Specialty Pharmaceutical Drugs** - The 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. You may also obtain specialty drugs through a Walgreens retail pharmacy 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.** A list of specialty drugs is available on our Web site at [bcbsm.com/pharmacy](http://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". 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](http://bcbsm.com/pharmacy).

## Member's responsibility (copays and coinsurance amounts)

**Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual out-of-pocket maximum required under your Simply Blue HSA medical coverage.** Benefits are not payable until you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are required to pay applicable prescription drug copays and coinsurance amounts which are subject to your annual out-of-pocket maximums.

**Note:** The following prescription drug expenses will not apply to your Simply Blue HSA deductible or annual out-of-pocket maximum

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 20% member liability for covered drugs obtained from an out-of-network pharmacy

| 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  | After deductible is met, you pay \$10 copay | After deductible is met, you pay \$10 copay  | After deductible is met, you pay \$10 copay                 | After deductible is met, you pay \$10 copay plus an additional 20% of the BCBSM approved amount |
|                                                     | 31 to 83-day period | No coverage                                 | After deductible is met, you pay \$20 copay  | No coverage                                                 | No coverage                                                                                     |
|                                                     | 84 to 90-day period | After deductible is met, you pay \$20 copay | After deductible is met, you pay \$20 copay  | No coverage                                                 | No coverage                                                                                     |
| Preferred brand-name drugs                          | 1 to 30-day period  | After deductible is met, you pay \$40 copay | After deductible is met, you pay \$40 copay  | After deductible is met, you pay \$40 copay                 | After deductible is met, you pay \$40 copay plus an additional 20% of the BCBSM approved amount |
|                                                     | 31 to 83-day period | No coverage                                 | After deductible is met, you pay \$80 copay  | No coverage                                                 | No coverage                                                                                     |
|                                                     | 84 to 90-day period | After deductible is met, you pay \$80 copay | After deductible is met, you pay \$80 copay  | No coverage                                                 | No coverage                                                                                     |
| Nonpreferred brand-name drugs                       | 1 to 30-day period  | After deductible is met, you pay \$80 copay | After deductible is met, you pay \$80 copay  | After deductible is met, you pay \$80 copay                 | After deductible is met, you pay \$80 copay plus an additional 20% of the BCBSM approved amount |
|                                                     | 31 to 83-day period | No coverage                                 | After deductible is met, you pay \$160 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 | After deductible is met, you pay \$160 copay | After deductible is met, you pay \$160 copay | 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 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                                                                                                                                                                                                                | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty |
| Prescribed over-the-counter drugs - when covered by BCBSM                                                                                                                                                                         | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty |
| State-controlled drugs                                                                                                                                                                                                            | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty |
| FDA-approved <b>generic</b> and <b>select brand-name</b> prescription preventive drugs, supplements and vitamins as required by PPACA                                                                                             | 100% of approved amount                                                               | 100% of approved amount                                                               | 100% of approved amount                                                               | 80% of approved amount                                                                                                                                |
| Other FDA-approved <b>brand-name</b> prescription preventive drugs, supplements and vitamins as required by PPACA                                                                                                                 | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty |
| 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 Patient Protection and Affordable Care Act | 100% of approved amount                                                               | No coverage                                                                           | 100% of approved amount                                                               | 80% of approved amount                                                                                                                                |

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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                                                                                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| FDA-approved <b>generic</b> and <b>select brand-name</b> prescription contraceptive medication (non-self-administered drugs are not covered)                                                                                                          | 100% of approved amount                                                                                                                       | 100% of approved amount                                                                                                                       | 100% of approved amount                                                                                                                       | 80% of approved amount                                                                                                                                                                                    |
| Other FDA-approved <b>brand-name</b> prescription contraceptive medication (non-self-administered drugs are not covered)                                                                                                                              | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance                                                         | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance                                                         | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance                                                         | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance <b>plus</b> an additional 20% prescription drug out-of-network penalty                                              |
| Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs<br><br><b>Note:</b> Needles and syringes have no copay/coinsurance.                                                                            | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty for insulin or other covered injectable legend drug |
| Select diabetic supplies and devices (test strips, lancets and glucometers)<br><br>For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at <a href="http://BCBSM.com/pharmacy">BCBSM.com/pharmacy</a> . | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance                                                         | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance                                                         | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance                                                         | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty                                                     |

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

| Features of your prescription drug plan |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|-----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Custom 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"> <li>• <b>Generic drug tier</b> - 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.</li> <li>• <b>Preferred brand-name drug tier</b> - This tier includes non-specialty preferred brand-name drugs. These drugs are more expensive than generic and members pay more for them.</li> <li>• <b>Nonpreferred brand-name drug tier</b> - 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.</li> </ul> |
| Prior authorization/step therapy        | <p>A process that requires a physician to obtain approval from BCBSM <b>before</b> select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. <b>Step Therapy</b>, 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 <a href="http://bcbsm.com/pharmacy">bcbsm.com/pharmacy</a>.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

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## Features of your prescription drug plan

|                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Maximum allowable cost drugs | <p>When you receive a generic maximum allowable cost (MAC) drug from an in-network pharmacy, you pay your cost share as noted in your coverage.</p> <p>However, if you request a brand-name drug and the prescriber did not write "Dispense as Written" or "DAW" on the prescription, you must pay the difference between the maximum allowable cost and the Blue Cross Blue Shield of Michigan approved amount for the brand-name drug, plus your copayment.</p> <p>If the prescriber wrote "Dispense as Written" or "DAW" on the prescription, we will pay the pharmacy the approved amount for the brand-name drug, after deduction of your copayment.</p> |
| Quantity limits              | To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

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