



Blue Cross
Blue Shield
of Michigan

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

COUNTY OF CALHOUN

Flexible Blue PPO HSASM 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. 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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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.

Benefits	In-network	Out-of-network
Deductibles Note: Your deductible combines deductible amounts paid under your Simply Blue HSA medical coverage and your prescription drug coverage under another insurer. Note: The full family deductible must 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 (no 4th quarter carry-over)	\$4,000 for a one-person contract or \$8,000 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)
Flat-dollar copays	None	None
Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.	<ul style="list-style-type: none"> 20% of approved amount for most covered services 	<ul style="list-style-type: none"> 40% of approved amount for most covered services
Annual out-of-pocket maximums - your annual out-of-pocket maximum include amounts you paid for covered services under your BCBSM certificate and your prescription drug coverage under another insurer.	\$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
Lifetime dollar maximum	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 Note: 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 Note: 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)	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)	60% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible

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Benefits	In-network	Out-of-network
Well-baby and child care visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> • 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) Note: 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 Note: 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		
Routine screening colonoscopy	100% (no deductible or copay/coinsurance) for routine colonoscopy Note: Medically necessary colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	60% after out-of-network deductible
One routine colonoscopy per member per calendar year		

Physician office services		
Benefits	In-network	Out-of-network
Office visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Online visits - by physician or BCBSM selected vendor must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Employer on-site clinic	100% (no deductible or copay/coinsurance)	Not covered
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible

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Benefits	In-network	Out-of-network
Office consultations - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Urgent care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	80% after in-network deductible	80% after in-network deductible
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

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	80% after in-network deductible	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

Unlimited days

Note: Nonemergency services must be rendered in a **participating** hospital.

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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Alternatives to hospital care

Benefits	In-network	Out-of-network
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 90 days per member per calendar year
Hospice care	80% after in-network deductible	80% after in-network deductible 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 (after reaching dollar maximum, member transitions into individual case management)
Home health care: <ul style="list-style-type: none"> • must be medically necessary • must be provided by a participating home health care agency 	80% after in-network deductible	80% after in-network deductible
Infusion therapy: <ul style="list-style-type: none"> • must be medically necessary • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization - consult with your doctor 	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 participating ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	80% after in-network deductible	60% after out-of-network deductible
Voluntary sterilization for males	80% after in-network deductible	60% after out-of-network deductible
Note: For voluntary sterilizations for females, see " Preventive care services. "		
Voluntary abortions	80% after in-network deductible	60% after out-of-network deductible
Bariatric Surgery	Not covered	Not covered

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	80% after in-network deductible - in designated facilities only
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
Note: BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

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Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance treatment	80% after in-network deductible	60% after out-of-network deductible
Unlimited days		
Residential psychiatric treatment facility: <ul style="list-style-type: none"> covered mental health services must be performed in a residential treatment facility treatment must be preauthorized subject to medical criteria 	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> Facility and clinic 	80% after in-network deductible	80% after in-network deductible in participating facilities only
<ul style="list-style-type: none"> Online visits <p>Note: Online visits by a vendor are not covered.</p>	80% after in-network deductible	60% after out-of-network deductible
<ul style="list-style-type: none"> Physician's office 	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities only	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 behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization	Not covered	Not covered
<p>Note: 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.</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)	80% after in-network deductible	60% after out-of-network deductible
<p>Note: 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>Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.</p>		
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible

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Benefits	In-network	Out-of-network
Chiropractic spinal manipulation and osteopathic manipulative therapy	80% after in-network deductible	60% after out-of-network deductible
	Limited to a combined 24-visits maximum 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 60-visits maximum per member per calendar year	
Durable medical equipment	80% after in-network deductible	80% after in-network deductible
Note: 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.		
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	80% after in-network deductible	80% after in-network deductible
Prescription drugs	Not covered	Not covered

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Vision Coverage

Effective Date: On or after January 2022

Benefits-at-a-glance

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Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com**.

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

Member's responsibility (copays)		
Benefits	VSP network doctor	Non-VSP provider
Eye exam	\$5 copay	\$5 copay applies to charge
Prescription glasses (lenses and/or frames)	Combined \$10 copay	Member responsible for difference between approved amount and provider's charge, after \$10 copay
Medically necessary contact lenses	\$10 copay	Member responsible for difference between approved amount and provider's charge, after \$10 copay
Note: No copay is required for prescribed contact lenses that are not medically necessary.		

Eye exam		
Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	\$5 copay	Reimbursement up to \$50 less \$5 copay (member responsible for any difference)
One eye exam each calendar year		

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Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.	\$10 copay (one copay applies to both lenses and frames)	Reimbursement up to approved amount based on lens type less \$10 copay (member responsible for any difference)
	One pair of lenses, with or without frames, per calendar year	
Standard frames	\$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less \$10 copay (one copay applies to both frames and lenses)	Reimbursement up to \$70 less \$10 copay (member responsible for any difference)
Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	One frame per calendar year	

Contact Lenses

Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	\$10 copay	Reimbursement up to \$210 less \$10 copay (member responsible for any difference)
	Contact lenses up to the allowance per calendar year	
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	\$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	\$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Contact lenses up to the allowance per calendar year	

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Hearing Care Coverage Effective Date: On or after January 2022 Benefits-at-a-glance

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Member's responsibility (deductible and copay)

Note: Limited to a benefit maximum of \$3,000 for monaural hearing aids, \$6,000 for binaural hearing aids every 36 months per member for participating providers

Benefits	Participating provider	Nonparticipating provider
Deductible	Your Simply Blue HSA hearing care benefits are subject to the same deductible required under your Simply Blue HSA medical coverage. Hearing care benefits are not payable until after you have met the Simply Blue HSA annual deductible.	Not applicable
Copay/coinsurance	Your Simply Blue HSA hearing care benefits are subject to the same coinsurance required under your Simply Blue HSA medical coverage.	Not applicable

Covered services

You **must** receive the following services from a **hearing participating provider**. Hearing care services are **not** covered when performed by nonparticipating providers unless the services are performed outside of Michigan and the local Blue Cross and Blue Shield plan does **not** contract with providers for hearing care services. In this case, BCBSM will pay the approved amount for hearing aids and related covered services obtained from a nonparticipating provider. You may be responsible for charges that exceed our approved amount.

If you select a digitally controlled programmable hearing device, you may be responsible for charges that exceed the cost of a covered hearing aid

Benefits	Participating provider	Nonparticipating provider
Audiometric exam - one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered
Hearing aid evaluation - one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered
Ordering and fitting the hearing aid (a monaural or binaural hearing aid) - one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered

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Benefits	Participating provider	Nonparticipating provider
Hearing aid conformity test- one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered

Note: You **must** obtain a medical evaluation (sometimes called a medical clearance exam) of the ear performed by a physician-specialist before you receive your hearing aid. If a physician-specialist is not accessible, your primary care doctor may perform the medical evaluation. **This evaluation is not covered under your hearing care coverage, so you must pay for this exam unless your medical coverage includes coverage for office visits.**

A physician-specialist is a licensed doctor of medicine or osteopathy who is also board certified or in the process of being board certified as an otolaryngologist. A physician-specialist determines whether a patient has a hearing loss and whether such loss can be offset by a hearing aid.

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