



Simply BlueSM PPO HSA – Plan 1250/0% Medical Coverage with Prescription Drug Coverage 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.

| | In-network | Out-of-network * |
|---|--|---|
| Deductibles Note: Your deductible combines the deductible amounts paid under your Simply Blue HSA medical coverage and your Simply Blue prescription drug coverage. Note: The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract. | \$1,250 for a one-person contract or \$2,500 for a family contract (2 or more members) each calendar year (no 4 th quarter carry-over) | \$2,500 for a one-person contract or \$5,000 for a family contract (2 or more members) each calendar year (no 4 th quarter carry-over) |
| | Deductibles are based on amounts defined annually by the federal government for Simply Blue HSA-related health plans. Please call your customer service center for an annual update. | |
| Fixed dollar copays | None | None |
| Coinsurance amounts Note: Coinsurance amounts apply once the deductible has been met. | None | 20% of approved amount |
| Annual coinsurance maximums | Not applicable | \$1,000 for a one-person contract or \$2,000 for a family contract (2 or more members) each calendar year |
| Lifetime dollar maximum | None | |

Preventive care services

| | 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 | 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 |
| 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 |

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*

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| 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. | 80% 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. |
| | One per member per calendar year | |
| Routine screening colonoscopy | 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 percent copay. | 80% after out-of-network deductible |
| | One routine colonoscopy per member per calendar year | |

Physician office services

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|---|----------------------------------|-------------------------------------|
| Office visits | 100% after in-network deductible | 80% after out-of-network deductible |
| Outpatient and home medical care visits | 100% after in-network deductible | 80% after out-of-network deductible |
| Office consultations | 100% after in-network deductible | 80% after out-of-network deductible |
| Urgent care visits | 100% after in-network deductible | 80% after out-of-network deductible |

Emergency medical care

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| Hospital emergency room | 100% after in-network deductible | 100% after in-network deductible |
| Ambulance services – must be medically necessary | 100% after in-network deductible | 100% after in-network deductible |

Diagnostic services

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|-----------------------------------|----------------------------------|-------------------------------------|
| Laboratory and pathology services | 100% after in-network deductible | 80% after out-of-network deductible |
| Diagnostic tests and x-rays | 100% after in-network deductible | 80% after out-of-network deductible |
| Therapeutic radiology | 100% after in-network deductible | 80% after out-of-network deductible |

Maternity services provided by a physician

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| Prenatal and postnatal care | 100% after in-network deductible | 80% after out-of-network deductible |
| | Includes covered services provided by a certified nurse midwife | |
| Delivery and nursery care | 100% after in-network deductible | 80% after out-of-network deductible |
| | Includes covered services provided by a certified nurse midwife | |

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In-network

Out-of-network *

Hospital care

| | | |
|---|----------------------------------|-------------------------------------|
| Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital. | 100% after in-network deductible | 80% after out-of-network deductible |
| Unlimited days | | |
| Inpatient consultations | 100% after in-network deductible | 80% after out-of-network deductible |
| Chemotherapy | 100% after in-network deductible | 80% 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. | 100% after in-network deductible | 80% after out-of-network deductible |
| Unlimited days | | |
| Inpatient consultations | 100% after in-network deductible | 80% after out-of-network deductible |
| Chemotherapy | 100% after in-network deductible | 80% after out-of-network deductible |

Alternatives to hospital care

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| Skilled nursing care – must be in a participating skilled nursing facility | 100% after in-network deductible | 100% after in-network deductible |
| Limited to a maximum of 90 days per member per calendar year | | |
| Hospice care – must be provided through a participating hospice program | 100% after in-network deductible | 100% after in-network deductible |
| Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only ; limited to dollar maximum that is reviewed and adjusted periodically | | |
| Home health care – must be medically necessary and provided by a participating hospital | 100% after in-network deductible | 100% after in-network deductible |
| Home infusion therapy – must be medically necessary and given by participating home infusion therapy providers | 100% after in-network deductible | 100% after in-network deductible |

Surgical services

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| Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility | 100% after in-network deductible | 80% after out-of-network deductible |
| Presurgical consultations | 100% after in-network deductible | 80% after out-of-network deductible |
| Voluntary sterilization | 100% after in-network deductible | 80% after out-of-network deductible |
| 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% after in-network deductible | 100% after in-network deductible – in designated facilities only |
| Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) | 100% after in-network deductible | 80% after out-of-network deductible |
| Specified oncology clinical trials | 100% after in-network deductible | 80% after out-of-network deductible |
| Kidney, cornea and skin transplants | 100% after in-network deductible | 80% after out-of-network deductible |

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In-network

Out-of-network *

Mental health care and substance abuse treatment

Note: If your employer has **51 or more** employees (including seasonal and part-time) and is subject to the MHP law, covered mental health and substance abuse services are subject to the following coinsurance amounts. Mental health and substance abuse coinsurance amounts are included in the annual coinsurance maximums for all covered services. See “Annual coinsurance maximums” section for this amount. If you receive your health care benefits through a collectively bargained agreement, please contact your employer and/or union to determine when or if this benefit level applies to your plan.

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| Inpatient mental health care and inpatient substance abuse treatment | 100% after in-network deductible | 80% after out-of-network deductible |
| | Unlimited days | |
| Outpatient mental health care | 100% after in-network deductible | 80% after out-of-network deductible, in participating facilities only |
| Outpatient substance abuse treatment – in approved facilities only | 100% after in-network deductible | 100% after in-network deductible |

Note: If your employer has **50 or fewer** employees (all employees, not just eligible employees), covered mental health and substance abuse services are subject to the following coinsurance amounts. Mental health and substance abuse coinsurance amounts are **not** limited to a coinsurance maximum.

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| Inpatient mental health care and inpatient substance abuse treatment | 100% after in-network deductible | 80% 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 | 100% after in-network deductible | 80% after out-of-network deductible, in participating facilities only |
| | Limited to a maximum of 120 visits per member per calendar year | |
| Outpatient substance abuse treatment – in approved facilities only | 100% after in-network deductible | 100% after in-network deductible |
| | Up to the state-dollar amount that is adjusted annually | |

Other covered services

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| Outpatient Diabetes Management Program (ODMP) | 100% after in-network deductible | 80% after out-of-network deductible |
| Allergy testing and therapy | 100% after in-network deductible | 80% after out-of-network deductible |
| Chiropractic spinal manipulation and osteopathic manipulative therapy | 100% after in-network deductible | 80% 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 | 100% after in-network deductible | 80% 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 | 100% after in-network deductible | 100% after in-network deductible |
| Prosthetic and orthotic appliances | 100% after in-network deductible | 100% after in-network deductible |
| Private duty nursing | 100% after in-network deductible | 100% after in-network deductible |

* 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.



Prescription Drug Coverage 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 coinsurance/copay will be reduced by one-half for this initial fill (15 days) once applicable deductibles have been met.

Maximum Allowable Drugs – If your prescription is filled by any type of network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber did not write “Dispensed as Written” (DAW) on the prescription, you must pay the difference in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic **plus** the applicable coinsurance/copay.

Note: This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

Network pharmacy

Non-network pharmacy

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

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

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| Deductibles (each calendar year) Note: The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract. | Same as Simply Blue HSA medical coverage (no 4th quarter carry-over) Note: Includes deductible amounts paid under your Simply Blue HSA medical coverage. | Same as Simply Blue HSA medical coverage (no 4th quarter carry-over) Note: Includes deductible amounts paid under your Simply Blue HSA medical coverage. |
| Fixed dollar copays | None | None |
| Coinsurance Note: Coinsurance amounts apply once the deductible has been met. | None | 20% of approved amount Note: The 20% will not be applied toward your annual deductible, out-of-pocket maximum or lifetime maximum. |
| Annual coinsurance/copay maximums | Not applicable | \$1,000 for a one-person contract or \$2,000 for a family contract (2 or more members) each calendar year Note: Includes coinsurance/copay amounts paid under your Simply Blue HSA medical coverage. |
| Lifetime dollar maximum | None | |

A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a Medco pharmacy outside Michigan. Medco is an independent company providing pharmacy benefit services for Blues members. A **non-network** pharmacy is a pharmacy NOT in the Preferred Rx or Medco networks.



Network pharmacy

Non-network pharmacy

Covered services

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| FDA-approved drugs | Subject to Simply Blue HSA medical deductible and coinsurance | Subject to Simply Blue HSA medical deductible and coinsurance plus an additional 20% prescription drug out-of-network coinsurance |
| State-controlled drugs | Subject to Simply Blue HSA medical deductible and coinsurance | Subject to Simply Blue HSA medical deductible and coinsurance plus an additional 20% prescription drug out-of-network coinsurance |
| Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no copay. | Subject to Simply Blue HSA medical deductible and coinsurance | Subject to Simply Blue HSA medical deductible and coinsurance plus an additional 20% prescription drug out-of-network coinsurance |
| Mail order (home delivery) prescription drugs – up to a 90-day supply of medication by mail from Medco (BCBSM network mail order provider) | Subject to Simply Blue HSA medical deductible and coinsurance | No coverage |

Optional riders

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| Rider SB-HSA-CSR , cost sharing requirements | Changes the member's cost sharing requirements for out-of-state services. Covered services obtained outside the state of Michigan are paid at the approved amount for covered services provided by a Michigan non-network provider; exceptions apply. Special guidelines apply to "Out-of-area services." Note: This rider is available only to groups in the Upper Peninsula. |
| Rider XVA , excludes voluntary abortions | Excludes benefits for voluntary abortions. |
| Blue Advantage Rx certificate | Allows BCBSM members to purchase eligible prescription drugs and supplies from network pharmacies at the Blues' negotiated rate rather than full price. Note: Optional prescription drug riders are not available with this plan. |
| Preferred Rx Program certificate | Provides benefits for FDA-approved and state-controlled drugs, injectable insulin, and needles and syringes. Benefits are payable at 100% of the BCBSM-approved amount, less the member's copay when obtained from a Preferred Rx network pharmacy (in Michigan) or a Medco network pharmacy (outside Michigan). When a member chooses to go to a non-network pharmacy (a pharmacy not in the Preferred Rx or Medco networks), benefits are payable at 75% of the BCBSM-approved amount, less the member's copay. Coverage also requires dispensing of generic equivalent and co-branded formulary drugs. Benefits for contraceptive drugs and drugs dispensed for cosmetic purposes are not included. Note: When selecting prescription coverage, you must select one of the following triple-tier copay riders. |
| • Riders PD-TTC \$5/\$25/\$50 and PD-RX-CM (open formulary) | Imposes a triple-tier copay for prescription drugs. Included are provisions for up to a 90-day supply of prescription drugs, a revised MAC program and the mail-order program. |
| • Riders PD-TTC \$15/\$30/\$60 and PD-RX-CM (open formulary) | Imposes a triple-tier copay for prescription drugs. Included are provisions for up to a 90-day supply of prescription drugs, a revised MAC program and the mail-order program. |
| • Rider PD-TTC \$7/\$35/\$70-RXCM (open formulary) | Imposes a triple-tier copay for prescription drugs. Included are provisions for up to a 90-day supply of prescription drugs, a revised MAC program and the mail-order program. |
| • Rider PD-TTC \$10/\$40/\$80-RXCM (open formulary) | Imposes a triple-tier copay for prescription drugs. Included are provisions for up to a 90-day supply of prescription drugs, a revised MAC program and the mail-order program. |
| • Rider PD-TTC \$15/\$50/50%/\$70/ \$100-RXCM (open formulary) | Imposes a triple-tier copay for prescription drugs. Adds: provisions for up to a 90-day supply of prescription drugs when obtained from the 90-Day Retail Network, a Mandatory Maximum Allowable Cost (MAC) program, a Mandatory Preauthorization program, and the mail-order drug program |
| • Rider PD-TTC \$20/\$60/50%/\$80/\$100-RXCM (open formulary) | Imposes a triple-tier copay for prescription drugs. Adds: provisions for up to a 90-day supply of prescription drugs when obtained from the 90-Day Retail Network, a Mandatory Maximum Allowable Cost (MAC) program, a Mandatory Preauthorization program, and the mail-order drug program. |



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| <p>Rider CI, contraceptive injections Rider PCD, prescription contraceptive devices Rider PD-CM, prescription contraceptive medications</p> | <p>Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and intrauterine devices, and FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered).</p> <p>Note: These riders are only available as part of a prescription drug package. Riders CI and PCD are part of your medical-surgical coverage, subject to the same deductible and copay, if any, you pay for medical-surgical services. (Rider PCD waives the copay for services provided by a network provider.) Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.</p> |
| <p>Rider PD-XED, excludes elective drugs</p> | <p>Excludes coverage for all elective lifestyle drugs.</p> <p>Note: Elective lifestyle drugs are lifestyle drugs such as those that treat sexual impotency or infertility or help in weight loss or help to stop smoking. They are not designed to treat acute or chronic illnesses or prescribed for medical conditions that have no demonstrable physical harm if not treated.</p> <p>Note: This rider is not available for MHP impacted groups.</p> |
| <p>Rider PD-XED-MHP, excludes elective drugs</p> | <p>Excludes coverage for elective lifestyle drugs.</p> <p>Note: Elective lifestyle drugs are lifestyle drugs such as those that treat sexual impotency or infertility or help in weight loss. They are not designed to treat acute or chronic illnesses or prescribed for medical conditions that have no demonstrable physical harm if not treated. (Smoking cessation drugs are not considered an elective lifestyle drug and are a payable benefit when members are enrolled in this rider.)</p> <p>Note: If your employer has 51 or more employees (including seasonal and part-time) and is subject to the MHP law, this rider must be taken to be MHP compliant.</p> |