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# Simply Blue<sup>SM</sup> HSA PPO Plan 2000/0% LG Medical Coverage with Prescription Drugs Benefits-at-a-Glance

**Effective for groups on their plan year**

Online visit benefits available 07/01/2016

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.

**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 disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

## In-network

## Out-of-network \*

### 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.

	In-network	Out-of-network *
<b>Deductibles</b> <b>Note:</b> Your deductible <b>combines</b> deductible amounts paid under your Simply Blue HSA medical coverage <b>and</b> your Simply Blue prescription drug coverage. <b>Note:</b> The full family deductible <b>must</b> be met under a two-person or family contract before benefits are paid for any person on the contract.	\$2,000 for a one-person contract or \$4,000 for a family contract (2 or more members) each calendar year <b>(no 4<sup>th</sup> quarter carry-over)</b>	\$4,000 for a one-person contract or \$8,000 for a family contract (2 or more members) each calendar year <b>(no 4<sup>th</sup> quarter carry-over)</b>
<b>Flat-dollar copays</b>	See "Prescription Drugs" section	See "Prescription Drugs" section
<b>Coinsurance amounts (percent copays)</b> <b>Note:</b> Coinsurance amounts apply once the deductible has been met.	None	20% of approved amount for most covered services
<b>Annual out-of-pocket maximums</b> – applies to deductibles and coinsurance amounts for all covered services – including prescription drugs cost-sharing amounts	\$3,000 for a one-person contract or \$6,000 for a family contract (2 or more members) each calendar year	\$6,000 for a one-person contract or \$12,000 for a family contract (2 or more members) each calendar year
<b>Lifetime dollar maximum</b>	None	

\* 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. Cost-sharing may differ when you obtain covered services outside of Michigan. 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.

**In-network**

**Out-of-network \***

**Preventive care services**

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), one 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 sterilizations for females	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% 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) <b>Note:</b> Subsequent medically necessary mammograms performed during the <b>same</b> calendar year are subject to your deductible and coinsurance. One per member per calendar year	80% 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.
Routine screening colonoscopy	100% (no deductible or copay/coinsurance) for routine colonoscopy <b>Note:</b> Medically necessary colonoscopies performed during the <b>same</b> calendar year are subject to your deductible and coinsurance. One routine colonoscopy per member per calendar year	80% after out-of-network deductible

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**In-network**

**Out-of-network \***

**Physician office services**

Office visits – must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits – must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations – must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Online visits – must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits – must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

**Emergency medical care**

Hospital emergency room	100% after in-network deductible	100% after in-network deductible
Ambulance services – must be medically necessary	100% after in-network deductible	100% after in-network deductible

**Diagnostic services**

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

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

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

**Hospital care**

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies <b>Note:</b> Nonemergency services must be rendered in a <b>participating</b> hospital.	100% after in-network deductible	80% after out-of-network deductible
Unlimited days		
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible

**Alternatives to hospital care**

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

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**In-network**

**Out-of-network \***

**Surgical services**

Surgery – includes related surgical services and medically necessary facility services by a <b>participating</b> ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization for males <b>Note:</b> For voluntary sterilizations for females, see “Preventive care services.”	100% after in-network deductible	80% after out-of-network deductible
Elective abortions	Not covered	Not covered

**Human organ transplants**

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% after in-network deductible	100% after in-network deductible – in designated facilities <b>only</b>
Bone marrow transplants – must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials <b>Note:</b> BCBSM covers clinical trials in compliance with PPACA.	100% after in-network deductible	80% after out-of-network deductible
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

**Mental health care and substance abuse treatment**

<b>Inpatient</b> mental health care and <b>inpatient</b> substance abuse treatment	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services <b>must</b> be performed in a residential psychiatric treatment facility • treatment <b>must</b> 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 <b>only</b>
	• Physician’s office	80% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities <b>only</b>	100% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

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**In-network**

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**Autism spectrum disorders, diagnoses and treatment**

Applied behavioral analysis (ABA) treatment – when rendered by an approved board-certified behavioral analyst – is covered through age 18, subject to preauthorization <b>Note:</b> 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.	100% after in-network deductible	100% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible
	Physical, speech and occupational therapy <b>with an autism diagnosis</b> is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible

**Other covered services**

Outpatient Diabetes Management Program (ODMP) <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. <b>Note:</b> When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	100% after in-network deductible	80% after out-of-network deductible
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% after in-network deductible	80% after out-of-network deductible
	Limited to a <b>combined</b> 12-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy – when provided for rehabilitation	100% after in-network deductible	80% after out-of-network deductible <b>Note:</b> Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a <b>combined</b> 30-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.	100% after in-network deductible	100% after in-network deductible
Prosthetic and orthotic appliances	100% after in-network deductible	100% after in-network deductible
Private duty nursing care	100% after in-network deductible	100% after in-network deductible

**See Prescription Drug Coverage Benefits-at-a-Glance for prescription drug benefits.**

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