



Simply BlueSM PPO – Plan 2500 with Prescription Drugs One-Subscriber Group 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, copay and/or coinsurance. For a complete description of benefits, please see the applicable BCBSM certificates and riders if your group is underwritten or your summary plan description 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.

In-network

Out-of-network *

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

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

Deductibles	\$2,500 for one member \$5,000 for the family (when two or more members are covered under your contract) each calendar year	\$5,000 for one member \$10,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network deductible amounts also apply toward the in-network deductible.
Fixed dollar copays	<ul style="list-style-type: none"> \$40 copay for office visits \$40 copay for urgent care visits \$250 copay for emergency room visits 	\$250 copay for emergency room visits
Coinsurance amounts Note: Coinsurance amounts apply once the deductible has been met.	<ul style="list-style-type: none"> 50% of approved amount for mental health care, substance abuse treatment and private duty nursing 20% of approved amount for most other covered services 	<ul style="list-style-type: none"> 50% of approved amount for mental health care, substance abuse treatment and private duty nursing 40% of approved amount for most other covered services
Annual coinsurance maximums – excludes fixed dollar copays and mental health care, substance abuse treatment and private duty nursing coinsurance amounts	\$2,500 for one member \$5,000 for two or more members each calendar year	\$5,000 for one member \$10,000 for two or more members each calendar year Note: Out-of-network coinsurance amounts also apply toward the in-network maximum.
Lifetime dollar maximum	None	

Preventive care services

Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

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



In-network

Out-of-network *

Preventive care services, *continued*

Well-baby and child care visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit 	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
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. <hr/> One per member per calendar year	60% after out-of-network deductible Note: Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
Colonoscopy – routine or medically necessary	100% for routine colonoscopy (no deductible or copay/coinsurance) Note: Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and coinsurance. <hr/> One routine colonoscopy per member per calendar year	60% after out-of-network deductible

Physician office services

Office visits – must be medically necessary	\$40 copay per office visit Note: Simply Blue applies deductibles and coinsurance to office visit 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
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	\$40 copay per office visit	60% after out-of-network deductible

Urgent care visits

Urgent care visits	\$40 copay per office visit	60% after out-of-network deductible
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In-network

Out-of-network *

Emergency medical care

Hospital emergency room	\$250 copay per visit (copay waived if admitted)	\$250 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

Prenatal and postnatal care	80% after in-network deductible	60% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	

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	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	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care – must be provided through a participating hospice program	100% (no deductible or copay/coinsurance)	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	
Home health care – must be medically necessary and provided by a participating hospital	80% after in-network deductible	80% after in-network deductible
Home infusion therapy – must be medically necessary and given by participating home infusion therapy providers	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	80% after in-network deductible	60% after out-of-network deductible

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In-network

Out-of-network *

Human organ transplants

Specified human organ transplants – in designated facilities only, when 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 – when 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

Mental health care and substance abuse treatment

Inpatient mental health care and inpatient substance abuse treatment	50% after in-network deductible	50% after out-of-network deductible
	Limited to a combined maximum of 60 days per member per calendar year with a lifetime maximum of 120 days	
Outpatient mental health care • Facility and clinic • Physician's office	50% after in-network deductible	50% after in-network deductible
	50% after in-network deductible	50% after out-of-network deductible
	Limited to a maximum of 50 visits per member per calendar year with a lifetime maximum of 120 visits	
Outpatient substance abuse treatment – in approved facilities only	50% after in-network deductible	50% after in-network deductible
	Up to the state-dollar amount that is adjusted annually	

Other covered services

Outpatient Diabetes Management Program (ODMP)	80% after in-network deductible	60% after out-of-network deductible
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$40 copay per office visit	60% after out-of-network deductible
	Limited to a combined maximum of 12 visits per member per calendar year	
Outpatient physical, speech and occupational therapy – provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a combined maximum of 30 visits per member per calendar year	
Durable medical equipment	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	50% after in-network deductible	50% after in-network deductible

Optional rider

Rider XVA , excludes voluntary abortions	Excludes benefits for voluntary abortions.
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Blue Preferred[®] Rx Prescription Drug Coverage with \$20 / \$60 50% / \$80 minimum / \$100 maximum Formulary Brand Name Triple-Tier Copay Open Formulary Benefits-at-a-Glance

Specialty Drugs – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel[®] and Humira[®]) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many 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 Medco. (Medco 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. Log in under "I am a Member." If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

		90-day retail network pharmacy	** Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
Member's responsibility (copays)					
Tier 1 – Generic or prescribed over-the-counter drugs	1 to 30-day period	\$20 copay	\$20 copay	\$20 copay	\$20 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$40 copay	No coverage	No coverage
	84 to 90-day period	\$40 copay	\$40 copay	No coverage	No coverage
Tier 2 – Formulary brand-name drugs	1 to 30-day period	\$60 copay	\$60 copay	\$60 copay	\$60 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$120 copay	No coverage	No coverage
	84 to 90-day period	\$120 copay	\$120 copay	No coverage	No coverage
Tier 3 – Nonformulary brand-name drugs	1 to 30-day period	\$80 or 50% of the approved amount (whichever is greater), but no more than \$100	\$80 or 50% of the approved amount (whichever is greater), but no more than \$100	\$80 or 50% of the approved amount (whichever is greater), but no more than \$100	\$80 or 50% of the approved amount (whichever is greater), but no more than \$100 plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$160 or 50% of the approved amount (whichever is greater), but no more than \$200	No coverage	No coverage
	84 to 90-day period	\$160 or 50% of the approved amount (whichever is greater), but no more than \$200	\$160 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.



90-day retail network pharmacy

**** Network mail order provider**

Network pharmacy (not part of the 90-day retail network)

Non-network pharmacy

Covered services

	90-day retail network pharmacy	** Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
State-controlled drugs	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no copay.	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	75% of approved amount less plan copay for the insulin or other covered injectable legend drug

**** Note:** BCBSM will not pay for drugs obtained from non-network mail order providers, including Internet providers.

Features of your prescription drug plan

Mandatory preauthorization	A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. Step Therapy , an initial step in the “Prior Authorization” process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at bcbsm.com . Log in under <i>I am a Member</i> and click on <i>Prescription Drugs</i> .
Mandatory maximum allowable cost (MAC) drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a generic equivalent drug, you pay only the copay. If you obtain a formulary brand name drug when a generic equivalent drug is available, you MUST pay the difference in cost between the formulary brand name drug dispensed and the maximum allowable cost for the generic drug plus your copay regardless of whether you or your doctor requests the formulary brand name drug. If you obtain a nonformulary brand-name drug when a generic equivalent is available, the nonformulary brand-name drug is not a covered benefit. Exception: 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.
Physician-administered injectable drugs	Injectable drugs administered by a health care professional (not self-administered) are not covered under the pharmacy benefit, but may be covered under your medical benefit.
Drug interchange and generic copay waiver	Certain drugs may not be covered for future prescriptions if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at bcbsm.com . If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at bcbsm.com .