Blue Cross Blue Shield of Michigan

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

GlidePath℠ Sustainable health care solutions

Simply Blue PPO HSA LG – Plan 2000/0% Medical Coverage℠ with Prescription Drugs Benefits-at-a-Glance

Effective for groups on their plan year beginning on or after January 1, 2014

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, copay and /or 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: To be eligible for coverage, the following services require your provider to obtain approval **before** they are provided – select radiology services, inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, rehabilitation therapy and applied behavioral analyses.

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. **Note:** The full family deductible **must** 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 or $4,000 for a family contract (2 or more members) each calendar year (**no 4th quarter carry-over**)	$4,000 for a one-person contract or $8,000 for a family contract (2 or more members) each calendar year (**no 4th quarter carry-over**)
	Deductibles are based on amounts defined annually by the federal government for Simply Blue HSA-related health plans. Please call your customer service center for an annual update.	
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.	None	20% of approved amount for most covered services

* Services from a provider for which there is no Michigan PPO network and services from a 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 *

Member's responsibility (deductibles, copays, coinsurance and dollar maximums), *continued*

Annual out-of-pocket maximums – applies to deductibles and coinsurance amounts for all covered services – including prescription drug cost-sharing amounts	$3,000 for a one-person contract or $6,000 for a family contract (2 or more members) each calendar year	$6,000 for a one-person contract or $12,000 for a family contract (2 or more members) each calendar year
Lifetime dollar maximum	None	

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)	80% after out-of-network deductible, with a 20% coinsurance
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, with a 20% coinsurance
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 6 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

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	In-network	Out-of-network *
Preventive care services, *continued*		
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.	80% after out-of-network deductible, with a 20% coinsurance **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
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.	80% after out-of-network deductible, with a 20% coinsurance
	One routine colonoscopy per member per calendar year	
Physician office services		
Office visits – must be medically necessary	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
Outpatient and home medical care visits – must be medically necessary	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
Office consultations – must be medically necessary	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
Urgent care visits – must be medically necessary	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
Emergency medical care		
Hospital emergency room	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)
Ambulance services – must be medically necessary	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)
Diagnostic services		
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible, with a 20% coinsurance
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible, with a 20% coinsurance
Therapeutic radiology	100% after in-network deductible	80% after out-of-network deductible, with a 20% coinsurance
Maternity services provided by a physician or certified nurse midwife		
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
Postnatal care	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
Delivery and nursery care	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance

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	In-network	Out-of-network *
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
	Unlimited days	
Inpatient consultations	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
Chemotherapy	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
Alternatives to hospital care		
Skilled nursing care – must be in a **participating** skilled nursing facility	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)
	Limited to a maximum of 90 days per member per calendar year	
Hospice care	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)
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	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)
Surgical services		
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
Presurgical consultations	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see "**Preventive care services.**"	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance

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	In-network	Out-of-network *
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)	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance) – in designated facilities **only**
Bone marrow transplants – must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
Kidney, cornea and skin transplants	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
Mental health care and substance abuse treatment		
Inpatient mental health care and **inpatient** substance treatment	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
	Unlimited days	
Outpatient mental health care: • Facility and clinic	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance), in participating facilities **only**
• Physician's office	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
Outpatient substance abuse treatment – in approved facilities **only**	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance (in-network cost-sharing will apply if there is no PPO network)
Autism spectrum disorders, diagnoses and treatment		
Applied behavioral analysis (ABA) treatment – when rendered by an approved board-certified behavioral analyst – is limited to a maximum of 25 hours of direct line therapy per week per member, through age 18 **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. ABA and AAEC services are not available outside of Michigan.	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
	Physical, speech and occupational therapy **with an autism diagnosis** is limited to the same annual **combined** limit as for physical, speech and occupational therapy for other diagnoses	
Other covered services, including mental health services, for autism spectrum disorder	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance

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	In-network	Out-of-network *
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 a network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 100% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	80% after out-of-network deductible, with a 20% coinsurance
Allergy testing and therapy	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance
	Limited to a **combined** 12-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy – provided for rehabilitation	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible, with a 20% coinsurance **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 30-visit maximum per member per calendar year (visits are **combined** with therapies for autism spectrum disorder)	
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.	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)
Prosthetic and orthotic appliances	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)
Private duty nursing care	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)

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Simply Blue℠ PPO HSA LG – Prescription Drug Coverage Triple-Tier Copay, Open Formulary Benefits-at-a-Glance

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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 initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

Member's responsibility (copays)

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 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 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

		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 – Generic or select prescribed over-the-counter drugs	1 to 30-day period	$10 copay	$10 copay	$10 copay	$10 copay ***plus*** an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	$20 copay	No coverage	No coverage
	84 to 90-day period	$20 copay	$20 copay	No coverage	No coverage
Tier 2 – Formulary (preferred) brand-name drugs	1 to 30-day period	$40 copay	$40 copay	$40 copay	$40 copay ***plus*** an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	$80 copay	No coverage	No coverage
	84 to 90-day period	$80 copay	$80 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.

Member's responsibility (copays), *continued*

		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 – Nonformulary (nonpreferred) brand-name drugs	1 to 30-day period	$80 copay	$80 copay	$80 copay	$80 copay ***plus*** an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	$160 copay	No coverage	No coverage
	84 to 90-day period	$160 copay	$160 copay	No coverage	No coverage

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 prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay ***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	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay ***plus*** an additional 20% prescription drug out-of-network penalty
State-controlled drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay ***plus*** an additional 20% prescription drug out-of-network penalty
FDA-approved **generic** and **select brand name** prescription preventive drugs, supplements, and vitamins	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	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay ***plus*** an additional 20% prescription drug out-of-network penalty

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Covered services, *continued*

	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 **generic** and **select brand name** prescription contraceptive medication (non-self-administered drugs and devices 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 and devices are not covered)	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay ***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.	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay for the insulin or other covered injectable legend drug ***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

BCBSM Custom Formulary	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 formulary is to provide members with the greatest therapeutic value at the lowest possible cost. ▪ **Tier 1 (generic)** – 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, making them the most cost-effective option for the treatment. ▪ **Tier 2 (preferred brand)** – Tier 2 includes brand-name drugs from the Custom Formulary. Preferred brand name drugs are also safe and effective, but require a higher copay. ▪ **Tier 3 (nonpreferred brand)** – 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 for these drugs.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.

Features of your prescription drug plan, *continued*

Mandatory maximum allowable cost drugs	If your prescription is filled by an in-network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a nonpreferred brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
Drug interchange and generic copay waiver	BCBSM's drug interchange and generic copay 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. In select cases BCBSM may waive the initial copay 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.