



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

## WAYNE COUNTY

### 0070027780097 - 084DK

### Effective Date: 01/01/2022

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](http://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. | \$1,400 for a one-person contract<br>\$2,800 for a family contract (2 or more members) each calendar year<br><b>(no 4th quarter carry-over)</b><br><br>Deductibles are based on amounts defined annually by the federal government for Simply Blue HSA-related health plans. Deductibles may increase annually. Please call your customer service center for an annual update. | \$2,800 for a one-person contract<br>\$5,600 for a family contract (2 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>   | 20% of approved amount for most covered services   | 40% of approved amount for most covered services  |
| <b>Note:</b> Coinsurance amounts apply once the deductible has been met.  |  |   |
| <b>Annual out-of-pocket maximums</b> -applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts  | \$2,300 for a one-person contract<br>\$4,600 for a family contract (2 or more members) each calendar year  | \$4,600 for a one-person contract<br>\$9,200 for a family contract (2 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), one 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 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)   | 60% 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"> <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> <p>One per member per calendar year</p>   | 60% 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> |
| Routine screening colonoscopy   | 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> <p>One routine colonoscopy per member per calendar year</p>   | 60% after out-of-network deductible  |

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## Physician office services

| Benefits   | In-network                      | Out-of-network                      |
|--|---------------------------------|-------------------------------------|
| Office visits - must be medically necessary  | 80% after in-network deductible | 60% after out-of-network deductible |
| Online visits - by physician or <b>BCBSM</b> selected vendor must be medically necessary | 80% after in-network deductible | 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                                       | 80% after in-network deductible | 60% after out-of-network deductible |
| Urgent care visits - must be medically necessary   | 80% after in-network deductible | 60% after out-of-network deductible |

## Emergency medical care

| Benefits   | In-network                      | Out-of-network                  |
|--|---------------------------------|---------------------------------|
| Hospital emergency room                          | 80% after in-network deductible | 80% after in-network deductible |
| 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                      |
|---------------------------|---|-------------------------------------|
| Prenatal care visits      | 100% (no deductible or copay/coinsurance) | 60% after out-of-network deductible |
| Postnatal care            | 80% after in-network deductible           | 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                      |
| <b>Note:</b> Nonemergency services must be rendered in a participating hospital.                 |                                 |                                     |
| Inpatient consultations  | 80% after in-network deductible | 60% after out-of-network deductible |

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| Benefits     | In-network                      | Out-of-network                      |
|--------------|---------------------------------|-------------------------------------|
| 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 <b>participating</b> skilled nursing facility  | 80% after in-network deductible<br>Limited to a maximum of 90 days per member per calendar year   | 80% after in-network deductible |
| Hospice care  | 80% after in-network deductible<br>Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods-provided through a <b>participating hospice program only</b> ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management) | 80% after in-network deductible |
| Home health care:<br>• must be medically necessary<br>• must be provided by a <b>participating</b> home health care agency  | 80% after in-network deductible   | 80% after in-network deductible |
| Infusion therapy:<br>• must be medically necessary<br>• must be given by a <b>participating</b> Home Infusion Therapy (HIT) provider or in a <b>participating</b> freestanding Ambulatory Infusion Center (AIC)<br>• 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 <b>participating</b> ambulatory surgery facility | 80% after in-network deductible | 60% after out-of-network deductible |
| Presurgical consultations  | 80% after in-network deductible | 60% after out-of-network deductible |
| Voluntary sterilization for males  | 80% after in-network deductible | 60% after out-of-network deductible |
| <b>Note:</b> For voluntary sterilizations for females, see " <b>Preventive care services.</b> "  |                                 |                                     |
| Voluntary 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 <b>designated</b> facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) | 80% after in-network deductible | 80% 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)   | 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                                  |
| <b>Note:</b> BCBSM covers clinical trials in compliance with PPACA.   |                                 |  |

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| Benefits                            | In-network                      | Out-of-network                      |
|-------------------------------------|---------------------------------|-------------------------------------|
| 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)

| Benefits  | In-network                      | Out-of-network  |
|---|---------------------------------|---|
| Inpatient mental health care and inpatient substance treatment  | 80% after in-network deductible | 60% after out-of-network deductible<br>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> | 80% after in-network deductible | 60% after out-of-network deductible   |
| Outpatient mental health care: <ul style="list-style-type: none"> <li>Facility and clinic</li> </ul>  | 80% after in-network deductible | 80% after in-network deductible in participating facilities <b>only</b>                             |
| <ul style="list-style-type: none"> <li>Online visits - by physician or <b>BCBSM</b> selected vendor</li> </ul>  | 80% after in-network deductible | 60% after out-of-network deductible   |
| <ul style="list-style-type: none"> <li>Physician's office</li> </ul>  | 80% after in-network deductible | 60% after out-of-network deductible   |
| Outpatient substance use disorder treatment-in approved facilities <b>only</b>  | 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-is covered through age 18, subject to preauthorization   | Not covered | Not covered    |
| <b>Note:</b> 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. |             |                |
| Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder   | Not covered | Not covered    |
| Other covered services, including mental health services, for autism spectrum disorder   | Not covered | Not covered    |

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## Other covered services

| Benefits   | In-network   | Out-of-network  |
|--|--|---|
| Outpatient Diabetes Management Program (ODMP)  | 80% after in-network deductible  | 60% after out-of-network deductible   |
| <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.   |  |   |
| <b>Note:</b> When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.  |  |   |
| Allergy testing and therapy  | 80% after in-network deductible  | 60% after out-of-network deductible   |
| Chiropractic spinal manipulation and osteopathic manipulative therapy  | 80% after in-network deductible  | 60% after out-of-network deductible   |
|  | Limited to a <b>combined</b> 24-visit maximum per member per calendar year |   |
| Outpatient physical, speech and occupational therapy-provided for rehabilitation   | 80% after in-network deductible  | 60% after out-of-network deductible   |
|  |  | <b>Note:</b> Services at nonparticipating outpatient physical therapy facilities are not covered. |
|  | Limited to a <b>combined</b> 60-visit maximum per member per calendar year |   |
| Durable medical equipment  | 80% after in-network deductible  | 80% after in-network deductible   |
| <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. |  |   |
| Prosthetic and orthotic appliances   | 80% after in-network deductible  | 80% after in-network deductible   |
| Private duty nursing care  | 80% after in-network deductible  | 80% after in-network deductible   |

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## Simply Blue HSA with Prescription Drugs

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**Specialty Pharmaceutical Drugs** - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, 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 Prime will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to the 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](http://bcbsm.com/pharmacy). If you have any questions, please call AllianceRx Walgreens Prime 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](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. The 20% member liability for covered drugs obtained from an out-of-network pharmacy will not contribute to your annual out-of-pocket maximum.

Benefits are not payable until after 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.

| 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  |
|--|---------------------|---|---|---|--|
| Tier 1 -<br>Generic 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 60-day period | No coverage                                 | After deductible is met, you pay \$20 copay | No coverage   | No coverage  |
|  | 61 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  |
| Tier 2 -<br>Preferred brand-name drugs | 1 to 30-day period  | After deductible is met, you pay \$35 copay | After deductible is met, you pay \$35 copay | After deductible is met, you pay \$35 copay                 | After deductible is met, you pay \$35 copay <b>plus</b> an additional 20% prescription drug out-of-network copay from an out-of-network retail pharmacy provider |
|  | 31 to 60-day period | No coverage                                 | After deductible is met, you pay \$70 copay | No coverage   | No coverage  |
|  | 61 to 83-day period | No coverage                                 | After deductible is met, you pay \$70 copay | No coverage   | No coverage  |
|  | 84 to 90-day period | After deductible is met, you pay \$70 copay | After deductible is met, you pay \$70 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  |
|--|---------------------|--|--|---|--|
| Tier 3 - Nonpreferred brand-name drugs** | 1 to 30-day period  | After deductible is met, you pay \$50 copay  | After deductible is met, you pay \$50 copay  | After deductible is met, you pay \$50 copay                 | After deductible is met, you pay \$50 copay plus an additional 20% of BCBSM approved amount for the drug |
|  | 31 to 60-day period | No coverage                                  | After deductible is met, you pay \$100 copay | No coverage   | No coverage  |
|  | 61 to 83-day period | No coverage                                  | After deductible is met, you pay \$100 copay | No coverage   | No coverage  |
|  | 84 to 90-day period | After deductible is met, you pay \$100 copay | After deductible is met, you pay \$100 copay | No coverage   | No coverage  |

\* 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 |
| 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  |
| 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  |

14/28K-28/56KAS;ADM PLANR JAN;ASCMOD 8203 MED;ASCMOD 8220 DRG;CDH-HSA;CSRXP10/40/80AS;HEQ;SB-HSA-OT ASC;SB-HSA-RA ASC;SBD HSA ASC;SBD HSA OLV ASC;SBDHSAOCSM24ASC;SBHSA-EDMP ASC;SBHSAPREVRX500A;SD ASC

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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   |
|--|---|---|---|---|
| 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   | 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 |
| <b>Note:</b> Needles and syringes have no copay/coinsurance.   |   |   |   |   |
| Select diabetic supplies and devices (test strips, lancets and glucometers)  | 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   |
| 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> . |   |   |   |   |

\* 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"> <li>• <b>Tier 1 (generic)</b> - Tier 1 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>Tier 2 (preferred brand)</b> - Tier 2 includes brand-name drugs from the Custom Select Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance.</li> <li>• <b>Tier 3 (nonpreferred brand)</b> - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.</li> </ul> |
| Quantity limits                   | To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.  |
| HSA preventive prescription drugs | You have coverage for preventive prescription drugs on the BCBSM HSA Preventive Rx Drug List when provided by in-network pharmacies, payable up to an annual benefit maximum of \$500 (no deductible or copay/coinsurance). When the benefit maximum has been reached, the cost-sharing requirements of your plan will apply. A list of commonly prescribed preventive drugs is available upon request. A member may also call the customer service telephone number found on the back of his or her identification card to inquire about a particular drug.   |
| Exclusions                        | <p>The following drugs are not covered:</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• State-controlled drugs</li> <li>• Brand-name drugs that have a generic equivalent available</li> <li>• Drugs to treat erectile dysfunction and weight loss</li> <li>• Prenatal vitamins (prescribed and over-the-counter)</li> <li>• Brand-name drugs used to treat heartburn</li> <li>• Compounded drugs, with some exceptions</li> <li>• Cosmetic drugs</li> </ul>   |

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