



Blue Cross
Blue Shield
of Michigan

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

WAYNE COUNTY COMMUNITY COLLE A11DT9

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Simply Blue PPO HSASM ASC with Rx

Effective Date: On or after January 2023

Benefits-at-a-glance

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

Preauthorization for Specialty 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 diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

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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 an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. 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.

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

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

| Benefits | In-network | Out-of-network |
|---|---|---|
| Deductibles Note: Your deductible combines 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. | \$2,000 for a one-person contract \$4,000 for a family contract (two or more members) each calendar year (no 4th quarter carry-over) | \$4,000 for a one-person contract \$8,000 for a family contract (two or more members) each calendar year (no 4th quarter carry-over) |
| Flat-dollar copays | See "Prescription Drugs" section | See "Prescription Drugs" section |
| Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met. | None | 20% of approved amount for most covered services |
| Annual out-of-pocket maximums -applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts | \$4,000 for a one-person contract \$8,000 for a family contract (two or more members) each calendar year | \$8,000 for a one-person contract \$16,000 for a family contract (two or more members) each calendar year |
| Lifetime dollar maximum | None | |

Preventive care services

| Benefits | In-network | Out-of-network |
|---|---|-------------------------------------|
| Health maintenance exam-includes chest x-ray, EKG, cholesterol screening and other select lab procedures | 100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity. | Not covered |
| Gynecological exam | 100% (no deductible or copay/coinsurance), two per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity. | Not covered |
| Pap smear screening- laboratory and pathology services | 100% (no deductible or copay/coinsurance), one per member per calendar year | Not covered |
| Voluntary sterilizations for females | 100% (no deductible or copay/coinsurance) | 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) | 80% after out-of-network deductible |
| Contraceptive injections | 100% (no deductible or copay/coinsurance) | 80% after out-of-network deductible |

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| Benefits | In-network | Out-of-network |
|---|---|--|
| Well-baby and child care visits | 100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> • 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 |
| 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, if applicable. | 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 | | |
| Routine screening colonoscopy | 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, if applicable. | 80% after out-of-network deductible |
| One routine colonoscopy per member per calendar year | | |

| Physician office services | | |
|---|----------------------------------|-------------------------------------|
| Benefits | In-network | Out-of-network |
| Office visits - must be medically necessary | 100% after in-network deductible | 80% after out-of-network deductible |
| Online visits - by physician must be medically necessary Note: Online visits by a vendor are not covered. | 100% after in-network deductible | 80% after out-of-network deductible |
| Outpatient and home medical care visits - must be medically necessary | 100% after in-network deductible | 80% after out-of-network deductible |
| Office consultations - must be medically necessary | 100% after in-network deductible | 80% after out-of-network deductible |

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| Benefits | In-network | Out-of-network |
|--|----------------------------------|-------------------------------------|
| Urgent care visits - must be medically necessary | 100% after in-network deductible | 80% after out-of-network deductible |

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

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

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| Benefits | In-network | Out-of-network |
|---|---|----------------------------------|
| Hospice care | 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 (after reaching dollar maximum, member transitions into individual case management) | |
| Home health care: <ul style="list-style-type: none"> must be medically necessary must be provided by a participating home health care agency | 100% after in-network deductible | 100% after in-network deductible |
| Infusion therapy: <ul style="list-style-type: none"> 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 | 100% after in-network deductible | 100% after in-network deductible |

| Surgical services | | |
|--|----------------------------------|-------------------------------------|
| Benefits | In-network | Out-of-network |
| 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 for males | 100% after in-network deductible | 80% after out-of-network deductible |
| Note: For voluntary sterilizations for females, see " Preventive care services. " | | |
| Voluntary abortions | 100% after in-network deductible | 80% after out-of-network deductible |

| Human organ transplants | | |
|---|----------------------------------|--|
| Benefits | In-network | Out-of-network |
| Specified human organ transplants - must be in a designated facility and 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-must be 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 |
| Note: BCBSM covers clinical trials in compliance with PPACA. | | |
| Kidney, cornea and skin transplants | 100% after in-network deductible | 80% after out-of-network deductible |

| Behavioral Health Services (Mental Health and Substance Use Disorder) | | |
|--|----------------------------------|-------------------------------------|
| Benefits | In-network | Out-of-network |
| Inpatient mental health care and inpatient substance treatment | 100% after in-network deductible | 80% after out-of-network deductible |
| | Unlimited days | |

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| Benefits | In-network | Out-of-network |
|--|----------------------------------|---|
| Residential psychiatric treatment facility: <ul style="list-style-type: none"> covered mental health services must be performed in a residential psychiatric treatment facility Treatment must be preauthorized subject to medical criteria | 100% after in-network deductible | 80% after out-of-network deductible |
| Outpatient mental health care: <ul style="list-style-type: none"> Facility and clinic | 100% after in-network deductible | 100% after in-network deductible in participating facilities only |
| <ul style="list-style-type: none"> Online visits <p>Note: Online visits by a vendor are not covered.</p> | 100% after in-network deductible | 80% after out-of-network deductible |
| <ul style="list-style-type: none"> Physician's office | 100% after in-network deductible | 80% after out-of-network deductible |
| Outpatient substance use disorder treatment-in approved facilities only | 100% after in-network deductible | 80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network) |

| Autism spectrum disorders, diagnoses and treatment | | |
|---|--|-------------------------------------|
| Benefits | In-network | Out-of-network |
| Applied behavior analysis (ABA) treatment - when rendered by an approved licensed behavior analyst - subject to preauthorization <p>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.</p> | 100% after in-network deductible | 100% after in-network deductible |
| Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder | 100% after in-network deductible | 80% after out-of-network deductible |
| | Physical, speech and occupational therapy with an autism diagnosis is unlimited | |
| Other covered services, including mental health services, for autism spectrum disorder | 100% after in-network deductible | 80% after out-of-network deductible |

| Other covered services | | |
|---|--|-------------------------------------|
| Benefits | In-network | Out-of-network |
| Outpatient Diabetes Management Program (ODMP) <p>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.</p> <p>Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.</p> | 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 12-visit maximum per member per calendar year | |

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| Benefits | In-network | Out-of-network |
|---|--|--|
| 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 30-visit maximum per member per calendar year | |
| Durable medical equipment | 100% after in-network deductible | 100% after in-network deductible |
| 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. | | |
| Prosthetic and orthotic appliances | 100% after in-network deductible | 100% after in-network deductible |
| Private duty nursing care | 100% after in-network deductible | 80% after out-of-network deductible |

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WAYNE COUNTY COMMUNITY COLLE A1IDT9 0070119080002 Simply Blue HSA with Prescription Drugs Effective Date: On or after January 2023 Benefits-at-a-glance

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

Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Pharmacy, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. AllianceRx Walgreens 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 the OptumRx home delivery pharmacy. (OptumRx is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at bcbsm.com/pharmacy. If you have any questions, please call AllianceRx Walgreens 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 will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

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

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

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

| Benefits | | 90-day retail network pharmacy | * In-network mail order provider | In-network pharmacy (not part of the 90-day retail network) | Out-of-network pharmacy |
|---|---------------------|---|---|---|---|
| Generic or prescribed over-the-counter prescription drugs | 1 to 30-day period | 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 the BCBSM approved amount |
| | 31 to 83-day period | No coverage | After deductible is met, you pay \$20 copay | No coverage | No coverage |

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| Benefits | | 90-day retail network pharmacy | * In-network mail order provider | In-network pharmacy (not part of the 90-day retail network) | Out-of-network pharmacy |
|-------------------------------|---------------------|--|--|---|---|
| Preferred brand-name drugs | 84 to 90-day period | After deductible is met, you pay \$20 copay | After deductible is met, you pay \$20 copay | No coverage | No coverage |
| | 1 to 30-day period | 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 the BCBSM approved amount |
| | 31 to 83-day period | No coverage | After deductible is met, you pay \$80 copay | No coverage | No coverage |
| Nonpreferred brand-name drugs | 84 to 90-day period | After deductible is met, you pay \$80 copay | After deductible is met, you pay \$80 copay | No coverage | No coverage |
| | 1 to 30-day period | 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 the BCBSM approved amount |
| | 31 to 83-day period | No coverage | After deductible is met, you pay \$160 copay | No coverage | No coverage |
| | 84 to 90-day period | 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.

| Covered services | | | | |
|---|---|---|---|---|
| Benefits | 90-day retail network pharmacy | * In-network mail order provider | In-network pharmacy (not part of the 90-day retail network) | Out-of-network pharmacy |
| FDA-approved drugs | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty |
| Prescribed over-the-counter drugs - when covered by BCBSM | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty |
| State-controlled drugs | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty |
| FDA-approved generic and select brand-name prescription preventive drugs, supplements and vitamins as required by PPACA | 100% of approved amount | 100% of approved amount | 100% of approved amount | 80% of approved amount |

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|---|---|---|---|---|
| Other FDA-approved brand-name prescription preventive drugs, supplements and vitamins as required by PPACA | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty |
| Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act | 100% of approved amount | No coverage | 100% of approved amount | 80% of approved amount |
| FDA-approved 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 | 80% of approved amount |
| Other FDA-approved brand-name prescription contraceptive medication (non-self-administered drugs are not covered) | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance 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. | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty for insulin or other covered injectable legend drug |
| Select diabetic supplies and devices (test strips, lancets and glucometers) For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy . | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance | Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty |

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

Features of your prescription drug plan

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| Custom Drug List | <p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> • Generic drug tier - This tier includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. • Preferred brand-name drug tier - This tier includes non-specialty preferred brand-name drugs. These drugs are more expensive than generic and members pay more for them • Nonpreferred brand-name drug tier - This tier includes non-specialty brand-name drugs for which there's either a generic alternative or a more cost-effective preferred brand-name drug available. Members pay more for these nonpreferred brand-name drugs. |
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ADM COB-3;ADM PLANR JAN;DHSAD2KIN4KON A;HSAOPM4KIN8KONA;PDTC104080RXCMB;SB-HSA-AMB ASC;SBD HSA ASC;SBDHSAC0IN20ONA;SD ASC

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Features of your prescription drug plan

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| 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 preauthorization) will be covered. Step Therapy , an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at bcbsm.com/pharmacy . |
| Maximum allowable cost drugs | When an in-network pharmacy fills a prescription with a MAC drug, we will pay the pharmacy the maximum allowable cost of the drug after minus your cost share. |
| Quantity limits | To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits. |

ADM COB-3;ADM PLANR JAN;DHSAD2KIN4KON A;HSAOPM4KIN8KONA;PDTTC104080RXCM;SB-HSA-AMB ASC;SBD HSA ASC;SBDHSAC0IN20ONA;SD ASC

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