Blue Cross Blue Shield of Michigan

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

Location/Subgroup: MICHIGAN THERAPEUTIC CONSULT
Group-Division: 007043165-0000

Simply Blue^{SM} PPO Gold $2000 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.

* 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.

Location/Subgroup: MICHIGAN THERAPEUTIC CONSULT
Group-Division: 007043165-0000

Benefits	In-network	Out-of-network *
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.		
Deductibles	$2,000 for one member $4,000 for the family (when two or more members are covered under your contract) each calendar year	$4,000 for one member $8,000 for the family (when two or more members are covered under your contract) each calendar year **Note**: Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $30 copay for office visits and office consultations with a primary care physician • $50 copay for office visits and office consultations with a specialist • $30 copay for medical online visits • $30 copay for chiropractic and osteopathic manipulative therapy • $150 copay for emergency room visits • $60 copay for urgent care visits	$150 copay for emergency room visits
Coinsurance amounts (percent copays) **Note**: Coinsurance amounts apply once the deductible has been met.	• 20% of approved amount for most other covered services • 50% of approved amount for bariatric surgery	• 40% of approved amount for most other covered services • 50% of approved amount for bariatric surgery
Annual out-of-pocket maximums Applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drugs cost-sharing amounts	$7,350 for one member, $14,700 for the family (when two or more members are covered under your contract) each calendar year	$14,700 for one member, $29,400 for the family (when two or more members are covered under your contract) each calendar year **Note**: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	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

* 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.

Location/Subgroup: MICHIGAN THERAPEUTIC CONSULT
Group-Division: 007043165-0000

Benefits	In-network	Out-of-network *
Preventive care services		
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note**: Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening Laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices Includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 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 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.	60% after out-of-network deductible **Note**: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider. One per member per calendar year.

* 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.

Location/Subgroup: MICHIGAN THERAPEUTIC CONSULT
Group-Division: 007043165-0000

Benefits	In-network	Out-of-network *
Preventive care services		
Colonoscopy Routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note**: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance. One per member per calendar year.	60% after out-of-network deductible One per member per calendar year.
Physician office services		
Office visits Must be medically necessary	• $30 copay for each office visit with a primary care physician • $50 copay for each office visit with a specialist **Note**: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible
Online visits - by physician must be medically necessary **Note**: Online visits by a non-BCBSM selected vendor are not covered.	$30 copay per online visit	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	• $30 copay for each office consultation with a primary care physician • $50 copay for each office consultation with a specialist **Note**: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible
Urgent care visits		

* 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.

Location/Subgroup: MICHIGAN THERAPEUTIC CONSULT
Group-Division: 007043165-0000

Benefits	In-network	Out-of-network *
Urgent care visits		
Urgent care visits Must be medically necessary	$60 copay per urgent care visit **Note**: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible
Emergency medical care		
Hospital emergency room	$150 copay per visit (copay waived if admitted)	$150 copay per visit (copay waived if admitted)
Ambulance services Must be medically necessary	80% after in-network deductible	80% after in-network deductible
Diagnostic services		
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		
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		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note**: Nonemergency services must be rendered in a participating hospital.	80% after in-network deductible Unlimited days	60% after out-of-network deductible Unlimited days
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care Must be in a participating skilled nursing facility	80% after in-network deductible Limited to a maximum of 120 days per member per calendar year	80% after in-network deductible Limited to a maximum of 120 days per member per calendar year

* 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.

Location/Subgroup: MICHIGAN THERAPEUTIC CONSULT
Group-Division: 007043165-0000

Benefits	In-network	Out-of-network *
Alternatives to hospital care		
Hospice care	100% (no deductible or copay/coinsurance) Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	100% (no deductible or copay/coinsurance) Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)
Home health care • must be medically necessary • must be provided by a participating home health care agency	80% after in-network deductible	80% after in-network deductible
Infusion therapy • must be medically necessary • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization – consult with your doctor	80% after in-network deductible	80% after in-network deductible
Surgical services		
Surgery Includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males **Note**: For voluntary sterilizations for females, see “Preventive care services.”	80% after in-network deductible	60% after out-of-network deductible
Elective Abortions	Covered 80% after in-network deductible	Covered 60% after out-of-network deductible
Bariatric surgery	50% after in-network deductible Limited to a lifetime maximum of one bariatric procedure per member.	50% after out-of-network deductible Limited to a lifetime maximum of one bariatric procedure per member.
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% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) In designated facilities only
Bone marrow transplants Must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

* 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.

Location/Subgroup: MICHIGAN THERAPEUTIC CONSULT
Group-Division: 007043165-0000

Benefits	In-network	Out-of-network *
Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)		
Inpatient mental health care and inpatient substance use disorder treatment	80% after in-network deductible Unlimited days	60% 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	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: **• Facility and clinic**	80% after in-network deductible	80% after in-network deductible In participating facilities only
Outpatient mental health care: **• Online visits** **Note**: Online visits by a non-BCBSM selected vendor are not covered	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: **• Physician office**	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment In approved facilities only	80% after in-network deductible	60% after out-of-network deductible (In-network cost-sharing will apply if there is no PPO network)
Autism spectrum disorders, diagnoses and treatment		
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.	80% after in-network deductible	80% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after in-network deductible Physical, speech and occupational therapy with an autism diagnosis is unlimited.	60% after out-of-network deductible Physical, speech and occupational therapy with an autism diagnosis is unlimited.
Other covered services, including mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible
Other covered services		
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.	• 80% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible
Rehabilitative care: **Outpatient physical and occupational therapy**	80% after in-network deductible	60% after out-of-network deductible **Note**: Services at nonparticipating outpatient physical therapy facilities are not covered.

* 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.

Location/Subgroup: MICHIGAN THERAPEUTIC CONSULT
Group-Division: 007043165-0000

Benefits	In-network	Out-of-network *
Other covered services		
Rehabilitative care: **Chiropractic and osteopathic manipulation**	$30 copay per office visit **Limited to a 30-visit maximum per member per calendar year** **Note**: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy	60% after out-of-network deductible **Limited to a 30-visit maximum per member per calendar year** **Note**: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy
Outpatient speech therapy – when provided for rehabilitative care	80% after in-network deductible Limited to a 30-visit maximum per member per calendar year.	60% after out-of-network deductible Limited to a 30-visit maximum per member per calendar year.
Habilitative care: **Outpatient physical and occupational therapy (excludes chiropractic and osteopathic manipulation)**	80% after in-network deductible **Limited to a 30-visit maximum per member per calendar year** **Note**: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical and occupational therapy	60% after out-of-network deductible **Note**: Services at nonparticipating outpatient physical therapy facilities are not covered. Limited to a 30-visit maximum per member per calendar year Note: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy and occupational therapy.
Outpatient speech therapy - when provided for habilitative care	80% after in-network deductible Limited to a 30-visit maximum per member per calendar year.	60% after out-of-network deductible Limited to a 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.	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	Not covered	Not covered

* 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.

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 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 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 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 initial quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at **bcbsm.com/pharmacy**.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copays and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The 25% member liability for covered drugs obtained from an out-of-network pharmacy will **not** contribute to your annual out-of-pocket maximum.

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy(not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic drugs	1 to 30-day period	You pay $15 copay	You pay $15 copay	You pay $15 copay	You pay $15 copay plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $30 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $35 copay	No coverage	No coverage
	84 to 90-day period	You pay $35 copay	You pay $35 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay $50 copay	You pay $50 copay	You pay $50 copay	You pay $50 copay plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $100 copay	No coverage	No coverage

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
	61 to 83-day period	No coverage	You pay $140 copay	No coverage	No coverage
	84 to 90-day period	You pay $140 copay	You pay $140 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay $70 copay or 50% of the approved amount (whichever is greater), but no more than $100	You pay $70 copay or 50% of the approved amount (whichever is greater), but no more than $100	You pay $70 copay or 50% of the approved amount (whichever is greater), but no more than $100	You pay $70 copay or 50% of the approved amount (whichever is greater), but no more than $100 plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $140 copay or 50% of the approved amount (whichever is greater), but no more than $200	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $200 copay or 50% of the approved amount (whichever is greater), but no more than $290	No coverage	No coverage
	84 to 90-day period	You pay $200 copay or 50% of the approved amount (whichever is greater), but no more than $290	You pay $200 copay or 50% of the approved amount (whichever is greater), but no more than $290	No coverage	No coverage
Tier 4 - Generic and preferred brand-name specialty drugs	1 to 30-day period	You pay 20% of the approved amount, but no more than $200	You pay 20% of the approved amount, but no more than $200	You pay 20% of the approved amount, but no more than $200	You pay 20% of the approved amount, but no more than $200 plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage
Tier 5 - Nonpreferred brand-name specialty drugs	1 to 30-day period	You pay 25% of approved amount, but no more than $300	You pay 25% of approved amount, but no more than $300	You pay 25% of approved amount, but no more than $300	You pay 25% of the approved amount, but no more than $300 plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage

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

Covered services

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy(not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved **generic** and **select brand name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
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 PPACA.	100% of approved amount	No coverage	100% of approved amount	75% of approved amount
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	75% of approved amount
Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug

* 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 Select 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. • **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 Select Drug List. 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. • **Tier 4 (generic and preferred brand-name specialty)** - Tier 4 includes covered specialty drugs listed as generic drugs (Tier 1) or preferred brand-name drugs (Tier 2) from the Custom Select Drug List. These drugs have a proven record for safety and effectiveness, and offer the best value to our members. They have the lowest specialty drug copay. • **Tier 5 (nonpreferred brand-name specialty)** - Tier 5 includes covered specialty drugs listed as nonpreferred brand name (Tier 3). These drugs may not have a proven record for safety or their clinical value may not be as high as the specialty drugs in Tier 4. They have the highest specialty drug copay.
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. 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**.
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 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.
Exclusions	The following drugs are not covered: • Over-the-counter drugs and drugs with comparable OTC counterparts (e.g., antihistamines, cough/cold and acne treatment) unless deemed an Essential Health Benefit or not considered a covered service • State-controlled drugs • Brand-name drugs that have a generic equivalent available • Drugs to treat erectile dysfunction and weight loss • Prenatal vitamins (prescribed and over-the-counter) • Brand-name drugs used to treat heartburn • Compounded drugs, with some exceptions • Cosmetic drugs

Vision Coverage (Pediatric)
Benefits-at-a-glance
Effective for groups on their plan year

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com**.

Note: Vision benefits are only available to members up to age 19. Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

Member's responsibility (copays)

Benefits	In-network	Out-of-network
Eye exam	None	None
Prescription glasses (lenses and/or frames)	None	None
Medically necessary contact lenses	None	None

Eye exam

Benefits	In-network	Out-of-network
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	100% of approved amount	Reimbursement up to $34 (member responsible for any difference)
	One eye exam per calendar year	

Lenses and Frames

Benefits	In-network	Out-of-network
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary	100% of approved amount	Reimbursement up to approved amount based on lens type (member responsible for any difference)
	One pair of lenses, with or without frames, per calendar year	
Note: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.		
Standard frames from a "select" collection	100% of approved amount	Reimbursement up to $38.25 (member responsible for any difference)
	One frame per calendar year	

Contact Lenses

Benefits	In-network	Out-of-network
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	100% of approved amount	Reimbursement up to $210 (member responsible for any difference)
	Covered - annual supply	
Standard (one pair annually) • Monthly (six-month supply) • Bi-weekly (three-month supply) • Dailies (three-month supply)	100% of approved amount	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Covered according to quantities outlined in your certificate, per calendar year	