



**Group #17305-001**  
**Effective March 1, 2011**

## Simply Blue<sup>SM</sup> PPO HSA – Plan 1250/0% Medical Coverage with Prescription Drug Coverage

Benefits-at-a-Glance w/CI, PCD, PDCM

The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This BAAG is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

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 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 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> Your deductible combines deductible amounts paid under your Simply Blue HSA medical coverage and your Simply Blue prescription drug coverage. <b>Note:</b> The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract.	\$1,250 for a one person contract or \$2,500 for a family contract (2 or more members) each calendar year (no 4 <sup>th</sup> quarter carry-over)	\$2,500 for a one person contract or \$5,000 for a family contract (2 or more members) each calendar year (no 4 <sup>th</sup> quarter carry-over)
	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>	Based on prescription drug copay rider selected	Based on prescription drug copay rider selected
<b>Coinsurance amounts</b> <b>Note:</b> Coinsurance amounts apply once the deductible has been met.	None	20% of approved amount
<b>Annual coinsurance/copay maximums –</b> <b>Note:</b> Your coinsurance/copay dollar maximum <b>combines</b> coinsurance/copay amounts paid under your Simply Blue HSA medical coverage and your Simply Blue prescription drug coverage.	\$1,000 for a one person contract or \$2,000 for a family contract (2 or more members) each calendar year – applies to prescription drug copays	\$2,000 for a one person contract or \$4,000 for a family contract (2 or more members) each calendar year
<b>Lifetime dollar maximum</b>	None	

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**

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
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 percent copay. <hr style="border-top: 1px dashed black;"/> One per member per calendar year	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.
Colonoscopy – routine or medically necessary	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. <hr style="border-top: 1px dashed black;"/> 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	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	

**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 120 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 (after reaching dollar maximum, member transitions into individual case management)	
Home health care – must be medically necessary and provided by a <b>participating</b> home health care agency	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

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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	100% after in-network deductible	80% 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% 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

**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 • Facility and clinic  • Physician’s office	100% after in-network deductible	100% after in-network deductible, in participating facilities <b>only</b>
	100% after in-network deductible **	80% after out-of-network deductible
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 combined maximum of 60 days per member per calendar year with a lifetime maximum of 120 days	
Outpatient mental health care • Facility and clinic  • Physician’s office	100% after in-network deductible	80% after in-network deductible, in participating facilities <b>only</b>
	100% after in-network deductible	80% after out-of-network deductible
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	

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**In-network**

**Out-of-network \***

**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

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## Prescription Drug Coverage

### Benefits-at-a-Glance

**Specialty Drugs** – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira® ) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at [bcbsm.com](http://bcbsm.com). Log in under "I am a Member." If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

**BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your coinsurance/copay will be reduced by one-half for this initial fill (15 days) once applicable deductibles have been met.**

**Maximum Allowable Cost** – If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug with a generic equivalent, you **MUST** pay the difference in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug plus your applicable copay regardless of whether you or your physician requests the brand-name drug. Exception: If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay.

**Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

#### Network pharmacy

#### Non-network pharmacy

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

**Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and annual coinsurance/copay maximum required under your Simply Blue HSA medical coverage.** Benefits are **not** payable until after you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are required to pay applicable prescription drug copays which are subject to your annual coinsurance/copay dollar maximums.

	Network pharmacy	Non-network pharmacy
<b>Deductibles (each calendar year)</b> <b>Note:</b> the full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract.	Same as Simply Blue HSA medical coverage <b>(no 4th quarter carry-over)</b>  <b>Note:</b> Includes deductible amounts paid under your Simply Blue HSA medical coverage.	Same as Simply Blue HSA medical coverage <b>(no 4th quarter carry-over)</b>  <b>Note:</b> Includes deductible amounts paid under your Simply Blue HSA medical coverage.
<b>Fixed dollar copays</b> <b>Note:</b> Fixed dollar copays apply once the deductible has been met.	Based on prescription drug copay rider selected	Based on prescription drug copay rider selected
<b>Coinsurance amounts</b>	None	None
<b>Annual coinsurance/copay maximums</b>	\$1,000 for a one-person contract or \$2,000 for a family contract (2 or more members) each calendar year – applies to prescription drug copays	\$2,000 for a one-person contract or \$4,000 for a family contract (2 or more members) each calendar year  <b>Note:</b> Includes coinsurance/copay amounts paid under your Simply Blue HSA medical coverage.
<b>Lifetime dollar maximum</b>	None	

A network pharmacy is a Preferred Rx pharmacy in Michigan or a Medco pharmacy outside Michigan. Medco is an independent company providing pharmacy benefit services for Blues members. A non-network pharmacy is a pharmacy NOT in the Preferred Rx or Medco networks.



**Network pharmacy**

**Non-network pharmacy**

**Covered services**

FDA-approved drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay <i>plus</i> an additional 20% prescription drug out-of-network copay
State-controlled drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay <i>plus</i> an additional 20% prescription drug out-of-network copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs <b>Note:</b> Needles and syringes have no copay.	Subject to Simply Blue HSA medical deductible and prescription drug copay	Subject to Simply Blue HSA medical deductible and prescription drug copay <i>plus</i> an additional 20% prescription drug out-of-network copay
Mail order (home delivery) prescription drugs – up to a 90-day supply of medication by mail from Medco (BCBSM network mail order provider)	Subject to Simply Blue HSA medical deductible and prescription drug copay	No coverage

**Riders**

<b>Rider CI</b> , contraceptive injections <b>Rider PCD</b> , prescription contraceptive devices <b>Rider PD-CM</b> , 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). <b>Note:</b> 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.
<b>Preferred Rx Program certificate</b>	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.
<b>Rider PD-TTC \$7/\$35/\$70-RXCM (open formulary)</b>	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.

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