Blue Cross Blue Shield of Michigan

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

GlidePath℠

Comparison Benefit Chart – Menu B PPO Medical Plans with Rx B

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

Preauthorization for Select Services – Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo**. Select ***Approving covered services*****.**

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

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

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

Online visit benefits available 07/01/2016

Benefits	Simply Blue PPO℠ Plan 250 LG Medical Coverage		Simply Blue PPO℠ Plan 500 LG Medical Coverage		Simply Blue PPO℠ Plan 1000 LG Medical Coverage		Simply Blue PPO HSA℠ Plan 1250/20% LG Medical Coverage		Simply Blue PPO HSA℠ Plan 2000/0% LG Medical Coverage	
	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network
Member's responsibility (deductibles, copays, coinsurance and dollar maximums) **Note:** If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.							**Note:** Your deductible **combines** deductible amounts paid under your Simply Blue PPO HSA medical coverage **and** your Simply Blue PPO HSA 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.			
Deductibles	$250 for one member, $500 for the family (when two or more members are covered under your contract) each calendar year	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible.	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible.	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year	$2,000 for one member, $4,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible.	$1,300 for a one-person contract or $2,600 for a family contract (2 or more members) each calendar year (**no 4th quarter carry-over**) Deductibles are based on amounts defined annually by the federal government for Simply Blue HSA-related health plans. Deductibles may increase each calendar year. Please call your customer service center for an annual update.	$2,600 for a one-person contract or $5,200 for a family contract (2 or more members) each calendar year (**no 4th quarter carry-over**)	$2,000 for a one-person contract or $4,000 for a family contract (2 or more members) each calendar year (**no 4th quarter carry-over**) 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.	$4,000 for a one-person contract or $8,000 for a family contract (2 or more members) each calendar year (**no 4th quarter carry-over**)

Benefits	Simply Blue PPO[SM] Plan 250 LG Medical Coverage		Simply Blue PPO[SM] Plan 500 LG Medical Coverage		Simply Blue PPO[SM] Plan 1000 LG Medical Coverage		Simply Blue PPO HSA[SM] Plan 1250/20% LG Medical Coverage		Simply Blue PPO HSA[SM] Plan 2000/0% LG Medical Coverage	
	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network
Member's responsibility (deductibles, copays, coinsurance and dollar maximums), *continued*										
Flat-dollar copays	• $20 for office visits and office consultations with a **primary care physician** • $30 for chiropractic and osteopathic manipulative therapy • $40 for office visits and office consultations with a **specialist** • $60 for urgent care visits • $150 for emergency room visits • $20 for online visits	$150 for emergency room visits	• $20 for office visits and office consultations with a **primary care physician** • $30 for chiropractic and osteopathic manipulative therapy • $40 for office visits and office consultations with a **specialist** • $60 for urgent care visits • $150 for emergency room visits • $20 for online visits	$150 for emergency room visits	• $30 for office visits and office consultations with a **primary care physician** • $30 for chiropractic and osteopathic manipulative therapy • $50 for office visits and office consultations with a **specialist** • $60 for urgent care visits • $150 for emergency room visits • $30 for online visits	$150 for emergency room visits	See "Menu B Prescription Drug 3-Tier Plans" section	See "Menu B Prescription Drug 3-Tier Plans" section	See "Menu B Prescription Drug 3-Tier Plans" section	See "Menu B Prescription Drug 3-Tier Plans" section
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing care • 20% of approved amount for most other covered services	• 50% of approved amount for private duty nursing care • 40% of approved amount for most other covered services	• 50% of approved amount for private duty nursing care • 20% of approved amount for most other covered services	• 50% of approved amount for private duty nursing care • 40% of approved amount for most other covered services	• 50% of approved amount for private duty nursing care • 20% of approved amount for most other covered services	• 50% of approved amount for private duty nursing care • 40% of approved amount for most other covered services	20% of approved amount for most covered services	40% of approved amount for most covered services	None	20% of approved amount for most covered services
Annual Coinsurance Maximum – applies to coinsurance amounts for all covered services – including mental health and substance abuse services – but does not apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	$1,500 for one member , $3,000 for the family (when two or more members are covered under your contract) each calendar year	$3,000 for one member, $6,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.	$1,500 for one member , $3,000 for the family (when two or more members are covered under your contract) each calendar year	$3,000 for one member, $6,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.	$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 coinsurance amounts also count toward the in-network coinsurance maximum.	None	None	None	None

Benefits	Simply Blue PPO℠ Plan 250 LG Medical Coverage		Simply Blue PPO℠ Plan 500 LG Medical Coverage		Simply Blue PPO℠ Plan 1000 LG Medical Coverage		Simply Blue PPO HSA℠ Plan 1250/20% LG Medical Coverage		Simply Blue PPO HSA℠ Plan 2000/0% LG Medical Coverage	
	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network
Member's responsibility (deductibles, copays, coinsurance and dollar maximums), ***continued***										
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if applicable	$6,350 for one member, $12,700 for the family (when two or more members are covered under your contract) each calendar year	$12,700 for one member, $25,400 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.	$6,350 for one member, $12,700 for the family (when two or more members are covered under your contract) each calendar year	$12,700 for one member, $25,400 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.	$6,350 for one member, $12,700 for the family (when two or more members are covered under your contract) each calendar year	$12,700 for one member, $25,400 for two or more members each calendar year **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.	$2,250 for a one-person contract or $4,500 for a family contract (2 or more members) each calendar year	$4,500 for a one-person contract or $9,000 for a family contract (2 or more members) each calendar year	$3,000 for a one-person contract or $6,000 for a family contract (2 or more members) each calendar year	$6,000 for a one-person contract or $12,000 for a family contract (2 or more members) each calendar year
Preventive care services										
Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible (no coinsurance)	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible (no coinsurance)	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible (no coinsurance)	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

Benefits	Simply Blue PPO℠ Plan 250 LG Medical Coverage		Simply Blue PPO℠ Plan 500 LG Medical Coverage		Simply Blue PPO℠ Plan 1000 LG Medical Coverage		Simply Blue PPO HSA℠ Plan 1250/20% LG Medical Coverage		Simply Blue PPO HSA℠ Plan 2000/0% LG Medical Coverage	
	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network
Preventive care services, *continued*										
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered	100% (no deductible or copay/coinsurance)	Not covered	100% (no deductible or copay/coinsurance)	Not covered	100% (no deductible or copay/coinsurance)	Not covered	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	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered	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	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered	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	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

Benefits	Simply Blue PPO℠ Plan 250 LG Medical Coverage		Simply Blue PPO℠ Plan 500 LG Medical Coverage		Simply Blue PPO℠ Plan 1000 LG Medical Coverage		Simply Blue PPO HSA℠ Plan 1250/20% LG Medical Coverage		Simply Blue PPO HSA℠ Plan 2000/0% LG Medical Coverage	
	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network
Preventive care services, *continued*										
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the **same** calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the **same** calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the **same** calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the **same** calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.	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:** 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		One per member per calendar year		One per member per calendar year		One per member per calendar year		One per member per calendar year	
Colonoscopy – routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the **same** calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the **same** calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the **same** calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible	100% (no deductible or copay/coinsurance) for routine colonoscopy **Note:** Medically necessary colonoscopies performed during the **same** calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible	100% (no deductible or copay/coinsurance) for routine colonoscopy **Note:** Medically necessary colonoscopies performed during the **same** calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible
	One per member per calendar year		One per member per calendar year		One per member per calendar year		One routine colonoscopy per member per calendar year		One routine colonoscopy per member per calendar year	
Physician office services										
Office visits – must be medically necessary	• $20 copay for each office visit with a **primary care physician** • $40 copay for each office visit with a **specialist** **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible	• $20 copay for each office visit with a **primary care physician** • $40 copay for each office visit with a **specialist** **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible	• $30 copay for each office visit with a **primary care physician** • $50 copay for each office visit with a **specialist** **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible

Benefits	Simply Blue PPO[SM] Plan 250 LG Medical Coverage		Simply Blue PPO[SM] Plan 500 LG Medical Coverage		Simply Blue PPO[SM] Plan 1000 LG Medical Coverage		Simply Blue PPO HSA[SM] Plan 1250/20% LG Medical Coverage		Simply Blue PPO HSA[SM] Plan 2000/0% LG Medical Coverage	
	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network
Physician office services, *continued*										
Outpatient and home medical care visits – must be medically necessary	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible
Office consultations – must be medically necessary	• $20 copay for each office consultation with **primary care physician** • $40 copay for each office consultation with a **specialist** **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible	• $20 copay for each office consultation with **primary care physician** • $40 copay for each office consultation with a **specialist** **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible	• $30 copay for each office consultation with **primary care physician** • $50 copay for each office consultation with a **specialist** **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible

Benefits	Simply Blue PPO[SM] Plan 250 LG Medical Coverage		Simply Blue PPO[SM] Plan 500 LG Medical Coverage		Simply Blue PPO[SM] Plan 1000 LG Medical Coverage		Simply Blue PPO HSA[SM] Plan 1250/20% LG Medical Coverage		Simply Blue PPO HSA[SM] Plan 2000/0% LG Medical Coverage	
	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network
Urgent care visits										
Urgent care visits	$60 copay per office visit **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible	$60 copay per office visit **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible	$60 copay per office visit **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible	80% after in-network deductible **Note**: Must be medically necessary	60% after out-of-network deductible **Note**: Must be medically necessary	100% after in-network deductible (no coinsurance) **Note**: Must be medically necessary	80% after out-of-network deductible **Note**: Must be medically necessary
Emergency medical care										
Hospital emergency room	$150 copay per visit (copay waived if admitted)	$150 copay per visit (copay waived if admitted)	$150 copay per visit (copay waived if admitted)	$150 copay per visit (copay waived if admitted)	$150 copay per visit (copay waived if admitted)	$150 copay per visit (copay waived if admitted)	80% after in-network deductible	80% after in-network deductible	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)
Ambulance services – must be medically necessary	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)
Diagnostic services										
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible

Benefits	Simply Blue PPO℠ Plan 250 LG Medical Coverage		Simply Blue PPO℠ Plan 500 LG Medical Coverage		Simply Blue PPO℠ Plan 1000 LG Medical Coverage		Simply Blue PPO HSA℠ Plan 1250/20% LG Medical Coverage		Simply Blue PPO HSA℠ Plan 2000/0% LG Medical Coverage	
	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network
Maternity services provided by a physician or certified nurse midwife										
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Postnatal care	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	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.	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible
	Unlimited days		Unlimited days		Unlimited days		Unlimited days		Unlimited days	
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible

Benefits	Simply Blue PPO℠ Plan 250 LG Medical Coverage		Simply Blue PPO℠ Plan 500 LG Medical Coverage		Simply Blue PPO℠ Plan 1000 LG Medical Coverage		Simply Blue PPO HSA℠ Plan 1250/20% LG Medical Coverage		Simply Blue PPO HSA℠ Plan 2000/0% LG Medical Coverage	
	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network
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	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)
	Limited to a maximum of 120 days per member per calendar year		Limited to a maximum of 120 days per member per calendar year		Limited to a maximum of 120 days per member per calendar year		Limited to a maximum of 90 days per member per calendar year		Limited to a maximum of 90 days per member per calendar year	
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	80% after in-network deductible	80% after in-network deductible	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)		Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)		Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)		Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)		Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization – consult with your doctor	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)

Benefits	Simply Blue PPO[SM] Plan 250 LG Medical Coverage		Simply Blue PPO[SM] Plan 500 LG Medical Coverage		Simply Blue PPO[SM] Plan 1000 LG Medical Coverage		Simply Blue PPO HSA[SM] Plan 1250/20% LG Medical Coverage		Simply Blue PPO HSA[SM] Plan 2000/0% LG Medical Coverage	
	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network
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	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see "**Preventive care services.**"	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible
Human organ transplants										
Specified human organ transplants – must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) – in designated facilities **only**	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) – in designated facilities **only**	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) – in designated facilities **only**	80% after in-network deductible	80% after in-network deductible – in designated facilities **only**	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance) – in designated facilities **only**
Bone marrow transplants – must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible

Benefits	Simply Blue PPO[SM] Plan 250 LG Medical Coverage		Simply Blue PPO[SM] Plan 500 LG Medical Coverage		Simply Blue PPO[SM] Plan 1000 LG Medical Coverage		Simply Blue PPO HSA[SM] Plan 1250/20% LG Medical Coverage		Simply Blue PPO HSA[SM] Plan 2000/0% LG Medical Coverage	
	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network
Mental health care and substance abuse treatment										
Inpatient mental health care and **inpatient** substance abuse treatment	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible
	Unlimited days		Unlimited days		Unlimited days		Unlimited days		Unlimited days	
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment **must** be preauthorized subject to medical criteria	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible
Outpatient mental health care:										
• Facility and clinic	80% after in-network deductible	80% after in-network deductible, in participating facilities **only**	80% after in-network deductible	80% after in-network deductible, in participating facilities **only**	80% after in-network deductible	80% after in-network deductible, in participating facilities **only**	80% after in-network deductible	80% after in-network deductible, in participating facilities **only**	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance), in participating facilities **only**
• Physician's office	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities **only**	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Benefits	Simply Blue PPO[SM] Plan 250 LG Medical Coverage		Simply Blue PPO[SM] Plan 500 LG Medical Coverage		Simply Blue PPO[SM] Plan 1000 LG Medical Coverage		Simply Blue PPO HSA[SM] Plan 1250/20% LG Medical Coverage		Simply Blue PPO HSA[SM] Plan 2000/0% LG Medical Coverage	
	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network
Autism spectrum disorders, diagnoses and treatment										
Applied behavioral analysis (ABA) treatment – when rendered by an approved board-certified behavioral analyst – is covered through age 18, subject to preauthorization **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited		Physical, speech and occupational therapy **with an autism diagnosis** is unlimited		Physical, speech and occupational therapy **with an autism diagnosis** is unlimited		Physical, speech and occupational therapy **with an autism diagnosis** is unlimited		Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible

Benefits	Simply Blue PPO[SM] Plan 250 LG Medical Coverage		Simply Blue PPO[SM] Plan 500 LG Medical Coverage		Simply Blue PPO[SM] Plan 1000 LG Medical Coverage		Simply Blue PPO HSA[SM] Plan 1250/20% LG Medical Coverage		Simply Blue PPO HSA[SM] Plan 2000/0% LG Medical Coverage	
	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network
Other covered services										
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 80% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/ coinsurance) for diabetes self-management training	60% after out-of-network deductible	• 80% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/ coinsurance) for diabetes self-management training	60% after out-of-network deductible	• 80% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/ coinsurance) for diabetes self-management training	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$30 copay per office visit **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam.	60% after out-of-network deductible	$30 copay per office visit **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam.	60% after out-of-network deductible	$30 copay per office visit **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam.	60% after out-of-network deductible	80% after in-network deductible	60% after out-of-network deductible	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible
	Limited to a **combined** 12-visit maximum per member per calendar year		Limited to a **combined** 12-visit maximum per member per calendar year		Limited to a **combined** 12-visit maximum per member per calendar year		Limited to a **combined** 12-visit maximum per member per calendar year		Limited to a **combined** 12-visit maximum per member per calendar year	

Benefits	Simply Blue PPO[SM] Plan 250 LG Medical Coverage		Simply Blue PPO[SM] Plan 500 LG Medical Coverage		Simply Blue PPO[SM] Plan 1000 LG Medical Coverage		Simply Blue PPO HSA[SM] Plan 1250/20% LG Medical Coverage		Simply Blue PPO HSA[SM] Plan 2000/0% LG Medical Coverage	
	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network
Other covered services, *continued*										
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.	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.	100% after in-network deductible (no coinsurance)	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 30-visit maximum per member per calendar year		Limited to a **combined** 30-visit maximum per member per calendar year		Limited to a **combined** 30-visit maximum per member per calendar year		Limited to a **combined** 30-visit maximum per member per calendar year		Limited to a **combined** 30-visit maximum per member per calendar year	
Durable medical equipment **Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	80% after in-network deductible	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)
Private duty nursing care	50% after in-network deductible	50% after in-network deductible	50% after in-network deductible	50% after in-network deductible	50% after in-network deductible	50% after in-network deductible	80% after in-network deductible	80% after in-network deductible	100% after in-network deductible (no coinsurance)	100% after in-network deductible (no coinsurance)

Comparison Benefit Chart – Menu B Prescription Drug 3-Tier Plans

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 Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a **90-Day Retail Network provider or** mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the 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 may limit the initial fill of **select** controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. **Subsequent fills** of the **same** medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at **bcbsm.com/pharmacy**

Benefits	Blue Preferred® Rx Prescription Drug Coverage LG				Simply Blue PPO HSA℠ – Prescription Drug Coverage LG			
	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**	**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**
Member's responsibility (copays and coinsurance amounts)								
	Note: Your prescription drug copays, including mail order copays, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum: • any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug • the 25% member liability for covered drugs obtained from an out-of-network pharmacy				**Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual out-of-pocket maximum required under your Simply Blue HSA medical coverage.** Benefits are not payable until after you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are required to pay applicable prescription drug copays which are subject to your annual out-of-pocket maximums. **Note:** The following prescription drug expenses will not apply to your Simply Blue HSA deductible or annual out-of-pocket maximum: • any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug • the 20% member liability for covered drugs obtained from an out-of-network pharmacy			
Tier 1 – Generic or select prescribed over-the-counter drugs	1 to 30-day period	$10 copay	$10 copay	$10 copay	$10 copay ***plus*** an additional 25% of BCBSM approved amount for the drug	After deductible is met, you pay $10 copay	After deductible is met, you pay $10 copay	After deductible is met, you pay $10 copay	After deductible is met, you pay $10 copay ***plus*** an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	$20 copay	No coverage	No coverage	No coverage	After deductible is met, you pay $20 copay	No coverage	No coverage
	84 to 90-day period	$20 copay	$20 copay	No coverage	No coverage	After deductible is met, you pay $20 copay	After deductible is met, you pay $20 copay	No coverage	No coverage
Tier 2 –Preferred brand-name drugs	1 to 30-day period	$40 copay	$40 copay	$40 copay	$40 copay ***plus*** an additional 25% of BCBSM approved amount for the drug	After deductible is met, you pay $40 copay	After deductible is met, you pay $40 copay	After deductible is met, you pay $40 copay	After deductible is met, you pay $40 copay ***plus*** an additional 20% of BCBSM approved amount for the drug

Benefits		Blue Preferred® Rx Prescription Drug Coverage LG				Simply Blue PPO HSA℠ – Prescription Drug Coverage LG			
		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**	**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**
Member's responsibility (copays and coinsurance amounts), *continued*									
Tier 2 –Preferred brand-name drugs	31 to 83-day period	No coverage	$80 copay	No coverage	No coverage	No coverage	After deductible is met, you pay $80 copay	No coverage	No coverage
	84 to 90-day period	$80 copay	$80 copay	No coverage	No coverage	After deductible is met, you pay $80 copay	After deductible is met, you pay $80 copay	No coverage	No coverage
Tier 3 –Nonpreferred brand-name drugs	1 to 30-day period	$80 copay	$80 copay	$80 copay	$80 copay ***plus*** an additional 25% of BCBSM approved amount for the drug	After deductible is met, you pay $80 copay	After deductible is met, you pay $80 copay	After deductible is met, you pay $80 copay	After deductible is met, you pay $80 copay ***plus*** an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	$160 copay	No coverage	No coverage	No coverage	After deductible is met, you pay $160 copay	No coverage	No coverage
	84 to 90-day period	$160 copay	$160 copay	No coverage	No coverage	After deductible is met, you pay $160 copay	After deductible is met, you pay $160 copay	No coverage	No coverage

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

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

Benefits	Blue Preferred® Rx Prescription Drug Coverage LG				Simply Blue PPO HSA℠ – Prescription Drug Coverage LG			
	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**	**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**
Covered services								
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance	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	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance	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
State-controlled drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance	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 **generic** and **select brand name** prescription preventive drugs, supplements, and vitamins (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand name** prescription preventive drugs, supplements, and vitamins (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance	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 **generic** and **select brand name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance	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
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	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 for the insulin or other covered injectable legend drug ***plus*** an additional 20% prescription drug out-of-network penalty

Benefits	Blue Preferred® Rx Prescription Drug Coverage LG	Simply Blue PPO HSA℠ – Prescription Drug Coverage LG

Features of your prescription drug plan

BCBSM Custom Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the Drug List is to provide members with the greatest therapeutic value at the lowest possible cost. ▪ **Tier 1 (generic)** – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. ▪ **Tier 2 (preferred brand)** – 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. ▪ **Tier 3 (nonpreferred brand)** – Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by an in-network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your applicable copay/coinsurance regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a nonpreferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay/coinsurance. **Note:** This MAC difference will not be applied toward your annual in-network deductible, your annual coinsurance maximum or your annual out-of-pocket maximum, if applicable.
Drug interchange and generic copay/coinsurance waiver	BCBSM’s drug interchange and generic copay waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/coinsurance. In select cases BCBSM may waive the initial copay/coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.