DELTA COLLEGE
A1KWQ5
0070003380010
Simply Blue℠ HSA PPO with Rx ASC
Effective Date: On or after January 2024
Benefits-at-a-glance

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$1,600 for a one-person contract</td>
<td>$3,200 for a one-person contract</td>
</tr>
<tr>
<td></td>
<td>$3,200 for a family contract (two or more</td>
<td>$6,400 for a family contract (two or more</td>
</tr>
<tr>
<td></td>
<td>members) each calendar year</td>
<td>members) each calendar year</td>
</tr>
<tr>
<td></td>
<td>(no 4th quarter carry-over)</td>
<td>(no 4th quarter carry-over)</td>
</tr>
<tr>
<td><strong>Note:</strong> Your deductible combines deductible amounts paid under your Simply Blue HSA medical coverage and your Simply Blue prescription drug coverage.</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Flat-dollar copays**

- In-network: See "Prescription Drugs" section
- Out-of-network: See "Prescription Drugs" section

**Coinsurance amounts (percent copays)**

- In-network: None
- Out-of-network: 20% of approved amount for most covered services

**Annual out-of-pocket maximums**

- In-network:
  - $2,250 for a one-person contract
  - $4,500 for a family contract (two or more members) each calendar year
- Out-of-network:
  - $4,500 for a one-person contract
  - $9,000 for a family contract (two or more members) each calendar year

**Lifetime dollar maximum**

- In-network: None
- Out-of-network: None

### Preventive care services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health maintenance exam-includes chest x-ray, EKG, cholesterol screening and other select lab procedures</td>
<td>100% (no deductible or copay/coinsurance), one per member per calendar year</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Additional well-women visits may be allowed based on medical necessity.</td>
<td></td>
</tr>
<tr>
<td>Gynecological exam</td>
<td>100% (no deductible or copay/coinsurance), two per member per calendar year</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Additional well-women visits may be allowed based on medical necessity.</td>
<td></td>
</tr>
<tr>
<td>Pap smear screening- laboratory and pathology services</td>
<td>100% (no deductible or copay/coinsurance), one per member per calendar year</td>
<td>Not covered</td>
</tr>
<tr>
<td>Voluntary sterilization of female reproductive organs</td>
<td>100% (no deductible or copay/coinsurance)</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>Prescription contraceptive devices-includes insertion and removal of an intrauterine device by a licensed physician</td>
<td>100% (no deductible or copay/coinsurance)</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>Contraceptive injections</td>
<td>100% (no deductible or copay/coinsurance)</td>
<td>80% after out-of-network deductible</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-baby and Well-child visits</td>
<td>100% (no deductible or copay/coinsurance)</td>
<td>Not covered</td>
</tr>
<tr>
<td>- 8 visits, birth through 12 months</td>
<td></td>
<td></td>
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<tr>
<td>- 6 visits, 13 months through 23 months</td>
<td></td>
<td></td>
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<tr>
<td>- 6 visits, 24 months through 35 months</td>
<td></td>
<td></td>
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<tr>
<td>- 2 visits, 36 months through 47 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Visits beyond 47 months are limited to one per member per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>under the health maintenance exam benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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</td>
<td>100% (no deductible or copay/coinsurance)</td>
<td>Not covered</td>
</tr>
<tr>
<td>Fecal occult blood screening</td>
<td>100% (no deductible or copay/coinsurance), one per member per calendar year</td>
<td>Not covered</td>
</tr>
<tr>
<td>Flexible sigmoidoscopy exam</td>
<td>100% (no deductible or copay/coinsurance), one per member per calendar year</td>
<td>Not covered</td>
</tr>
<tr>
<td>Prostate specific antigen (PSA) screening</td>
<td>100% (no deductible or copay/coinsurance), one per member per calendar year</td>
<td>Not covered</td>
</tr>
<tr>
<td>Routine mammogram and related reading</td>
<td>100% (no deductible or copay/coinsurance)</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable.</td>
<td>Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.</td>
<td></td>
</tr>
<tr>
<td>Colonoscopy - routine or medically necessary</td>
<td>100% (no deductible or copay/coinsurance)</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>Note: Medically necessary colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One routine colonoscopy per member per calendar year</td>
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<td></td>
</tr>
</tbody>
</table>

### Physician office services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits - must be medically necessary</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>Online visits - by physician must be medically necessary</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
</tbody>
</table>

**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.

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## Benefits

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient and home medical care visits - must be medically necessary</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>Office consultations - must be medically necessary</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>Urgent care visits - must be medically necessary</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
</tbody>
</table>

## Emergency medical care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital emergency room</td>
<td>100% after in-network deductible</td>
<td>100% after in-network deductible</td>
</tr>
<tr>
<td>Ambulance services - must be medically necessary</td>
<td>100% after in-network deductible</td>
<td>100% after in-network deductible</td>
</tr>
</tbody>
</table>

## Diagnostic services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory and pathology services</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>Diagnostic tests and x-rays</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>Therapeutic radiology</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
</tbody>
</table>

## Maternity services provided by a physician or certified nurse midwife

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal care visits</td>
<td>100% (no deductible or copay/coinsurance)</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>Postnatal care</td>
<td>100% (no deductible or copay/coinsurance)</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>Delivery and nursery care</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
</tbody>
</table>

## Hospital care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>Note: Nonemergency services must be rendered in a participating hospital.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient consultations</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
</tbody>
</table>

Unlimited days

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Alternatives to hospital care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing care- must be in a participating skilled nursing facility</td>
<td>100% after in-network deductible Limited to a maximum of 90 days per member per calendar year</td>
<td>100% after in-network deductible</td>
</tr>
<tr>
<td>Hospice care</td>
<td>100% after in-network deductible</td>
<td>100% after in-network deductible</td>
</tr>
<tr>
<td></td>
<td>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)</td>
<td></td>
</tr>
<tr>
<td>Home health care:</td>
<td>100% after in-network deductible</td>
<td>100% after in-network deductible</td>
</tr>
<tr>
<td>• must be medically necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• must be provided by a participating home health care agency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infusion therapy:</td>
<td>100% after in-network deductible</td>
<td>100% after in-network deductible</td>
</tr>
<tr>
<td>• must be medically necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• may use drugs that require preauthorization-consult with your doctor</td>
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<td></td>
</tr>
</tbody>
</table>

Surgical services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery-includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>Presurgical consultations</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>Voluntary sterilization of male reproductive organs</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td><strong>Note:</strong> For voluntary sterilization of female reproductive organs, see &quot;Preventive care services.&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary abortions</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
</tbody>
</table>

Human organ transplants

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specified human organ transplants - must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)</td>
<td>100% after in-network deductible</td>
<td>100% after in-network deductible</td>
</tr>
<tr>
<td>Bone marrow transplants-must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>Specified oncology clinical trials</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td><strong>Note:</strong> BCBSM covers clinical trials in compliance with PPACA.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney, cornea and skin transplants</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
</tbody>
</table>
### Behavioral Health Services (Mental Health and Substance Use Disorder)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient mental health care and inpatient substance use disorder treatment</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
</tbody>
</table>
| 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% after out-of-network deductible |
| Outpatient mental health care:  
  • Facility and clinic | 100% after in-network deductible | 100% after in-network deductible in participating facilities only |
|  • Online visits | 100% after in-network deductible | 80% after out-of-network deductible |
|  • Physician’s office | 100% after in-network deductible | 80% after out-of-network deductible |
| Outpatient substance use disorder treatment in approved facilities only | 100% after in-network deductible | 80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network) |

### Autism spectrum disorders, diagnoses and treatment

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

### Other covered services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Diabetes Management Program (ODMP)</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
</tbody>
</table>

- **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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<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy testing and therapy</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>Chiropractic spinal manipulation and osteopathic manipulative therapy</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td></td>
<td>Limited to a combined 36-visit maximum per member per calendar year</td>
<td></td>
</tr>
<tr>
<td>Outpatient physical, speech and occupational therapy-provided for</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>rehabilitation</td>
<td></td>
<td><strong>Note:</strong> Services at nonparticipating outpatient physical therapy facilities are not covered.</td>
</tr>
<tr>
<td></td>
<td>Limited to a combined 30-visit maximum per member per calendar year</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>100% after in-network deductible</td>
<td>100% after in-network deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> 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.</td>
</tr>
<tr>
<td>Prosthetic and orthotic appliances</td>
<td>100% after in-network deductible</td>
<td>100% after in-network deductible</td>
</tr>
<tr>
<td>Private duty nursing care</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>Approved infertility services-includes medical evaluation, diagnostic</td>
<td>100% after in-network deductible</td>
<td>80% after out-of-network deductible</td>
</tr>
<tr>
<td>services and assisted reproductive technology treatment to manage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>infertility</td>
<td></td>
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</tr>
<tr>
<td>Massage therapy - covered with a prescription from a M.D, D.O.,</td>
<td>$70 visit maximum after in-network deductible</td>
<td>$70 visit maximum subject to 80% after out-of-network deductible</td>
</tr>
<tr>
<td>Chiropractor, Physician Assistant or, Nurse Practitioner prior to receipt</td>
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<td></td>
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<tr>
<td>of services, and performed by a licensed Massage Therapist (with no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>diagnostic restrictions)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> Limited to 9 visits per member, per calendar year. Separate from physical, occupational, and speech therapy visit maximums.</td>
</tr>
</tbody>
</table>
Simply Blue℠ HSA PPO with Rx ASC
Effective Date: On or after January 2024

Benefits-at-a-glance

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

**Specialty Pharmaceutical Drugs** - The 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. You may also obtain specialty drugs through a Walgreens retail pharmacy 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. 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”. 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

<table>
<thead>
<tr>
<th>Benefits</th>
<th>90-day retail network pharmacy</th>
<th>* In-network mail order provider</th>
<th>In-network pharmacy (not part of the 90-day retail network)</th>
<th>Out-of-network pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic or select prescribed over-the-counter drugs</td>
<td>1 to 30-day period</td>
<td>After deductible is met, you pay $20 copay</td>
<td>After deductible is met, you pay $20 copay</td>
<td>After deductible is met, you pay $20 copay</td>
</tr>
<tr>
<td></td>
<td>31 to 83-day period</td>
<td>No coverage</td>
<td>After deductible is met, you pay $40 copay</td>
<td>No coverage</td>
</tr>
<tr>
<td></td>
<td>84 to 90-day period</td>
<td>After deductible is met, you pay $40 copay</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
</tbody>
</table>
### Covered services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>90-day retail network pharmacy</th>
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<th>In-network pharmacy (not part of the 90-day retail network)</th>
<th>Out-of-network pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred brand-name drugs 1 to 30-day period</td>
<td>After deductible is met, you pay $60 copay</td>
<td>After deductible is met, you pay $60 copay</td>
<td>After deductible is met, you pay $60 copay</td>
<td>After deductible is met, you pay $60 copay plus an additional 20% of the BCBSM approved amount</td>
</tr>
<tr>
<td>31 to 83-day period</td>
<td>No coverage</td>
<td>After deductible is met, you pay $120 copay</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
<tr>
<td>Nonpreferred brand-name drugs 84 to 90-day period</td>
<td>After deductible is met, you pay $120 copay</td>
<td>After deductible is met, you pay $120 copay</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
<tr>
<td>1 to 30-day period</td>
<td>After deductible is met, you pay $80 or 50% of the approved amount (whichever is greater), but no more than $100</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
<tr>
<td>31 to 83-day period</td>
<td>After deductible is met, you pay $160 or 50% of the approved amount (whichever is greater), but no more than $200</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
<tr>
<td>84 to 90-day period</td>
<td>After deductible is met, you pay $160 or 50% of the approved amount (whichever is greater), but no more than $200</td>
<td>No coverage</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
</tbody>
</table>

**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.

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Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.
<table>
<thead>
<tr>
<th>Benefits</th>
<th>90-day retail network pharmacy</th>
<th>* In-network mail order provider</th>
<th>In-network pharmacy (not part of the 90-day retail network)</th>
<th>Out-of-network pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>FDA-approved <strong>generic</strong> and <strong>select brand-name</strong> prescription preventive drugs, supplements and vitamins as required by PPACA</td>
<td>100% of approved amount</td>
<td>100% of approved amount</td>
<td>100% of approved amount</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Other FDA-approved <strong>brand-name</strong> prescription preventive drugs, supplements and vitamins as required by PPACA</td>
<td>Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance</td>
<td>Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance</td>
<td>Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance</td>
<td>Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty</td>
</tr>
<tr>
<td>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</td>
<td>100% of approved amount</td>
<td>No coverage</td>
<td>100% of approved amount</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>FDA-approved <strong>generic</strong> and <strong>select brand-name</strong> prescription contraceptive medication (non-self-administered drugs are not covered)</td>
<td>100% of approved amount</td>
<td>100% of approved amount</td>
<td>100% of approved amount</td>
<td>80% of approved amount</td>
</tr>
<tr>
<td>Other FDA-approved <strong>brand-name</strong> prescription contraceptive medication (non-self-administered drugs are not covered)</td>
<td>Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance</td>
<td>Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance</td>
<td>Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance</td>
<td>Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty</td>
</tr>
<tr>
<td>Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs</td>
<td>Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug</td>
<td>Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug</td>
<td>Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug</td>
<td>Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug plus an additional 20% prescription drug out-of-network penalty</td>
</tr>
</tbody>
</table>

**Note:** Needles and syringes have no copay/coinsurance.

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 |

* 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-specially preferred brand-name drugs. These drugs are more expensive than generic and members pay more for them.  
  - **Nonpreferred brand-name drug tier** - This tier includes non-specialty brand-name drugs for which there’s either a generic alternative or a more cost-effective preferred brand-name drug available. Members pay more for these nonpreferred brand-name drugs. |
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Prior authorization/step therapy</td>
<td>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. <strong>Step Therapy</strong>, 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 <a href="http://bcbsm.com/pharmacy">bcbsm.com/pharmacy</a>.</td>
</tr>
</tbody>
</table>
| Maximum allowable cost drugs | When you receive a generic maximum allowable cost (MAC) drug from an in-network pharmacy, you pay your cost share as noted in your coverage.  
  However, if you request a brand-name drug and the prescriber did not write "Dispense as Written" or "DAW" on the prescription, you must pay the difference between the maximum allowable cost and the Blue Cross Blue Shield of Michigan approved amount for the brand-name drug, plus your copayment.  
  If the prescriber wrote "Dispense as Written" or "DAW" on the prescription, we will pay the pharmacy the approved amount for the brand-name drug, after deduction of your copayment. |
| Quantity limits | To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits. |
DELTA COLLEGE
A1KWQ5
0070003380010
Vision Coverage
Effective Date: On or after January 2024
Benefits-at-a-glance

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

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call 1-800-877-7195 or log on to the VSP Web site at vsp.com.

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

<table>
<thead>
<tr>
<th>Member's responsibility (copays)</th>
<th>VSP network doctor</th>
<th>Non-VSP provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye exam</td>
<td>$5 copay</td>
<td>$5 copay applies to charge</td>
</tr>
<tr>
<td>Prescription glasses (lenses and/or frames)</td>
<td>Combined $10 copay</td>
<td>Member responsible for difference between approved amount and provider's charge, after $10 copay</td>
</tr>
<tr>
<td>Medically necessary contact lenses</td>
<td>$10 copay</td>
<td>Member responsible for difference between approved amount and provider's charge, after $10 copay</td>
</tr>
<tr>
<td>Note: No copay is required for prescribed contact lenses that are not medically necessary.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eye exam</th>
<th>VSP network doctor</th>
<th>Non-VSP provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.</td>
<td>$5 copay</td>
<td>Reimbursement up to $45 less $5 copay (member responsible for any difference)</td>
</tr>
</tbody>
</table>

One eye exam in any period of 12 consecutive months
## Lenses and frames

<table>
<thead>
<tr>
<th>Benefits</th>
<th>VSP network doctor</th>
<th>Non-VSP provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard lenses</strong> (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.</td>
<td>$10 copay (one copay applies to <strong>both</strong> lenses and frames)</td>
<td>Reimbursement up to approved amount based on lens type less $10 copay (member responsible for any difference)</td>
</tr>
<tr>
<td><strong>Note:</strong> All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.</td>
<td></td>
<td><strong>One pair of lenses, with or without frames, in any period of 12 <strong>consecutive</strong> months</strong></td>
</tr>
<tr>
<td><strong>Standard frames</strong></td>
<td>$100 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $10 copay (one copay applies to <strong>both</strong> frames and lenses)</td>
<td>Reimbursement up to $70 less $10 copay (member responsible for any difference)</td>
</tr>
</tbody>
</table>

## Contact Lenses

<table>
<thead>
<tr>
<th>Benefits</th>
<th>VSP network doctor</th>
<th>Non-VSP provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medically necessary contact lenses</strong> (requires prior authorization approval from VSP and must meet criteria of medically necessary)</td>
<td>$10 copay</td>
<td>Reimbursement up to $210 less $10 copay (member responsible for any difference)</td>
</tr>
<tr>
<td><strong>Contact lenses up to the allowance in any period of 12 <strong>consecutive</strong> months</strong></td>
<td></td>
<td><strong>Contact lenses up to the allowance in any period of 12 <strong>consecutive</strong> months</strong></td>
</tr>
<tr>
<td><strong>Elective contact lenses that improve vision</strong> (prescribed, but do not meet criteria of medically necessary)</td>
<td>$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)</td>
<td>$85 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)</td>
</tr>
</tbody>
</table>

Contact lenses up to the allowance in any period of 12 **consecutive** months.
DELTA COLLEGE
A1KWQ5
0070003380010
Hearing Care Coverage
Effective Date: On or after January 2024
Benefits-at-a-glance

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Member's responsibility (deductible and copay)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Participating provider</th>
<th>Nonparticipating provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible Note: You are required to meet the annual calendar year deductible under your Simply Blue HSA coverage before using your hearing care benefits</td>
<td>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.</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Copay/coinsurance</td>
<td>Your Simply Blue HSA hearing care benefits are subject to the same coinsurance required under your Simply Blue HSA medical coverage.</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Participating provider</th>
<th>Nonparticipating provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiometric exam - one every 36 months</td>
<td>100% of approved amount after Simply Blue HSA deductible and coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hearing aid evaluation- one every 36 months</td>
<td>100% of approved amount after Simply Blue HSA deductible and coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Ordering and fitting the hearing aid (a monaural hearing aid only) - one every 36 months</td>
<td>100% of approved amount after Simply Blue HSA deductible and coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hearing aid conformity test- one every 36 months</td>
<td>100% of approved amount after Simply Blue HSA deductible and coinsurance</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
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.