



## Simply Blue<sup>SM</sup> PPO HSA – Plan 3000/0% 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, copay and/or coinsurance. For a complete description of benefits, please see the applicable BCBSM certificates and riders if your group is underwritten or your summary plan description 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.

### In-network

### Out-of-network \*

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

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

	In-network	Out-of-network *
<b>Deductibles</b> <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.	\$3,000 for a one-person contract or \$6,000 for a family contract (2 or more members) each calendar year ( <b>no 4<sup>th</sup> quarter carry-over</b> )	\$6,000 for a one-person contract or \$12,000 for a family contract (2 or more members) each calendar year ( <b>no 4<sup>th</sup> quarter carry-over</b> )
	Deductibles are based on amounts defined annually by the federal government for Simply Blue HSA-related health plans. Please call your customer service center for an annual update.	
<b>Fixed dollar copays</b>	None	None
<b>Coinsurance amounts</b> <b>Note:</b> Coinsurance amounts apply once the deductible has been met.	None	20% of approved amount
<b>Annual coinsurance maximums</b>	Not applicable	\$1,000 for a one-person contract or \$2,000 for a family contract (2 or more members) each calendar year
<b>Lifetime dollar maximum</b>	None	

#### Preventive care services

	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	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Well-baby and child care visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> <li>• 6 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

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

\* Services from a provider for which there is no Michigan PPO network and services from a non-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, *continued***

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 same calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible <b>Note:</b> Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
	One per member per calendar year	
Routine screening colonoscopy	100% for routine colonoscopy (no deductible or copay/coinsurance) <b>Note:</b> Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	80% after out-of-network deductible
	One routine colonoscopy per member per calendar year	

**Physician office services**

Office visits	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits	100% after in-network deductible	80% after out-of-network deductible
Office consultations	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits	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**

Prenatal and postnatal care	100% after in-network deductible	80% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	100% after in-network deductible	80% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	

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**In-network**

**Out-of-network \***

**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 – must be provided through a <b>participating</b> hospice program	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		
Home health care – must be medically necessary and provided by a <b>participating</b> hospital	100% after in-network deductible	100% after in-network deductible
Home infusion therapy – must be medically necessary and given by <b>participating</b> home infusion therapy providers	100% after in-network deductible	100% after in-network deductible

**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	100% after in-network deductible	80% after out-of-network deductible
<b>Human organ transplants</b>		
Specified human organ transplants – in designated facilities only, when 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 – when 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	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

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**In-network**

**Out-of-network \***

**Mental health care and substance abuse treatment**

**Note:** If your employer has **51 or more** employees (including seasonal and part-time) and is subject to the MHP law, covered mental health and substance abuse services are subject to the following coinsurance amounts. Mental health and substance abuse coinsurance amounts are included in the annual coinsurance maximums for all covered services. See “Annual coinsurance maximums” section for this amount. If you receive your health care benefits through a collectively bargained agreement, please contact your employer and/or union to determine when or if this benefit level applies to your plan.

Inpatient mental health care and inpatient substance abuse treatment	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Outpatient mental health care	100% after in-network deductible	80% after out-of-network deductible, in participating facilities <b>only</b>
Outpatient substance abuse treatment – in approved facilities <b>only</b>	100% after in-network deductible	100% after in-network deductible

**Note:** If your employer has **50 or fewer** employees (all employees, not just eligible employees), covered mental health and substance abuse services are subject to the following coinsurance amounts. Mental health and substance abuse coinsurance amounts are **not** limited to a coinsurance maximum.

Inpatient mental health care and inpatient substance abuse treatment	100% after in-network deductible	80% after out-of-network deductible
	Limited to a <b>combined</b> maximum of 60 days per member per calendar year with a lifetime maximum of 120 days	
Outpatient mental health care	100% after in-network deductible	80% after out-of-network deductible, in participating facilities <b>only</b>
	Limited to a maximum of 120 visits per member per calendar year	
Outpatient substance abuse treatment – in approved facilities <b>only</b>	100% after in-network deductible	100% after in-network deductible
	Up to the state-dollar amount that is adjusted annually	

**Other covered services**

Outpatient Diabetes Management Program (ODMP)	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> maximum of 12 visits per member per calendar year	
Outpatient physical, speech and occupational therapy – 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> maximum of 30 visits per member per calendar year	
Durable medical equipment	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	100% after in-network deductible	100% after in-network deductible
Prescription drugs	Not covered	Not covered

**Optional riders**

<b>Rider SB-HSA-CSR</b> , cost sharing requirements	Changes the member's cost sharing requirements for out-of-state services. Covered services obtained outside the state of Michigan are paid at the approved amount for covered services provided by a Michigan non-network provider; exceptions apply. Special guidelines apply to “Out-of-area services.” <b>Note:</b> This rider is available only to groups in the Upper Peninsula.
<b>Rider XVA</b> , excludes voluntary abortions	Excludes benefits for voluntary abortions.

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