



PROCTOR FINANCIAL

SIMPLY BLUE HEALTH SAVINGS ACCOUNT GROUP BENEFITS  
CERTIFICATE WITH PRESCRIPTION DRUGS LG

Coverage for: Individual/Family | Plan Type: PPO

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



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bcbsm.com](http://www.bcbsm.com) or call the number on the back of your BCBSM ID card. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call the number on the back of your BCBSM ID card to request a copy.

| Important Questions   | Answers  |  | Why this Matters:   |
|---|--|--|---|
|   | In-Network   | Out-of-Network                         |   |
| What is the overall <u>deductible</u> ?   | \$2,000 Individual/<br>\$4,000 Family  | \$4,000 Individual/<br>\$8,000 Family  | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.   |
| Are there services covered before you meet your <u>deductible</u> ?   | Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .  |  | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at ( <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> ).   |
| Are there other <u>deductibles</u> for specific services?   | No.  |  | You don't have to meet <u>deductibles</u> for specific services.  |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?<br>(May include a <u>coinsurance</u> maximum) | \$3,000 Individual/<br>\$6,000 Family  | \$6,000 Individual/<br>\$12,000 Family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.  |
| What is not included in the <u>out-of-pocket limit</u> ?  | <u>Premiums</u> , <u>balance-billing</u> charges, any <u>pharmacy</u> penalty and health care this <u>plan</u> doesn't cover.                                      |  | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .  |
| Will you pay less if you use a <u>network provider</u> ?  | Yes. See ( <a href="http://www.bcbsm.com">http://www.bcbsm.com</a> ) or call the number on the back of your BCBSM ID card for a list of <u>network providers</u> . |  | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?  | No.  |  | You can see the <u>specialist</u> you choose without a <u>referral</u> .  |



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event   | Services You May Need                               | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|--|---|---|---|--|
|  |   | In-Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)                    |  |
| <b>If you visit a health care provider's office or clinic</b>  | Primary care visit to treat an injury or illness    | 20% <u>coinsurance</u>  | 40% <u>coinsurance</u>  | None   |
|  | <u>Specialist</u> visit                             | 20% <u>coinsurance</u>  | 40% <u>coinsurance</u>  | None   |
|  | <u>Preventive care/ screening/ immunization</u>     | No Charge; <u>deductible</u> does not apply   | Not covered   | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.  |
| <b>If you have a test</b>  | <u>Diagnostic test</u> (x-ray, blood work)          | 20% <u>coinsurance</u>  | 40% <u>coinsurance</u>  | None   |
|  | Imaging (CT/PET scans, MRIs)                        | 20% <u>coinsurance</u>  | 40% <u>coinsurance</u>  | May require <u>preauthorization</u>  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.bcbsm.com/druglists">www.bcbsm.com/druglists</a> | Generic or select prescribed over-the-counter drugs | \$15 <u>copay</u> for retail 30-day supply; \$30 <u>copay</u> for retail or mail order 90-day supply  | In-Network <u>copay</u> plus an additional 20% of the approved amount | <u>Preauthorization</u> , step therapy and quantity limits may apply to select drugs. <u>Preventive</u> drugs covered in full. 90-day supply not covered out of network. Select diabetic supplies and devices may be covered under the prescription drug program.  |
|  | Preferred brand-name drugs                          | \$50 <u>copay</u> for retail 30-day supply; \$100 <u>copay</u> for retail or mail order 90-day supply   | In-Network <u>copay</u> plus an additional 20% of the approved amount | <u>Preauthorization</u> , step therapy and quantity limits may apply to select drugs. <u>Preventive</u> drugs covered in full. 90-day supply not covered out of network. Pharmacy Specialty drugs obtained from other than an Exclusive Specialty Pharmacy <u>Network provider</u> will not be covered. Select diabetic supplies and devices may be covered under the prescription drug program. |
|  | Nonpreferred brand-name drugs                       | \$70 <u>copay</u> or 50% <u>coinsurance</u> of the approved amount (whichever is greater), but no more than \$100 <u>copay</u> for retail 30-day supply; \$140 <u>copay</u> or 50% <u>coinsurance</u> of the approved amount (whichever is greater), but no more than \$200 <u>copay</u> for retail or mail order 90-day supply | In-Network <u>copay</u> plus an additional 20% of the approved amount |  |

| Common Medical Event  | Services You May Need                          | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information  |
|---|--|--|---|---|
|   |  | In-Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)  |   |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>  | None  |
|   | Physician/surgeon fees                         | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>  | None  |
| If you need immediate medical attention   | <u>Emergency room care</u>                     | 20% <u>coinsurance</u>   | 20% <u>coinsurance</u>  | None  |
|   | <u>Emergency medical transportation</u>        | 20% <u>coinsurance</u>   | 20% <u>coinsurance</u>  | Mileage limits apply  |
|   | <u>Urgent care</u>                             | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>  | None  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)             | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>  | <u>Preauthorization</u> is required   |
|   | Physician/surgeon fee                          | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>  | None  |
| If you need behavioral health services (mental health and substance use disorder) | Outpatient services                            | 20% <u>coinsurance</u>   | 20% <u>coinsurance</u> for mental health; 40% <u>coinsurance</u> for substance use disorder | None  |
|   | Inpatient services                             | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>  | <u>Preauthorization</u> is required.  |
| If you are pregnant   | Office visits                                  | Prenatal: No Charge; <u>deductible</u> does not apply<br>Postnatal: 20% <u>coinsurance</u> | Prenatal: 40% <u>coinsurance</u><br>Postnatal: 40% <u>coinsurance</u>                       | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services <u>cost share</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> . |
|   | Childbirth/delivery professional services      | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>  | None  |
|   | Childbirth/delivery facility services          | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>  | None  |

| Common Medical Event  | Services You May Need  | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|---|--|--|--|--|
|   |  | In-Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)   |  |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>  | 20% <u>coinsurance</u>   | 20% <u>coinsurance</u>   | Physician certification required.  |
|   | <u>Rehabilitation services</u>   | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | Physical, Speech and Occupational Therapy is limited to a combined maximum of 30 visits per member, per calendar year.   |
|   | <u>Habilitation services</u>   | 20% <u>coinsurance</u> for Applied Behavioral Analysis; 20% <u>coinsurance</u> for Physical, Speech and Occupational Therapy | 20% <u>coinsurance</u> for Applied Behavioral Analysis; 40% <u>coinsurance</u> for Physical, Speech and Occupational Therapy | Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified behavioral analyst – is covered through age 18, subject to <u>preauthorization</u> . |
|   | <u>Skilled nursing care</u>  | 20% <u>coinsurance</u>   | 20% <u>coinsurance</u>   | <u>Preauthorization</u> is required. Limited to 90 days per member per calendar year   |
|   | <u>Durable medical equipment</u>   | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.   |
|   | <u>Hospice services</u>  | 20% <u>coinsurance</u>   | 20% <u>coinsurance</u>   | Physician certification required. Visit limits apply.  |
|   | <b>If your child needs dental or eye care</b><br>For more information on pediatric vision or dental, contact your plan administrator | Children's eye exam  | Not covered  | Not covered  |
| Children's glasses  |  | Not covered  | Not covered  | None   |
| Children's dental check-up  |  | Not covered  | Not covered  | None   |

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture treatment
- Hearing aids
- Routine eye care (Adult)
- Cosmetic surgery
- Infertility treatment
- Routine foot care
- Dental care (Adult)
- Long term care
- Weight loss programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Coverage provided outside the United States. See <http://provider.bcbs.com>
- Private-duty nursing
- Chiropractic care
- Non-emergency care when traveling outside the U.S.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor’s Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov) or by calling the number on the back of your BCBSM ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or <http://www.michigan.gov/difs> or [difs-HICAP@michigan.gov](mailto:difs-HICAP@michigan.gov)

### **Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### **Does this plan meet Minimum Value Standards? Yes**

If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

### **Language Access Services: See Addendum**

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

**About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible **\$2,000**
- Specialist coinsurance **20%**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

This **EXAMPLE** event includes services like:  
Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

**Total Example Cost** **\$12,700**

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,000        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$1,000        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,060</b> |

**Managing Joe's Type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible **\$2,000**
- Specialist coinsurance **20%**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

This **EXAMPLE** event includes services like:  
Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

**Total Example Cost** **\$5,600**

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,000        |
| <u>Copayments</u>                 | \$500          |
| <u>Coinsurance</u>                | \$200          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,720</b> |

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The plan's overall deductible **\$2,000**
- Specialist coinsurance **20%**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

This **EXAMPLE** event includes services like:  
Emergency room care (*including medical supplies*)  
Diagnostic tests (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

**Total Example Cost** **\$2,800**

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,000        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$200          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,200</b> |

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or coinsurance, or benefits not otherwise covered.







Blue Cross  
Blue Shield  
of Michigan

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

## PROCTOR FINANCIAL

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Simply Blue PPO HSA<sup>SM</sup> LG with Rx

Effective Date: On or after January 2022

### Benefits-at-a-glance

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

**Preauthorization for 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](http://bcbsm.com/importantinfo). Select **Approving covered services**.

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

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

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

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

**Note:** If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

| Benefits  | In-network   | Out-of-network   |
|---|--|--|
| <b>Deductibles</b><br><br><b>Note:</b> Your deductible <b>combines</b> deductible amounts paid under your Simply Blue HSA medical coverage <b>and</b> your Simply Blue prescription drug coverage.<br><br><b>Note:</b> The full family deductible <b>must</b> be met under a two-person or family contract before benefits are paid for any person on the contract. | \$2,000 for a one-person contract or \$4,000 for a family contract (2 or more members) each calendar year <b>(no 4th quarter carry-over)</b> | \$4,000 for a one-person contract or \$8,000 for a family contract (2 or more members) each calendar year <b>(no 4th quarter carry-over)</b> |
| <b>Flat-dollar copays</b>   | See "Prescription Drugs" section   | See "Prescription Drugs" section   |
| <b>Coinsurance amounts (percent copays)</b><br><br><b>Note:</b> Coinsurance amounts apply once the deductible has been met.   | 20% of approved amount for most covered services   | 40% of approved amount for most covered services   |
| <b>Annual out-of-pocket maximums</b> - applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts   | \$3,000 for a one-person contract \$6,000 for a family contract (2 or more members) each calendar year                                       | \$6,000 for a one-person contract \$12,000 for a family contract (2 or more members) each calendar year                                      |
| <b>Lifetime dollar maximum</b>  | None   |  |

Note - the percentages shown in the following sections reflect the **plan paid** amount.

## Preventive care services

| Benefits  | In-network  | Out-of-network                                  |
|---|---|---|
| Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures            | 100% (no deductible or copay/coinsurance), one per member per calendar year<br><br><b>Note:</b> Additional well-women visits may be allowed based on medical necessity. | Not covered                                     |
| Gynecological exam  | 100% (no deductible or copay/coinsurance), one per member per calendar year<br><br><b>Note:</b> Additional well-women visits may be allowed based on medical necessity. | Not covered                                     |
| 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% coinsurance after out-of-network deductible |
| Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician | 100% (no deductible or copay/coinsurance)   | 60% coinsurance after out-of-network deductible |
| Contraceptive injections  | 100% (no deductible or copay/coinsurance)   | 60% coinsurance after out-of-network deductible |

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| Benefits  | In-network  | Out-of-network   |
|---|---|--|
| Well-baby and child care visits   | 100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> <li>• 8 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 6 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> <li>• Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</li> </ul> | Not covered  |
| Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act | 100% (no deductible or copay/coinsurance)   | Not covered  |
| Fecal occult blood screening  | 100% (no deductible or copay/coinsurance), one per member per calendar year   | Not covered  |
| Flexible sigmoidoscopy exam   | 100% (no deductible or copay/coinsurance), one per member per calendar year   | Not covered  |
| Prostate specific antigen (PSA) screening   | 100% (no deductible or copay/coinsurance), one per member per calendar year   | Not covered  |
| Routine mammogram and related reading   | 100% (no deductible or copay/coinsurance)<br><br><b>Note:</b> Subsequent medically necessary mammograms performed during the <b>same</b> calendar year are subject to your deductible and coinsurance, if applicable.   | 60% coinsurance after out-of-network deductible<br><br><b>Note:</b> 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<br><br><b>Note:</b> Medically necessary colonoscopies performed during the <b>same</b> calendar year are subject to your deductible and coinsurance, if applicable.   | 60% coinsurance after out-of-network deductible  |
| One routine colonoscopy per member per calendar year  |   |  |

| Physician office services   |                                 |   |
|---|---------------------------------|---|
| Benefits  | In-network                      | Out-of-network                                  |
| Office visits - must be medically necessary                               | 80% after in-network deductible | 60% coinsurance after out-of-network deductible |
| Online visits - must be medically necessary                               | 80% after in-network deductible | 60% coinsurance after out-of-network deductible |
| <b>Note:</b> Online visits by a non-BCBSM selected vendor are not covered |                                 |   |
| Outpatient and home medical care visits - must be medically necessary     | 80% after in-network deductible | 60% coinsurance after out-of-network deductible |
| Office consultations - must be medically necessary                        | 80% after in-network deductible | 60% coinsurance after out-of-network deductible |

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| Benefits   | In-network                      | Out-of-network                                  |
|--|---------------------------------|---|
| Urgent care visits - must be medically necessary | 80% after in-network deductible | 60% coinsurance after out-of-network deductible |

## Emergency medical care

| Benefits   | In-network                      | Out-of-network                              |
|--|---------------------------------|---|
| Hospital emergency room                          | 80% after in-network deductible | 80% coinsurance after in-network deductible |
| Ambulance services - must be medically necessary | 80% after in-network deductible | 80% coinsurance after in-network deductible |

## Diagnostic services

| Benefits                          | In-network                      | Out-of-network                                  |
|-----------------------------------|---------------------------------|---|
| Laboratory and pathology services | 80% after in-network deductible | 60% coinsurance after out-of-network deductible |
| Diagnostic tests and x-rays       | 80% after in-network deductible | 60% coinsurance after out-of-network deductible |
| Therapeutic radiology             | 80% after in-network deductible | 60% coinsurance after out-of-network deductible |

## Maternity services provided by a physician or certified nurse midwife

| Benefits                  | In-network                                | Out-of-network                                  |
|---------------------------|---|---|
| Prenatal care visits      | 100% (no deductible or copay/coinsurance) | 60% coinsurance after out-of-network deductible |
| Postnatal care            | 80% after in-network deductible           | 60% coinsurance after out-of-network deductible |
| Delivery and nursery care | 80% after in-network deductible           | 60% coinsurance after out-of-network deductible |

## Hospital care

| Benefits   | In-network                      | Out-of-network                                  |
|--|---------------------------------|---|
| Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies | 80% after in-network deductible | 60% coinsurance after out-of-network deductible |

Unlimited days

**Note:** Nonemergency services must be rendered in a **participating** hospital.

|                         |                                 |   |
|-------------------------|---------------------------------|---|
| Inpatient consultations | 80% after in-network deductible | 60% coinsurance after out-of-network deductible |
| Chemotherapy            | 80% after in-network deductible | 60% coinsurance after out-of-network deductible |

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## Alternatives to hospital care

| Benefits  | In-network  | Out-of-network                              |
|---|---|---|
| Skilled nursing care - must be in a <b>participating</b> skilled nursing facility   | 80% after in-network deductible   | 80% coinsurance after in-network deductible |
|   | Limited to a maximum of 90 days per member per calendar year  |   |
| Hospice care  | 80% after in-network deductible   | 80% coinsurance after in-network deductible |
|   | Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a <b>participating</b> hospice program <b>only</b> ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management) |   |
| Home health care:<br><ul style="list-style-type: none"> <li>• must be medically necessary</li> <li>• must be provided by a <b>participating</b> home health care agency</li> </ul>  | 80% after in-network deductible   | 80% coinsurance after in-network deductible |
| Infusion therapy:<br><ul style="list-style-type: none"> <li>• must be medically necessary</li> <li>• must be given by a <b>participating</b> Home Infusion Therapy (HIT) provider or in a <b>participating</b> freestanding Ambulatory Infusion Center (AIC)</li> <li>• may use drugs that require preauthorization - consult with your doctor</li> </ul> | 80% after in-network deductible   | 80% coinsurance after in-network deductible |

## Surgical services

| Benefits   | In-network                      | Out-of-network                                  |
|--|---------------------------------|---|
| Surgery - includes related surgical services and medically necessary facility services by a <b>participating</b> ambulatory surgery facility | 80% after in-network deductible | 60% coinsurance after out-of-network deductible |
| Presurgical consultations  | 80% after in-network deductible | 60% coinsurance after out-of-network deductible |
| Voluntary sterilization for males  | 80% after in-network deductible | 60% coinsurance after out-of-network deductible |
| <b>Note:</b> For voluntary sterilizations for females, see " <b>Preventive care services.</b> "  |                                 |   |
| Elective abortions   | Not covered                     | Not covered                                     |

## Human organ transplants

| Benefits  | In-network                      | Out-of-network   |
|---|---------------------------------|--|
| Specified human organ transplants - must be in a <b>designated</b> facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) | 80% after in-network deductible | 80% coinsurance after in-network deductible - in designated facilities <b>only</b> |
| Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)   | 80% after in-network deductible | 60% coinsurance after out-of-network deductible                                    |
| Specified oncology clinical trials  | 80% after in-network deductible | 60% coinsurance after out-of-network deductible                                    |
| <b>Note:</b> BCBSM covers clinical trials in compliance with PPACA.   |                                 |  |
| Kidney, cornea and skin transplants   | 80% after in-network deductible | 60% coinsurance after out-of-network deductible                                    |

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

| Benefits  | In-network                      | Out-of-network  |
|---|---------------------------------|---|
| <b>Inpatient</b> mental health care and <b>inpatient</b> substance use disorder treatment   | 80% after in-network deductible | 60% coinsurance after out-of-network deductible   |
| Unlimited days  |                                 |   |
| Residential psychiatric treatment facility:<br><ul style="list-style-type: none"> <li>covered mental health services must be performed in a residential psychiatric treatment facility</li> <li>treatment must be preauthorized</li> <li>subject to medical criteria</li> </ul> | 80% after in-network deductible | 60% coinsurance after out-of-network deductible   |
| Outpatient mental health care:<br><ul style="list-style-type: none"> <li>Facility and clinic</li> </ul>   | 80% after in-network deductible | 80% coinsurance after in-network deductible in participating facilities <b>only</b>                             |
| <ul style="list-style-type: none"> <li>Online visits</li> </ul> <p><b>Note:</b> Online visits by a non-BCBSM selected vendor are not covered</p>  | 80% after in-network deductible | 60% coinsurance after out-of-network deductible   |
| <ul style="list-style-type: none"> <li>Physician's office</li> </ul>  | 80% after in-network deductible | 60% coinsurance after out-of-network deductible   |
| Outpatient substance use disorder treatment - in approved facilities <b>only</b>  | 80% after in-network deductible | 60% coinsurance after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network) |

## Autism spectrum disorders, diagnoses and treatment

| Benefits   | In-network   | Out-of-network                                  |
|--|--|---|
| Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization                                     | 80% after in-network deductible  | 80% coinsurance after in-network deductible     |
| <b>Note:</b> Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment. |  |   |
| Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder   | 80% after in-network deductible  | 60% coinsurance after out-of-network deductible |
|  | Physical, speech and occupational therapy <b>with an autism diagnosis</b> is unlimited |   |
| Other covered services, including mental health services, for autism spectrum disorder   | 80% after in-network deductible  | 60% coinsurance after out-of-network deductible |

## Other covered services

| Benefits   | In-network                      | Out-of-network                                  |
|--|---------------------------------|---|
| Outpatient Diabetes Management Program (ODMP)  | 80% after in-network deductible | 60% coinsurance after out-of-network deductible |
| <b>Note:</b> Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. |                                 |   |
| <b>Note:</b> When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.  |                                 |   |

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| Benefits   | In-network  | Out-of-network   |
|--|---|--|
| Allergy testing and therapy  | 80% after in-network deductible   | 60% coinsurance after out-of-network deductible  |
| Chiropractic spinal manipulation and osteopathic manipulative therapy  | 80% after in-network deductible<br><br>Limited to a <b>combined</b> 12-visit maximum per member per calendar year | 60% coinsurance after out-of-network deductible  |
| Outpatient physical, speech and occupational therapy - provided for rehabilitation   | 80% after in-network deductible<br><br>Limited to a <b>combined</b> 30-visit maximum per member per calendar year | 60% coinsurance after out-of-network deductible<br><br><b>Note:</b> Services at nonparticipating outpatient physical therapy facilities are not covered. |
| Durable medical equipment<br><br><b>Note:</b> Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers.<br><br><b>Note:</b> 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   | 60% coinsurance after out-of-network deductible  |
| Prosthetic and orthotic appliances<br><br><b>Note:</b> Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers.   | 80% after in-network deductible   | 60% coinsurance after out-of-network deductible  |
| Private duty nursing care  | 80% after in-network deductible   | 80% coinsurance after in-network deductible  |

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# PROCTOR FINANCIAL

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## Simply Blue HSA with Prescription Drugs

### Effective Date: On or after January 2022

### Benefits-at-a-glance

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

**Specialty Pharmaceutical Drugs** - The 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. You may obtain specialty drugs through a Walgreens retail pharmacy as well as long as the drug is available at that location. You may want to call ahead to confirm availability at the location. **If you go to a non-AllianceRx Walgreens Prime, you may be responsible for 100% of the cost of the specialty drug.** Other mail order prescription medications can continue to be sent to the OptumRx home delivery pharmacy. (OptumRx is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at [bcbsm.com/pharmacy](http://bcbsm.com/pharmacy). If you have any questions, please call AllianceRx Walgreens Prime customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

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

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

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

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

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

| Benefits   |                    | 90-day retail network pharmacy              | * In-network mail order provider            | In-network pharmacy (not part of the 90-day retail network) | Out-of-network pharmacy   |
|--|--------------------|---|---|---|---|
| Tier 1 - Generic or select prescribed over-the-counter drugs | 1 to 30-day period | After deductible is met, you pay \$15 copay | After deductible is met, you pay \$15 copay | After deductible is met, you pay \$15 copay                 | After deductible is met, you pay \$15 copay plus an additional 20% of the BCBSM approved amount |

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| Benefits                               |                     | 90-day retail network pharmacy  | * In-network mail order provider  | In-network pharmacy (not part of the 90-day retail network)  | Out-of-network pharmacy  |
|--|---------------------|---|---|--|--|
| Tier 2 - Preferred brand-name drugs    | 31 to 83-day period | No coverage   | After deductible is met, you pay \$30 copay   | No coverage  | No coverage  |
|  | 84 to 90-day period | After deductible is met, you pay \$30 copay   | After deductible is met, you pay \$30 copay   | No coverage  | No coverage  |
|  | 1 to 30-day period  | After deductible is met, you pay \$50 copay   | After deductible is met, you pay \$50 copay   | After deductible is met, you pay \$50 copay  | After deductible is met, you pay \$50 copay plus an additional 20% of the BCBSM approved amount  |
|  | 31 to 83-day period | No coverage   | After deductible is met, you pay \$100 copay  | No coverage  | No coverage  |
| Tier 3 - Nonpreferred brand-name drugs | 84 to 90-day period | After deductible is met, you pay \$100 copay  | After deductible is met, you pay \$100 copay  | No coverage  | No coverage  |
|  | 1 to 30-day period  | After deductible is met, you pay \$70 or 50% of the approved amount (whichever is greater), but no more than \$100  | After deductible is met, you pay \$70 or 50% of the approved amount (whichever is greater), but no more than \$100  | After deductible is met, you pay \$70 or 50% of the approved amount (whichever is greater), but no more than \$100 | After deductible is met, you pay \$70 copay or 50% of the approved amount (whichever is greater), but no more than \$100 plus an additional 20% of the BCBSM approved amount |
|  | 31 to 83-day period | No coverage   | After deductible is met, you pay \$140 or 50% of the approved amount (whichever is greater), but no more than \$200 | No coverage  | No coverage  |
|  | 84 to 90-day period | After deductible is met, you pay \$140 or 50% of the approved amount (whichever is greater), but no more than \$200 | After deductible is met, you pay \$140 or 50% of the approved amount (whichever is greater), but no more than \$200 | No coverage  | No coverage  |

**Note:** Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs. \* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

| Covered services  |   |   |   |   |
|---|---|---|---|---|
| Benefits  | 90-day retail network pharmacy  | * In-network mail order provider  | In-network pharmacy (not part of the 90-day retail network)                           | Out-of-network pharmacy   |
| FDA-approved drugs  | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty |
| Prescribed over-the-counter drugs - when covered by BCBSM | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty |

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| Benefits  | 90-day retail network pharmacy  | * In-network mail order provider  | In-network pharmacy (not part of the 90-day retail network)   | Out-of-network pharmacy   |
|---|---|---|---|---|
| State-controlled drugs  | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance   | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance   | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance   | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty   |
| FDA-approved <b>generic</b> and <b>select brand-name</b> prescription preventive drugs, supplements and vitamins as required by PPACA   | 100% of approved amount   | 100% of approved amount   | 100% of approved amount   | 80% of approved amount  |
| Other FDA-approved <b>brand-name</b> prescription preventive drugs, supplements and vitamins as required by PPACA   | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance   | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance   | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance   | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty   |
| Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act                     | 100% of approved amount   | No coverage   | 100% of approved amount   | 80% of approved amount  |
| FDA-approved <b>generic</b> and <b>select brand-name</b> prescription contraceptive medication (non-self-administered drugs are not covered)  | 100% of approved amount   | 100% of approved amount   | 100% of approved amount   | 80% of approved amount  |
| Other FDA-approved <b>brand-name</b> prescription contraceptive medication (non-self-administered drugs are not covered)  | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance   | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance   | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance   | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance <b>plus</b> an additional 20% prescription drug out-of-network penalty  |
| Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs<br><br><b>Note:</b> Needles and syringes have no copay/coinsurance.  | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty for insulin or other covered injectable legend drug |
| Select diabetic supplies and devices (test strips, lancets and glucometers)<br><br>For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at <a href="http://BCBSM.com/pharmacy">BCBSM.com/pharmacy</a> . | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance   | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance   | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance   | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty   |

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

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## Features of your prescription drug plan

|  |   |
|--|---|
| Custom Drug List                       | <p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> <li>• <b>Tier 1 (generic)</b> - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment.</li> <li>• <b>Tier 2 (preferred brand)</b> - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance.</li> <li>• <b>Tier 3 (nonpreferred brand)</b> - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.</li> </ul> |
| Prior authorization/step therapy       | <p>A process that requires a physician to obtain approval from BCBSM <b>before</b> select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. <b>Step Therapy</b>, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at <a href="http://bcbsm.com/pharmacy">bcbsm.com/pharmacy</a>.</p>   |
| Mandatory maximum allowable cost drugs | <p>If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you <b>MUST</b> pay the <b>difference</b> in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug <b>plus</b> your applicable copay regardless of whether you or your physician requests the brand name drug. <b>Exception:</b> If your physician requests and receives authorization for a nonformulary 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. <b>Note:</b> This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.</p>   |
| Quantity limits                        | <p>To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.</p>  |

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