Blue Cross Blue Shield of Michigan

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

MONTCALM COMMUNITY COLLEGE
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Effective Date: 07/01/2023

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.

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.

Eligibility Information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Dependent children**: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage until the end of the year in which they turn age 26

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

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

Note: Member cost-sharing requirements are administered on a plan year basis. Your plan year begins on July 1 and ends the following year on June 30.

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.	$1,500 for a one-person contract or $3,000 for a family contract (two or more members) each benefit year **(no 4th quarter carry-over)**	$3,000 for a one-person contract or $6,000 for a family contract (two or more members) each benefit year **(no 4th quarter carry-over)**
Note: The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract.	Deductibles 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.	
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.	20% of approved amount for most covered services	40% 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 benefit year	$8,000 for a one-person contract $16,000 for a family contract (two or more members) each benefit 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

Benefits	In-network	Out-of-network
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)	60% 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)	60% coinsurance after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% coinsurance after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
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.	60% 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.	60% 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	80% after in-network deductible	60% coinsurance after out-of-network deductible
Online visits - must be medically necessary **Note:** Online visits by a non-BCBSM selected vendor are not covered	80% after in-network deductible	60% coinsurance after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% coinsurance after out-of-network deductible
Office consultations - must be medically necessary	80% after in-network deductible	60% coinsurance after out-of-network deductible
Urgent care visits - must be medically necessary	80% after in-network deductible	60% coinsurance after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	80% after in-network deductible	80% coinsurance after in-network deductible
Ambulance services - must be medically necessary	80% after in-network deductible	80% coinsurance after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible	60% coinsurance after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% coinsurance after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% 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)	60% coinsurance after out-of-network deductible
Postnatal care	100% (no deductible or copay/coinsurance)	60% coinsurance after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% 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 **Note:** Nonemergency services must be rendered in a **participating** hospital.	80% after in-network deductible	60% coinsurance after out-of-network deductible
	Unlimited days	
Inpatient consultations	80% after in-network deductible	60% coinsurance after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% coinsurance 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	80% after in-network deductible	80% coinsurance after in-network deductible
	Limited to a maximum of 90 days per member per calendar year	
Hospice care	80% after in-network deductible	80% 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	80% after in-network deductible	80% 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	80% after in-network deductible	80% 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	80% after in-network deductible	60% coinsurance after out-of-network deductible
Presurgical consultations	80% after in-network deductible	60% coinsurance after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see **"Preventive care services."**	80% after in-network deductible	60% coinsurance after out-of-network deductible
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)	80% after in-network deductible	80% 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)	80% after in-network deductible	60% coinsurance after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible	60% coinsurance after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% coinsurance 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 use disorder treatment	80% after in-network deductible	60% 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	80% after in-network deductible	60% coinsurance after out-of-network deductible
Outpatient mental health care: • Facility and clinic	80% after in-network deductible	80% coinsurance after in-network deductible in participating facilities **only**
• Online visits **Note:** Online visits by a non-BCBSM selected vendor are not covered	80% after in-network deductible	60% coinsurance after out-of-network deductible
• Physician's office	80% after in-network deductible	60% coinsurance after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	80% after in-network deductible	60% 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 **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	80% after in-network deductible	80% coinsurance after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after in-network deductible	60% coinsurance after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	

Benefits	In-network	Out-of-network
Other covered services, including mental health services, for autism spectrum disorder	80% after in-network deductible	60% coinsurance after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	80% after in-network deductible	60% coinsurance after out-of-network deductible
Allergy testing and therapy	80% after in-network deductible	60% coinsurance after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	80% after in-network deductible	60% coinsurance 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	80% after in-network deductible	60% coinsurance 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 **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers. **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.	80% after in-network deductible	60% 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.	80% after in-network deductible	60% coinsurance after out-of-network deductible
Private duty nursing care	80% after in-network deductible	60% coinsurance after out-of-network deductible

Simply Blue HSA with Prescription Drugs

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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		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	After deductible is met, you pay $10 copay	After deductible is met, you pay $10 copay	After deductible is met, you pay $10 copay	After deductible is met, you pay $10 copay plus an additional 20% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	After deductible is met, you pay $20 copay	No coverage	No coverage
	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
Preferred brand-name drugs	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 BCBSM approved amount for the drug
	31 to 83-day period	No coverage	After deductible is met, you pay $80 copay	No coverage	No coverage
	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
Nonpreferred brand-name drugs	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 BCBSM approved amount for the drug

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
	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
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

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)	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

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, 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.
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**.

Features of your prescription drug plan

Mandatory maximum allowable cost drugs	If your prescription is filled by an in-network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug plus your applicable copay/coinsurance regardless of whether you or your physician requests the brand-name drug. **Exception:** If your physician requests and receives authorization for a nonpreferred brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay/coinsurance. **Note:** This MAC difference will not be applied toward your annual in-network deductible, your annual coinsurance, or your annual out-of-pocket maximum, if applicable.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

Hearing Care Coverage

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.

Member's responsibility (deductible and copay)

Benefits	Participating provider	Nonparticipating provider
Deductible **Note**: You are required to meet the annual calendar year deductible under your Simply Blue HSA coverage **before** using your hearing care benefits	**Your Simply Blue HSA hearing care benefits are subject to the same deductible required under your Simply Blue HSA medical coverage.** Hearing care benefits are **not** payable until after you have met the Simply Blue HSA annual deductible.	Not applicable
Copay/coinsurance	**Your Simply Blue HSA hearing care benefits are subject to the same coinsurance required under your Simply Blue HSA medical coverage.**	Not applicable

Covered services

You **must** receive the following services from **a hearing participating provider**. Hearing care services are **not** covered when performed by nonparticipating providers unless the services are performed outside of Michigan **and** the local Blue Cross and Blue Shield plan does **not** contract with providers for hearing care services. In this case, BCBSM will pay the approved amount for hearing aids and related covered services obtained from a nonparticipating provider. You may be responsible for charges that exceed our approved amount.

If you select a digitally controlled programmable hearing device, you may be responsible for charges that exceed the cost of a covered hearing aid.

Benefits	Participating provider	Nonparticipating provider
Audiometric exam - one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered
Hearing aid evaluation- one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered
Ordering and fitting the hearing aid (a monaural hearing aid only)- one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered
Hearing aid conformity test- one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered

Note: You **must** obtain a medical evaluation (sometimes called a medical clearance exam) of the ear performed by a physician-specialist before you receive your hearing aid. If a physician-specialist is not accessible, your primary care doctor may perform the medical evaluation. **This evaluation is not covered under your hearing care coverage, so you must pay for this exam unless your medical coverage includes coverage for office visits.**
A physician-specialist is a licensed doctor of medicine or osteopathy who is also board certified or in the process of being board certified as an otolaryngologist. A physician-specialist determines whether a patient has a hearing loss and whether such loss can be offset by a hearing aid.