Blue Cross Blue Shield of Michigan

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

WESTERN MICHIGAN UNIVERSITY
30 HOUR EMPLOYEES
Effective Date: 01/01/2025

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.

Prior authorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, receive prior authorization 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.

Prior authorization 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 prior authorization of the drugs. **If prior authorization 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.

Provider Networks

Your health care benefits include three provider networks or tiers

- **Tier 1:** Sindecuse Health Center and WMU-Unified Clinic. Members will experience the least out-of-pocket costs when services are provided at Sindecuse Health Center and WMU-Unified Clinic. This network will consist of Sindecuse Health Center and WMU-Unified Clinic. Tier 1 is considered In-network and unless otherwise noted, benefits will remain the same as Tier 2.
- **Tier 2:** BCBSM PPO In-network Facility and Professional Providers. When services are performed by a provider who is part of BCBSM's PPO In-network, members will experience greater out-of-pocket costs than services provided under Tier 1
- **Tier 3:** Out-of-network Facility and Professional Providers. Members are subject to the greatest out-of-pocket expenses when treatment is received from out-of-network providers without an authorized referral or in absence of an emergency situation

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

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Eligibility Information

Members	Eligibility Criteria
Dependents	• Subscriber's legal spouse or designated eligible individual (DEI), subject to criteria • **Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship, including eligible children of your same or opposite gender domestic partner; eligible for coverage through the last day of the month the dependent turns age 26.

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

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Deductible	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Level 1 deductible amounts also count toward the level 2 deductible. **Note:** Deductible may be waived for covered services performed in an Level 1 physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Level 2 deductible amounts also count toward the level 1 deductible. **Note:** Deductible may be waived for covered services performed in an Level 2 physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.	$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 level 1 and level 2 deductibles.
Flat-dollar copays	• $25 copay for office visits and office consultations with a **primary care provider** • $40 copay for office visits and office consultations with a **specialist** • $25 copay for medical online visits • $40 copay for urgent care visits • $150 copay for emergency room visits	• $25 copay for office visits and office consultations with a **primary care provider** • $40 copay for office visits and office consultations with a **specialist** • $25 copay for medical online visits • $40 copay for urgent care visits • $150 copay for emergency room visits	• $150 copay for emergency room visits
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 30% of approved amount for private duty nursing care • 10% of approved amount for mental health care and substance use disorder treatment • 10% of approved amount for most covered services (coinsurance waived for covered services performed in an in-network physician's office)	• 30% of approved amount for private duty nursing care • 10% of approved amount for mental health care and substance use disorder treatment • 10% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)	• 50% of approved amount for private duty nursing care • 30% of approved amount for mental health care and substance use disorder treatment • 30% of approved amount for most other covered services

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Annual out-of-pocket maximums - applies to deductibles, flat-dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	$2,000 for one member, $4,000 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	$4,000 for one member, $8,000 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 Tier 1 and Tier 2 out-of-pocket maximums.
Lifetime dollar maximum	None		

Preventive care services

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance) **Note:** Additional well-women visits may be allowed based on medical necessity.	100% (no deductible or copay/coinsurance) **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
	One per member per calendar year		
Gynecological exam	100% (no deductible or copay/coinsurance) **Note:** Additional well-women visits may be allowed based on medical necessity.	100% (no deductible or copay/coinsurance) **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
	Two per member per calendar year		
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
	One per member per calendar year		
Voluntary sterilization of female reproductive organs	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	70% 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% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Well-baby and Well-child visits	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered

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Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
	• 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		
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)	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
	One per member per calendar year		
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
	One per member per calendar year		
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
	One per member per calendar year		
Routine mammogram and related reading	100% (no deductible or copay/coinsurance)	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.	70% 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		
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy	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, if applicable.	70% after out-of-network deductible
	One per member per calendar year		

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Physician office services

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Office visits - must be medically necessary **Note:** This includes mental health and substance use disorder services equivalent to medical office visits.	• $25 copay for each office visit with a **primary care provider** • $40 copay for each office visit with a **specialist**	• $25 copay per office visit with a **primary care provider** • $40 copay per office visit with **specialist**	70% after out-of-network deductible
Online visits - by physician or **BCBSM** selected vendor must be medically necessary **Note:** Online visits by a non-BCBSM selected vendor are not covered. Not all services delivered virtually are considered an online visit, but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	$25 copay for online visits	$25 copay for online visits	70% after out-of-network deductible
Retail health center	$30 copay per visit	$30 copay per visit	70% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Office consultations - must be medically necessary	• $25 copay for each office consultation with a **primary care provider** • $40 copay for each office consultation with a **specialist**	• $25 copay per office consultation with a **primary care provider** • $40 copay per office consultation with a **specialist**	70% after out-of-network deductible
Urgent care visits - must be medically necessary	$40 copay per urgent care visit	$40 copay per urgent care visit	70% after out-of-network deductible

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	

Emergency medical care

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Hospital emergency room	$150 copay per visit (copay waived if admitted or for an accidental injury)	$150 copay per visit (copay waived if admitted or for an accidental injury)	$150 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	90% after Level 2 in-network deductible

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Diagnostic services

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Laboratory and pathology services	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Diagnostic tests and x-rays	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Therapeutic radiology	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Prenatal care visits	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Delivery and nursery care	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible

Hospital care

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
	Unlimited days		
Inpatient consultations	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Chemotherapy	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible

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Alternatives to hospital care

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Skilled nursing care - must be in a **participating** skilled nursing facility	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	90% after Level 2 in-network deductible
	Limited to a maximum of 120 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)
	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	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	90% after Level 2 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 prior authorization - consult with your doctor	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	90% after Level 2 in-network deductible

Surgical services

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Voluntary sterilization of male reproductive organs **Note:** For voluntary sterilization of female reproductive organs, see **"Preventive care services."**	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Expanded Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible

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Human organ transplants

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
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)	100% (no deductible or copay/coinsurance) - in designated facilities **only**
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Kidney, cornea and skin transplants	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Note: Some mental health and substance use disorder services are considered by BCBSM to be comparable to an office visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visitt, we will process the claim under your office visit benefit.

Note: BCBSM will cover mental health services performed - MD, DO, Fully Licensed Psychologists, Licensed Professional Counselor (LPC), and Clinical Licensed Master's Social Workers (CLMSWs), Limited Licensed Psychologists (LLPs), Social Workers who have the following social work degrees/certifications: MSSW and MMSW

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Inpatient mental health care and **inpatient** substance use disorder treatment	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% 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 requires prior authorization • subject to medical criteria	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	90% after Level 2 in-network deductible in participating facilities **only**
• Online visits - for services equivalent to a medical online visit **Note:** Online visits by a non-BCBSM selected vendor are not covered.	$25 copay per online visit	$25 copay per online visit	70% after out-of-network deductible

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Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
• Physician's office **Note:** For services equivalent to a medical office visit. See "**Physician Office Services**".	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Applied behavior analysis (ABA) treatment - subject to prior authorization **Note:** Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).	$25 copay per office visit	$25 copay per office visit	70% after out-of-network deductible **Note:** Services rendered by an approved licensed behavior analyst (LBA) will apply the in-network cost-sharing.
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited		
Other covered services, including nutritional counseling and mental health services, for autism spectrum disorder	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible

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Other covered services

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
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. **Note:** Glucose monitors, diabetic test strips and lancets are covered at 100% (no deductible or copay/coinsurance) of the approved amount.	• 90% after Level 1 in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	• 90% after Level 2 in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	70% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
	Limited to a **combined** 12-visit maximum per member per calendar year		
Outpatient physical, speech and occupational therapy - provided for rehabilitation	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year		
Durable medical equipment **Note:** DME items required under the preventive benefit 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 preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	90% after Level 2 in-network deductible
Prosthetic and orthotic appliances	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	90% after Level 2 in-network deductible
Private duty nursing care	70% after Level 1 in-network deductible	70% after Level 2 in-network deductible	50% after out-of-network deductible

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Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Massage therapy - covered with a prescription from a M.D, D.O., Chiropractor, Physician Assistant or, Nurse Practitioner prior to receipt of services, and performed by a licensed Massage Therapist (with no diagnostic restrictions) **Note:** Limited to 9 visits per member, per calendar year. Separate from physical, occupational, and speech therapy visit maximums.	$70 visit maximum subject to 90% after Level 1 in-network deductible	$70 visit maximum subject to 90% after Level 2 in-network deductible	$70 visit maximum subject to 70% after out-of-network deductible

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Preferred Rx Program ASC

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 preferred pharmacy for specialty drugs is **Walgreens Specialty Pharmacy**. Specialty drugs are covered only when dispensed through the Walgreens Specialty Pharmacy or through a participating Walgreens retail pharmacy, as long as the drug is available at that location. You may want to call ahead to confirm availability. **If you don't use Walgreens Specialty Pharmacy or a participating Walgreens retail pharmacy, you may be responsible for the full cost of the medication.**

A list of specialty drugs is available on our website at **bcbsm.com/pharmacy**. Click What are specialty drugs, then click Specialty Drug Program Rx Benefit Member Guide. The guide is updated monthly.

If you have additional questions, you can 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 Blue Cross defines as a "specialty pharmaceutical". We may make exceptions if a member requires more than a 30-day supply. Blue Cross reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay or 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)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, 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

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 select prescribed over-the-counter drugs	1 to 30-day period	You pay $10 copay	You pay $10 copay	You pay $10 copay	You pay $10 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $20 copay	No coverage	No coverage
	84 to 90-day period	You pay $25 copay	You pay $20 copay	No coverage	No coverage
Preferred brand-name drugs	1 to 30-day period	You pay $40 copay	You pay $40 copay	You pay $40 copay	You pay $40 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $80 copay	No coverage	No coverage
	84 to 90-day period	You pay $100 copay	You pay $80 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
Nonpreferred brand-name drugs	1 to 30-day period	You pay $80 copay	You pay $80 copay	You pay $80 copay	You pay $80 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $160 copay	No coverage	No coverage
	84 to 90-day period	You pay $200 copay	You pay $160 copay	No coverage	No coverage
Sindecuse Pharmacy Generic or select prescribed over-the-counter drugs	1 to 30-day period	Not applicable	Not applicable	You pay $10 copay	Not applicable
	31 to 83-day period	Not applicable	Not applicable	No coverage	Not applicable
	84 to 90-day period	Not applicable	Not applicable	You pay $22.50 copay	Not applicable
Sindecuse Pharmacy Preferred brand-name drugs	1 to 30-day period	Not applicable	Not applicable	You pay $40 copay	Not applicable
	31 to 83-day period	Not applicable	Not applicable	No coverage	Not applicable
	84 to 90-day period	Not applicable	Not applicable	You pay $90 copay	Not applicable
Sindecuse Pharmacy Nonpreferred brand-name drugs	1 to 30-day period	Not applicable	Not applicable	You pay $80 copay	Not applicable
	31 to 83-day period	Not applicable	Not applicable	No coverage	Not applicable
	84 to 90-day period	Not applicable	Not applicable	You pay $180 copay	Not applicable
Sindecuse Pharmacy Generic and preferred brand-name specialty drugs	1 to 30-day period	Not applicable	Not applicable	You pay 15% of the approved amount, but not more than $150	Not applicable
	31 to 83-day period	Not applicable	Not applicable	No coverage	Not applicable
	84 to 90-day period	Not applicable	Not applicable	Not applicable	Not applicable
Sindecuse Pharmacy Nonpreferred brand-name specialty drugs	1 to 30-day period	Not applicable	Not applicable	You pay 25% of the approved amount, but not more than $300	Not applicable
	31 to 83-day period	Not applicable	Not applicable	No coverage	Not applicable

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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
	84 to 90-day period	Not applicable	Not applicable	Not applicable	Not applicable
Generic and preferred brand-name specialty drugs	1 to 30-day period	**Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs** You pay 15% of the approved amount, but no more than $150 **Note:** No coverage for 31-90 day supply.			
Nonpreferred brand-name specialty drugs	1 to 30-day period	**Coverage only available through the Exclusive Pharmacy Network for Specialty Drugs** You pay 25% of the approved amount, but no more than $300 **Note:** No coverage for 31-90 day supply.			

* 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	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
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
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	75% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	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
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	75% of approved amount

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 **generic** and select **brand name** prescription contraceptive medication (non-self-administered drugs are not covered) **Note: Brand name** prescription contraceptive medication received from **Sindecuse Pharmacy** are covered at 100% of approved amount less plan copay/coinsurance.	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs are not covered) **Note: Brand name** prescription contraceptive medication received from **Sindecuse Pharmacy** are covered at 100% of approved amount less plan copay/coinsurance.	No coverage	No coverage	No coverage	No coverage
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
Diabetic test strips and lancets	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount

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

Features of your prescription drug plan

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. • **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/coinsurance, 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 then 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. • **Generic and preferred specialty drug tier** - This tier includes generic and preferred brand-name specialty drugs that are used to treat difficult health conditions. These drugs are generally more cost-effective than nonpreferred specialty drugs. • **Nonpreferred specialty drug tier** - This tier includes nonpreferred brand-name, specialty drugs that are used to treat difficult health conditions. Members pay more for nonpreferred specialty drugs because there are cost-effective generic or preferred drugs available.

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Features of your prescription drug plan

Maximum allowable cost drugs	For maximum allowable cost (MAC) Drugs, if you have a prescription filled by an in-network pharmacy, and the pharmacist fills it with a generic equivalent drug, you are required to pay only the copayment and/or deductible, if applicable. If you obtain a brand name drug when a generic equivalent drug is available, you must pay the difference between the maximum allowable cost and the BCBSM approved amount for the brand name drug plus your copayment and/or deductible, if applicable. **Note:** If your physician requests and receives authorization for a brand name drug from BCBSM's Pharmacy Services Department and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your copayment and/or deductible, if applicable.
Over-the-counter drugs	Excludes benefits for certain over-the-counter drugs.
Quantity of drugs	Your prescription drug coverage has eliminated authorization requirements for select prescription drugs, and quantities of drugs.
Erectile dysfunction drugs	Limited to no more than **6 doses** in a **30-day** period.
GLP-1 Products	GLP-1 products for conditions other than diabetes are not covered.

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