Simply Blue[SM] PPO HRA – Plan 2500
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.

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 *
Deductibles	$2,500 for one member, $5,000 for the family (when two or more members are covered under your contract) each calendar year	$5,000 for one member, $10,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also apply toward the in-network deductible.
Fixed dollar copays	• $30 copay for office visits • $30 copay for urgent care visits • $150 copay for emergency room visits	$150 copay for emergency room visits
Coinsurance amounts **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing • 20% of approved amount for most other covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse coinsurance amounts.	• 50% of approved amount for private duty nursing • 40% of approved amount for most other covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse coinsurance amounts.
Annual coinsurance maximums – applies to coinsurance amounts for all covered services – including mental health and substance abuse services – but **does not** apply to fixed dollar copays and private duty nursing coinsurance amounts **Note:** For groups with 50 or fewer employees or groups that are **not** subject to the MHP law, mental health care and substance abuse treatment coinsurance amounts **do not** contribute to the coinsurance maximum.	$2,500 for one member, $5,000 for two or more members each calendar year	$5,000 for one member, $10,000 for two or more members each calendar year **Note:** Out-of-network coinsurance amounts also apply toward the in-network maximum.
Lifetime dollar maximum	None	

***** 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		
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) • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible **Note:** 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	
Colonoscopy – routine or medically necessary	100% for routine colonoscopy (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	60% after out-of-network deductible
	One routine colonoscopy per member per calendar year	

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	In-network	Out-of-network *
Physician office services		
Office visits – must be medically necessary	$30 copay per office visit **Note:** Simply Blue applies deductibles and coinsurance to office visit services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office 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	$30 copay per office visit	60% after out-of-network deductible
Urgent care visits		
Urgent care visits	$30 copay per office visit	60% after out-of-network deductible
Emergency medical care		
Hospital emergency room	$150 copay per visit (copay waived if admitted)	$150 copay per visit (copay waived if admitted)
Ambulance services – must be medically necessary	80% after in-network deductible	80% after in-network deductible
Diagnostic services		
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		
Prenatal and postnatal care	80% after in-network deductible	60% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	80% after in-network deductible	60% after out-of-network deductible
	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

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	In-network	Out-of-network *

Alternatives to hospital care

Skilled nursing care – must be in a **participating** 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 – must be provided through a **participating** hospice program	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 **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – must be medically necessary and provided by a **participating** hospital	80% after in-network deductible	80% after in-network deductible
Home infusion therapy – must be medically necessary and given by **participating** home infusion therapy providers	80% after in-network deductible	80% after in-network deductible

Surgical services

Surgery – includes related surgical services and medically necessary facility services by a **participating** 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	80% after in-network deductible	60% after out-of-network deductible

Human organ transplants

Specified human organ transplants – in designated facilities only, when 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 **only**
Bone marrow transplants – when 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
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

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	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Outpatient mental health care		
• Facility and clinic	80% after in-network deductible	80% after in-network deductible
• Physician's office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities **only**	80% after in-network deductible	80% after in-network deductible

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	In-network	Out-of-network *

Mental health care and substance abuse treatment, *continued*

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	50% after in-network deductible	50% after out-of-network deductible
	Limited to a **combined** maximum of 60 days per member per calendar year with a lifetime maximum of 120 days	
Outpatient mental health care • Facility and clinic	50% after in-network deductible	50% after in-network deductible
• Physician's office	50% after in-network deductible	50% after out-of-network deductible
	Limited to a maximum of 50 visits per member per calendar year with a lifetime maximum of 120 visits	
Outpatient substance abuse treatment – in approved facilities **only**	50% after in-network deductible	50% after in-network deductible
	Up to the state-dollar amount that is adjusted annually	

Other covered services

Outpatient Diabetes Management Program (ODMP)	80% after in-network deductible	60% after out-of-network deductible
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$30 copay per office visit	60% after out-of-network deductible
	Limited to a **combined** maximum of 12 visits per member per calendar year	
Outpatient physical, speech and occupational therapy – provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** maximum of 30 visits per member per calendar year	
Durable medical equipment	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	50% after in-network deductible	50% after in-network deductible
Prescription drugs	Not covered	Not covered

Optional riders

Rider SB-HRA-CSR, 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." **Note:** This rider is available only to groups in the Upper Peninsula.
Rider SB-HRA-ET $250, emergency treatment copay requirement	Increases copay for facility emergency room treatment to $250 per visit.
Rider SB-HRA-UC $40, urgent care copay	Increases copay for urgent care visits to $40 per visit
Rider SB-HRA-OV $40, office visit copay	Increase copay for office visits and office consultations to $40. **Note:** Rider SB-HRA-OV $40 must be paired with riders SB-HRA-ET $250 and SB-HRA-UC $40.
Rider XVA, excludes voluntary abortions	Excludes benefits for voluntary abortions.
Blue Advantage Rx certificate	Allows BCBSM members to purchase eligible prescription drugs and supplies from network pharmacies at the Blues' negotiated rate rather than full price. **Note:** Optional prescription drug riders are **not** available with this plan.

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Preferred Rx Program certificate	Provides benefits for FDA-approved and state-controlled drugs, injectable insulin, and needles and syringes. Benefits are payable at 100% of the BCBSM-approved amount, less the member's copay when obtained from a Preferred Rx network pharmacy (in Michigan) or a Medco network pharmacy (outside Michigan). When a member chooses to go to a non-network pharmacy (a pharmacy **not** in the Preferred Rx or Medco networks), benefits are payable at 75% of the BCBSM-approved amount, less the member's copay. Coverage also requires dispensing of generic equivalent and co-branded formulary drugs. Benefits for contraceptive drugs and drugs dispensed for cosmetic purposes are not included. **Note:** When selecting prescription coverage, you **must** select one of the following triple-tier copay riders.
• **Riders PD-TTC $5/$25/$50** and **PD-RX-CM** (open formulary)	Imposes a triple-tier copay for prescription drugs. Included are provisions for up to a 90-day supply of prescription drugs, a revised MAC program and the mail-order program.
• **Riders PD-TTC $15/$30/$60** and **PD-RX-CM** (open formulary)	Imposes a triple-tier copay for prescription drugs. Included are provisions for up to a 90-day supply of prescription drugs, a revised MAC program and the mail-order program.
• **Rider PD-TTC $7/$35/$70-RXCM** (open formulary)	Imposes a triple-tier copay for prescription drugs. Included are provisions for up to a 90-day supply of prescription drugs, a revised MAC program and the mail-order program.
• **Rider PD-TTC $10/$40/$80-RXCM** (open formulary)	Imposes a triple-tier copay for prescription drugs. Included are provisions for up to a 90-day supply of prescription drugs, a revised MAC program and the mail-order program.
• **Rider PD-TTC $15/$50/50%/$70/ $100-RXCM** (open formulary)	Imposes a triple-tier copay for prescription drugs. Adds: provisions for up to a 90-day supply of prescription drugs when obtained from the 90-Day Retail Network, a Mandatory Maximum Allowable Cost (MAC) program, a Mandatory Preauthorization program, and the mail-order drug program
• **Rider PD-TTC $20/$60/50%/$80/$100-RXCM** (open formulary)	Imposes a triple-tier copay for prescription drugs. Adds: provisions for up to a 90-day supply of prescription drugs when obtained from the 90-Day Retail Network, a Mandatory Maximum Allowable Cost (MAC) program, a Mandatory Preauthorization program, and the mail-order drug program.
Rider CI, contraceptive injections **Rider PCD**, prescription contraceptive devices **Rider PD-CM**, prescription contraceptive medications	Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and intrauterine devices, and FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered). **Note:** These riders are only available as part of a prescription drug package. Riders CI and PCD are part of your medical-surgical coverage, subject to the same deductible and copay, if any, you pay for medical-surgical services. (Rider PCD waives the copay for services provided by a network provider.) Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.
Rider PD-XED, excludes elective drugs	Excludes coverage for all elective lifestyle drugs. **Note:** Elective lifestyle drugs are lifestyle drugs such as those that treat sexual impotency or infertility or help in weight loss or help to stop smoking. They are not designed to treat acute or chronic illnesses or prescribed for medical conditions that have no demonstrable physical harm if not treated. **Note:** This rider is not available for MHP impacted groups.
Rider PD-XED-MHP, excludes elective drugs	Excludes coverage for elective lifestyle drugs. **Note:** Elective lifestyle drugs are lifestyle drugs such as those that treat sexual impotency or infertility or help in weight loss. They are not designed to treat acute or chronic illnesses or 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 when members are enrolled in this rider**.) **Note:** If your employer has **51 or more** employees (including seasonal and part-time) and is subject to the MHP law, this rider must be taken to be MHP compliant.

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