



Blue Cross  
Blue Shield  
of Michigan

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

## PPO 4 RETIREES A1MTX8 0070118910022 Community Blue<sup>SM</sup> PPO 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 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](http://bcbsm.com/importantinfo). Select **Approving covered services**.

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

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

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

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

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## Eligibility Information

Members	Eligibility Criteria
Dependents	<ul style="list-style-type: none"> <li>Subscriber's legal spouse</li> <li><b>Dependent children:</b> related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26</li> </ul>
Sponsored dependents	<ul style="list-style-type: none"> <li>Dependents of the subscriber related by blood, marriage or legal adoption, over age 19 and not eligible as a dependent under the provisions of the subscriber's contract, provided the dependent meets all eligibility requirements. The subscriber is responsible for paying the cost of this coverage.</li> </ul>

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

Benefits	In-network	Out-of-network
<b>Deductible</b>	<p>\$500 for one member, \$1,000 for the family (when two or more members are covered under your contract) each calendar year</p> <p><b>Note:</b> Deductible may be waived for covered services performed in an in-network 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.</p>	<p>\$1,000 for one member, \$2,000 for the family (when two or more members are covered under your contract) each calendar year</p> <p><b>Note:</b> Out-of-network deductible amounts also count toward the in-network deductible.</p>
<b>Flat-dollar copays</b>	<ul style="list-style-type: none"> <li>\$20 copay for office visits and office consultations</li> <li>\$20 copay for medical online visits</li> <li>\$20 copay for chiropractic and osteopathic manipulative therapy</li> <li>\$100 copay for emergency room visits</li> <li>\$20 copay for urgent care visits</li> </ul>	<ul style="list-style-type: none"> <li>\$100 copay for emergency room visits</li> </ul>
<b>Coinsurance amounts (percent copays)</b>  <b>Note:</b> Coinsurance amounts apply once the deductible has been met.	<ul style="list-style-type: none"> <li>30% of approved amount for private duty nursing care</li> <li>20% of approved amount for mental health care and substance use disorder treatment</li> <li>20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)</li> </ul>	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing care</li> <li>40% of approved amount for mental health care and substance use disorder treatment</li> <li>40% of approved amount for most other covered services</li> </ul>
<b>Annual coinsurance maximums</b> - applies to coinsurance amounts for all covered services - but <b>does not</b> apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	<p>\$1,500 for one member, \$3,000 for the family (when two or more members are covered under your contract) each calendar year</p>	<p>\$3,000 for one member, \$6,000 for the family (when two or more members are covered under your contract) each calendar year</p> <p><b>Note:</b> Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.</p>

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Benefits	In-network	Out-of-network
<b>Annual out-of-pocket maximums</b> - applies to deductibles, flat-dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	\$6,350 for one member, \$12,700 for the family (when two or more members are covered under your contract) each calendar year	\$12,700 for one member, \$25,400 for the family (when two or more members are covered under your contract) each calendar year  <b>Note:</b> Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
<b>Lifetime dollar maximum</b>	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  <b>Note:</b> 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  <b>Note:</b> Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization of female reproductive organs	100% (no deductible or copay/coinsurance)	60% 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% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and Well-child visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> <li>8 visits, birth through 12 months</li> <li>6 visits, 13 months through 23 months</li> <li>6 visits, 24 months through 35 months</li> <li>2 visits, 36 months through 47 months</li> <li>Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</li> </ul>	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

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Benefits	In-network	Out-of-network
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)  <b>Note:</b> Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	60% after out-of-network deductible  <b>Note:</b> 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  <b>Note:</b> Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	60% after out-of-network deductible
	One per member per calendar year	

Physician office services		
Benefits	In-network	Out-of-network
Office visits - must be medically necessary	\$20 copay per office visit	60% after out-of-network deductible
Online visits - by physician must be medically necessary  <b>Note:</b> Online visits by a 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.	\$20 copay per online visit	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	\$20 copay per office consultation	60% after out-of-network deductible
Urgent care visits - must be medically necessary	\$20 copay per urgent care visit	60% after out-of-network deductible

Emergency medical care		
Benefits	In-network	Out-of-network
Hospital emergency room	\$100 copay per visit (copay waived if admitted or for an accidental injury)	\$100 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

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## Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% 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% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% 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	80% after in-network deductible	60% after out-of-network deductible
<b>Note:</b> Nonemergency services must be rendered in a <b>participating</b> hospital.	Unlimited days	
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

## Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a <b>participating</b> skilled nursing facility	80% after in-network deductible	80% after 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)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a <b>participating</b> hospice program <b>only</b> ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care:	80% after in-network deductible	80% after in-network deductible
<ul style="list-style-type: none"> <li>• must be medically necessary</li> <li>• must be provided by a <b>participating</b> home health care agency</li> </ul>		

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Benefits	In-network	Out-of-network
Infusion therapy: <ul style="list-style-type: none"> <li>• must be medically necessary</li> <li>• must be given by a <b>participating</b> Home Infusion Therapy (HIT) provider or in a <b>participating</b> freestanding Ambulatory Infusion Center (AIC)</li> <li>• may use drugs that require preauthorization - consult with your doctor</li> </ul>	80% after in-network deductible	80% after in-network deductible

## Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a <b>participating</b> ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization of male reproductive organs	80% after in-network deductible	60% after out-of-network deductible
<b>Note:</b> For voluntary sterilization of female reproductive organs, see " <b>Preventive care services.</b> "		
Voluntary abortions	80% after in-network deductible	60% after out-of-network deductible

## Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a <b>designated</b> 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) - in designated facilities <b>only</b>
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
<b>Note:</b> BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	80% after in-network deductible	60% 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 or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit or medical online visit, we will process the claim under your office visit or medical online visit benefit.

Benefits	In-network	Out-of-network
<b>Inpatient</b> mental health care and <b>inpatient</b> substance use disorder treatment	80% after in-network deductible	60% after out-of-network deductible
		Unlimited days

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Benefits	In-network	Out-of-network
Residential psychiatric treatment facility: <ul style="list-style-type: none"> <li>covered mental health services <b>must</b> be performed in a residential psychiatric treatment facility</li> <li>treatment <b>must</b> be preauthorized</li> <li>subject to medical criteria</li> </ul>	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> <li>Facility and clinic</li> </ul>	80% after in-network deductible	80% after in-network deductible in participating facilities <b>only</b>
<ul style="list-style-type: none"> <li>Online visits</li> </ul> <p><b>Note:</b> Online visits by a vendor are not covered.</p>	\$20 copay per online visit	60% after out-of-network deductible
<ul style="list-style-type: none"> <li>Physician's office</li> </ul>	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities <b>only</b>	80% after in-network deductible	60% 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	Not covered	Not covered
<p><b>Note:</b> 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).</p>		
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not covered	Not covered
Other covered services, including mental health services, for autism spectrum disorder	Not covered	Not covered

## Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP)	<ul style="list-style-type: none"> <li>80% after in-network deductible for diabetes medical supplies</li> <li>100% (no deductible or copay/coinsurance) for diabetes self-management training</li> </ul>	60% after out-of-network deductible
<p><b>Note:</b> Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider.</p> <p><b>Note:</b> When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.</p>		
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$20 copay per visit	60% after out-of-network deductible

Limited to a **combined** 24-visit maximum per member per calendar year

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Benefits	In-network	Out-of-network
Outpatient physical, speech and occupational therapy - provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible  <b>Note:</b> Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a <b>combined</b> 60-visit maximum per member per calendar year	
Durable medical equipment  <b>Note:</b> 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.	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	70% after in-network deductible	50% after out-of-network deductible
Special foods and formulas for Metabolic diseases	Not covered	Not covered

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## NON-UNION RETIREES

A1MTX8

0070118910022

Preferred Rx Program ASC

Effective Date: On or after January 2024

### Benefits-at-a-glance

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**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 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](http://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](http://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

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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
<b>Generic or select prescribed over-the-counter drugs</b>	1 to 30-day period	You pay nothing	You pay nothing	You pay nothing	You pay 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay nothing	No coverage	No coverage
	84 to 90-day period	You pay nothing	You pay nothing	No coverage	No coverage
<b>Preferred brand-name drugs</b>	1 to 30-day period	You pay \$30 copay	You pay \$30 copay	You pay \$30 copay	You pay \$30 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$30 copay	No coverage	No coverage
	84 to 90-day period	You pay \$30 copay	You pay \$30 copay	No coverage	No coverage
<b>Nonpreferred brand-name drugs</b>	1 to 30-day period	You pay \$30 copay	You pay \$30 copay	You pay \$30 copay	You pay \$30 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$30 copay	No coverage	No coverage
	84 to 90-day period	You pay \$30 copay	You pay \$30 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	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
Prescribed over-the-counter drugs - when covered by BCBSM	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 <b>generic</b> and <b>select brand-name</b> 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 <b>brand-name</b> 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

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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
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
FDA-approved <b>generic</b> and <b>select brand-name</b> prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved <b>brand-name</b> prescription contraceptive medication (non-self-administered drugs are not covered)	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
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs	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
<b>Note:</b> Needles and syringes have no copay/coinsurance.				
Select diabetic supplies and devices (test strips, lancets and glucometers)	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
For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at <a href="http://BCBSM.com/pharmacy">BCBSM.com/pharmacy</a> .				

\* 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	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> <li>• <b>Generic drug tier</b> - 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.</li> <li>• <b>Preferred brand-name drug tier</b> - This tier includes non-specialty preferred brand-name drugs. These drugs are more expensive than generic and members pay more for them.</li> <li>• <b>Nonpreferred brand-name drug tier</b> - 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.</li> </ul>
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## Features of your prescription drug plan

Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM <b>before</b> select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. <b>Step Therapy</b> , 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> .
Mandatory preauthorization	<p>A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications <b>before</b> prescribing a more expensive brand-name drug. It applies only to prescriptions being filled for the first time of a targeted medication.</p> <p>Before filling your <b>initial</b> prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at <a href="http://bcbsm.com/pharmacy">bcbsm.com/pharmacy</a>, <b>along with the preferred medications</b>.</p> <p>If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect <b>all</b> targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.</p>
Elective lifestyle drugs	<p>Benefits are excluded for elective lifestyle drugs.</p> <p><b>Note:</b> Elective lifestyle drugs are lifestyle drugs that treat sexual impotency or infertility, or help in weight loss. They are not designed to treat acute or chronic illnesses. These medications are prescribed for medical conditions that have no demonstrable physical harm if not treated. (Smoking cessation drugs are not considered an elective lifestyle drug and are a payable benefit.) BCBSM determines when a drug is an elective drug.</p>
Maximum allowable cost drugs	<p>When you receive a generic maximum allowable cost (MAC) drug from an in-network pharmacy, you pay your cost sharing as noted in your coverage.</p> <p>Select brand-name drugs will apply the generic cost share amount found in your cost-share rider. To determine your cost share tier please refer to our website: <a href="http://www.bcbsm.com/pharmacy">www.bcbsm.com/pharmacy</a>.</p>
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

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