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Simply Blue℠ HSA PPO Plan 4000/50% LG
Medical Coverage with Prescription Drugs
Benefits-at-a-Glance

Effective for groups on their plan year

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services – Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo**. Select ***Approving covered services.***

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals – BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician **must** contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

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.

	In-network	Out-of-network *
Deductibles **Note:** Your deductible **combines** deductible amounts paid under your Simply Blue HSA medical coverage **and** your Simply Blue prescription drug coverage.	$4,000 for one member, $8,000 for the family (when two or more members are covered under your contract) each calendar year (**no 4th quarter carry-over**)	$8,000 for one member, $16,000 for the family (when two or more members are covered under your contract) each calendar year (**no 4th quarter carry-over**)
Flat-dollar copays	See "Prescription Drugs" section	See "Prescription Drugs" section
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	50% of approved amount for most covered services	50% of approved amount for most covered services
Annual out-of-pocket maximums – applies to deductibles and coinsurance amounts for all covered services – including prescription drugs cost-sharing amounts	$6,350 for one member, $12,700 for the family (when two or more members are covered under your contract) each calendar year	$12,700 for one member, $25,400 for the family (when two or more members are covered under your contract) each calendar year
Lifetime dollar maximum	None	

* Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

	In-network	Out-of-network *
Preventive care services		
Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the **same** calendar year are subject to your deductible and coinsurance. One per member per calendar year	50% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
Routine screening colonoscopy	100% (no deductible or copay/coinsurance) for routine colonoscopy **Note:** Medically necessary colonoscopies performed during the **same** calendar year are subject to your deductible and coinsurance. One routine colonoscopy per member per calendar year	50% after out-of-network deductible

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	In-network	Out-of-network *
Physician office services		
Office visits – must be medically necessary	50% after in-network deductible	50% after out-of-network deductible
Outpatient and home medical care visits – must be medically necessary	50% after in-network deductible	50% after out-of-network deductible
Office consultations – must be medically necessary	50% after in-network deductible	50% after out-of-network deductible
Urgent care visits – must be medically necessary	50% after in-network deductible	50% after out-of-network deductible
Emergency medical care		
Hospital emergency room	50% after in-network deductible	50% after in-network deductible
Ambulance services – must be medically necessary	50% after in-network deductible	50% after in-network deductible
Diagnostic services		
Laboratory and pathology services	50% after in-network deductible	50% after out-of-network deductible
Diagnostic tests and x-rays	50% after in-network deductible	50% after out-of-network deductible
Therapeutic radiology	50% after in-network deductible	50% after out-of-network deductible
Maternity services provided by a physician or certified nurse midwife		
Prenatal care visits	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Postnatal care	50% after in-network deductible	50% after out-of-network deductible
Delivery and nursery care	50% after in-network deductible	50% after out-of-network deductible
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	50% after in-network deductible Unlimited days	50% after out-of-network deductible
Inpatient consultations	50% after in-network deductible	50% after out-of-network deductible
Chemotherapy	50% after in-network deductible	50% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care – must be in a **participating** skilled nursing facility	50% after in-network deductible Limited to a maximum of 90 days per member per calendar year	50% after in-network deductible
Hospice care	50% after in-network deductible Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	50% after in-network deductible
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	50% after in-network deductible	50% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization – consult with your doctor	50% after in-network deductible	50% after in-network deductible

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	In-network	Out-of-network *
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	50% after in-network deductible	50% after out-of-network deductible
Presurgical consultations	50% after in-network deductible	50% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see "**Preventive care services.**"	50% after in-network deductible	50% after out-of-network deductible
Elective abortions	Not covered	Not covered
Human organ transplants		
Specified human organ transplants – must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	50% after in-network deductible	50% after in-network deductible – in designated facilities **only**
Bone marrow transplants – must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	50% after in-network deductible	50% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	50% after in-network deductible	50% after out-of-network deductible
Kidney, cornea and skin transplants	50% after in-network deductible	50% after out-of-network deductible
Mental health care and substance abuse treatment		
Inpatient mental health care and **inpatient** substance abuse treatment	50% after in-network deductible Unlimited days	50% after out-of-network deductible Unlimited days
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment **must** be preauthorized • subject to medical criteria	50% after in-network deductible	50% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	50% after in-network deductible	50% after in-network deductible, in participating facilities **only**
• Physician's office	50% after in-network deductible	50% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities **only**	50% after in-network deductible	50% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

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	In-network	Out-of-network *
Autism spectrum disorders, diagnoses and treatment		
Applied behavioral analysis (ABA) treatment – when rendered by an approved board-certified behavioral analyst – is covered through age 18, subject to preauthorization **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	50% after in-network deductible	50% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	50% after in-network deductible	50% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	50% after in-network deductible	50% after out-of-network deductible
Other covered services		
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	50% after in-network deductible	50% after out-of-network deductible
Allergy testing and therapy	50% after in-network deductible	50% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	50% after in-network deductible	50% after out-of-network deductible
	Limited to a **combined** 12-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy – when provided for rehabilitation	50% after in-network deductible	50% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 30-visit maximum per member per calendar year	
Durable medical equipment **Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	50% after in-network deductible	50% after in-network deductible
Prosthetic and orthotic appliances	50% after in-network deductible	50% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

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Simply Blue℠ HSA PPO LG Prescription Drug Coverage Benefits-at-a-Glance

Effective for groups on their plan year

Specialty Pharmaceutical Drugs – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, 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. Walgreens Specialty Pharmacy 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 Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that 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 may limit the initial fill of **select** controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. **Subsequent fills** of the **same** medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at **bcbsm.com/pharmacy**.

Member's responsibility (coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copays and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum:

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

		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**
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible is met.	1 to 30-day period	After deductible is met, you pay 50% of approved amount	After deductible is met, you pay 50% of approved amount	After deductible is met, you pay 50% of approved amount	After deductible is met, you pay 50% of approved amount ***plus*** an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible is met, you pay 50% of approved amount	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay 50% of approved amount	After deductible is met, you pay 50% of approved amount	No coverage	No coverage

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

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Covered services

	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 copay/coinsurance	Subject to Simply Blue HSA medical deductible and copay/coinsurance	Subject to Simply Blue HSA medical deductible and copay/coinsurance	Subject to Simply Blue HSA medical deductible and 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 copay/coinsurance	Subject to Simply Blue HSA medical deductible and copay/coinsurance	Subject to Simply Blue HSA medical deductible and copay/coinsurance	Subject to Simply Blue HSA medical deductible and copay/coinsurance ***plus*** an additional 20% prescription drug out-of-network penalty
State-controlled drugs	Subject to Simply Blue HSA medical deductible and copay/coinsurance	Subject to Simply Blue HSA medical deductible and copay/coinsurance	Subject to Simply Blue HSA medical deductible and copay/coinsurance	Subject to Simply Blue HSA medical deductible and copay/coinsurance ***plus*** an additional 20% prescription drug out-of-network penalty
FDA-approved generic and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved brand-name prescription preventive drugs, supplements and vitamins as required by PPACA (non-self-administered drugs are not covered)	Subject to Simply Blue HSA medical deductible and copay/coinsurance	Subject to Simply Blue HSA medical deductible and copay/coinsurance	Subject to Simply Blue HSA medical deductible and copay/coinsurance	Subject to Simply Blue HSA medical deductible and copay/coinsurance ***plus*** an additional 20% prescription drug out-of-network penalty
FDA-approved **generic** and **select brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	Subject to Simply Blue HSA medical deductible and copay/coinsurance	Subject to Simply Blue HSA medical deductible and copay/coinsurance	Subject to Simply Blue HSA medical deductible and copay/coinsurance	Subject to Simply Blue HSA medical deductible and copay/coinsurance ***plus*** an additional 20% prescription drug out-of-network penalty
Disposable needles and syringes – when dispensed with insulin, or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	Subject to Simply Blue HSA medical deductible and copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and copay/coinsurance for the insulin or other covered injectable legend drug ***plus*** an additional 20% prescription drug out-of-network penalty

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.

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Features of your prescription drug plan

Clinical Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.
Drug interchange and generic copay/coinsurance waiver	BCBSM's drug interchange and generic copay/coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/coinsurance. In select cases BCBSM may waive the initial copay/coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Prescription drug preferred therapy	A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications **before** prescribing a more expensive brand-name drug, It applies only to prescriptions being filled for the first time of a targeted medication. Before filling your **initial** prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at **bcbsm.com/pharmacy**, **along with the preferred medications**. If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect **all** targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.