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of the Blue Cross and Blue Shield Association

Simply BlueSM HSA PPO Plan \$1500/0% LG

Simply Blue PPO HSASM LG with Rx

Benefits-at-a-glance

Effective for groups on their plan year

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

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

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

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

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

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

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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.

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

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

Benefits	In-network	Out-of-network
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.	\$1,500 for a one-person contract or \$3,000 for a family contract (two 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 annually. Please call your customer service center for an annual update.	\$3,000 for a one-person contract or \$6,000 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)	None	20% of approved amount for most covered services
Note: Coinsurance amounts apply once the deductible has been met.		
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), 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
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	80% coinsurance after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	80% coinsurance after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% coinsurance after out-of-network deductible

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Benefits	In-network	Out-of-network
Well-baby and child care visits	100% (no deductible or copay/coinsurance) 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% coinsurance 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% coinsurance after out-of-network deductible
One routine colonoscopy per member per calendar year		

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

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

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	100% after in-network deductible	100% coinsurance after in-network deductible
Ambulance services - must be medically necessary	100% after in-network deductible	100% coinsurance after in-network deductible

Diagnostic services

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

Maternity services provided by a physician or certified nurse midwife

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

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	100% after in-network deductible	80% coinsurance 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% coinsurance after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% coinsurance after out-of-network deductible

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Alternatives to hospital care		
Benefits	In-network	Out-of-network
Skilled nursing care - must be in a participating skilled nursing facility	100% after in-network deductible	100% coinsurance after in-network deductible
	Limited to a maximum of 90 days per member per calendar year	
Hospice care	100% after in-network deductible	100% coinsurance after in-network deductible
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a 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	100% after in-network deductible	100% coinsurance after in-network deductible
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	100% after in-network deductible	100% coinsurance after in-network deductible

Surgical services		
Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	100% after in-network deductible	80% coinsurance after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% coinsurance after out-of-network deductible
Voluntary sterilization for males	100% after in-network deductible	80% coinsurance after out-of-network deductible
Note: For voluntary sterilizations for females, see " Preventive care services. "		
Elective abortions	Not covered	Not covered

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% coinsurance 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% coinsurance after out-of-network deductible
Specified oncology clinical trials	100% after in-network deductible	80% coinsurance 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% coinsurance after out-of-network deductible

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Behavioral Health Services (Mental Health and Substance Use Disorder)		
Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance use disorder treatment	100% after in-network deductible	80% coinsurance after out-of-network deductible
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	100% after in-network deductible	80% coinsurance after out-of-network deductible
Outpatient mental health care: Facility and clinic	100% after in-network deductible	100% coinsurance after in-network deductible in participating facilities only
Online visits Note: Online visits by a non-BCBSM selected vendor are not covered	100% after in-network deductible	80% coinsurance after out-of-network deductible
Physician's office	100% after in-network deductible	80% coinsurance after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities only	100% after in-network deductible	80% coinsurance after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment		
Benefits	In-network	Out-of-network
Applied behavior analysis (ABA) treatment - when rendered by an approved licensed behavior analyst - subject to preauthorization	100% after in-network deductible	100% coinsurance after in-network deductible
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.		
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% after in-network deductible	80% coinsurance 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% coinsurance after out-of-network deductible

Other covered services		
Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP)	100% after in-network deductible	80% coinsurance after out-of-network deductible
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.		

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Benefits	In-network	Out-of-network
Allergy testing and therapy	100% after in-network deductible	80% coinsurance after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% after in-network deductible Limited to a combined 12-visit maximum per member per calendar year	80% coinsurance after out-of-network deductible
Outpatient physical, speech and occupational therapy - provided for rehabilitation	100% after in-network deductible Limited to a combined 30-visit maximum per member per calendar year	80% coinsurance after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
Durable medical equipment Note: Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers. 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.	100% after in-network deductible	80% coinsurance after out-of-network deductible
Prosthetic and orthotic appliances Note: Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers.	100% after in-network deductible	80% coinsurance after out-of-network deductible
Private duty nursing care	100% after in-network deductible	80% coinsurance after out-of-network deductible

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Simply BlueSM HSA PPO Plan \$1500/0% LG

Simply Blue HSA with Prescription Drugs

Benefits-at-a-glance

Effective for groups on their plan year

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.

Prescription Drug Discount Program - Prescription drug manufacturers provide coupon programs for certain medications. Your benefit plan requires you to take advantage of BCBSM-approved coupon programs for select medications. This benefit may lower the cost-sharing typically required for these drugs. Your out-of-pocket expense will be no more than your benefit cost-sharing. When a manufacturer coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum.

NOTE: Adjustments may be required to accurately reflect your annual out-of-pocket maximum to reflect your true out-of-pocket cost.

This program may be discontinued at any time if it is no longer supported by the vendor.

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. You may obtain specialty drugs through a Walgreens retail pharmacy as well as long as the drug is available at that location. You may want to call ahead to confirm availability at the location. **If you go to a non-AllianceRx Walgreens Pharmacy, you may be responsible for 100% of the cost of the specialty drug.** Other mail order prescription medications can continue to be sent to the OptumRx home delivery pharmacy. (OptumRx is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at bcbsm.com/pharmacy. 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	In-network pharmacy	Out-of-network pharmacy
Copay/Coinsurance	After deductible is met, you pay nothing	After deductible is met, you pay 20% of the approved amount plus an additional 20% of BCBSM approved amount for the drug

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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.

Covered services		
Benefits	In-network pharmacy	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 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 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 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	80% of approved amount
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 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	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	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 plus an additional 20% prescription drug out-of-network penalty
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs	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
Note: Needles and syringes have no copay/coinsurance.		
Select diabetic supplies and devices (test strips, lancets and glucometers)	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
For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy .		

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.

Features of your prescription drug plan	
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

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Features of your prescription drug plan

Mandatory maximum allowable cost drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you 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 regardless of whether you or your physician requests the brand name drug. Exception: If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. Note: This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
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