



Blue Cross  
Blue Shield  
of Michigan

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

## COUNTY OF CALHOUN SBHSA3500 PLAN

### Simply Blue PPO HSA<sup>SM</sup> 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](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 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
<b>Deductibles</b>	\$3,500 for one member, \$7,000 for the family (when two or more members are covered under your contract) each calendar year <b>(no 4th quarter carry-over)</b>	\$7,000 for one member, \$14,000 for the family (when two or more members are covered under your contract) each calendar year <b>(no 4th quarter carry-over)</b>
<b>Flat-dollar copays</b>	None	None
<b>Coinsurance amounts (percent copays)</b>	None	None
<b>Note:</b> Coinsurance amounts apply once the deductible has been met.		
<b>Annual out-of-pocket maximums</b> - applies to deductibles and coinsurance amounts for all covered services	\$3,500 for a one-person contract \$7,000 for a family contract (2 or more members) each calendar year	\$7,000 for a one-person contract \$14,000 for a family contract (2 or more members) each calendar year
<b>Lifetime dollar maximum</b>	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  <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)	100% 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)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	100% 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"> <li>• 8 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 <b>same</b> calendar year are subject to your deductible and coinsurance.	100% 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.
One per member per calendar year		
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.	100% 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	100% after in-network deductible	100% after out-of-network deductible
Online visits - by physician or <b>BCBSM</b> selected vendor must be medically necessary	100% after in-network deductible	100% 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	100% after in-network deductible	100% after out-of-network deductible

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Benefits	In-network	Out-of-network
Office consultations - must be medically necessary	100% after in-network deductible	100% after out-of-network deductible
Urgent care visits - must be medically necessary	100% after in-network deductible	100% after out-of-network deductible

## Emergency medical care

Benefits	In-network	Out-of-network
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

Benefits	In-network	Out-of-network
Laboratory and pathology services	100% after in-network deductible	100% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	100% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	100% 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)	100% after out-of-network deductible
Postnatal care	100% after in-network deductible	100% after out-of-network deductible
Delivery and nursery care	100% after in-network deductible	100% 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	100% after in-network deductible	100% after out-of-network deductible
Unlimited days		
<b>Note:</b> Nonemergency services must be rendered in a <b>participating</b> hospital.		
Inpatient consultations	100% after in-network deductible	100% after out-of-network deductible
Chemotherapy	100% after in-network deductible	100% 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 <b>participating</b> skilled nursing facility	100% after in-network deductible Limited to a maximum of 90 days per member per calendar year	100% after in-network deductible
Hospice care	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)	100% after in-network deductible
Home health care: <ul style="list-style-type: none"> <li>must be medically necessary</li> <li>must be provided by a <b>participating</b> home health care agency</li> </ul>	100% after in-network deductible	100% after in-network deductible
Infusion therapy: <ul style="list-style-type: none"> <li>must be medically necessary</li> <li>must be given by a <b>participating</b> Home Infusion Therapy (HIT) provider or in a <b>participating</b> freestanding Ambulatory Infusion Center (AIC)</li> <li>may use drugs that require preauthorization - consult with your doctor</li> </ul>	100% after in-network deductible	100% after in-network deductible

## Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a <b>participating</b> ambulatory surgery facility	100% after in-network deductible	100% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	100% after out-of-network deductible
Voluntary sterilization for males	100% after in-network deductible	100% after out-of-network deductible
<b>Note:</b> For voluntary sterilizations for females, see " <b>Preventive care services.</b> "		
Voluntary abortions	100% after in-network deductible	100% after out-of-network deductible
Bariatric surgery or any associated anesthesia services	Not covered	Not covered

## Human organ transplants

Benefits	In-network	Out-of-network
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	100% after out-of-network deductible
Specified oncology clinical trials	100% after in-network deductible	100% after out-of-network deductible
<b>Note:</b> BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	100% after in-network deductible	100% 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	100% after in-network deductible	100% after out-of-network deductible
Unlimited days		
Residential psychiatric treatment facility: <ul style="list-style-type: none"> <li>covered mental health services <b>must</b> be performed in a residential treatment facility</li> <li>treatment <b>must</b> be preauthorized</li> <li>subject to medical criteria</li> </ul>	100% after in-network deductible	100% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> <li>Facility and clinic</li> </ul>	100% after in-network deductible	100% after in-network deductible in participating facilities <b>only</b>
<ul style="list-style-type: none"> <li>Online visits</li> </ul> <p><b>Note:</b> Online visits by a vendor are not covered.</p>	100% after in-network deductible	100% after out-of-network deductible
<ul style="list-style-type: none"> <li>Physician's office</li> </ul>	100% after in-network deductible	100% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities <b>only</b>	100% after in-network deductible	100% 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><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.</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)	100% after in-network deductible	100% after out-of-network deductible
<p><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.</p> <p><b>Note:</b> When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.</p>		
Allergy testing and therapy	100% after in-network deductible	100% after out-of-network deductible

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Benefits	In-network	Out-of-network
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% after in-network deductible Limited to a <b>combined</b> 24-visits maximum per member per calendar year	100% after out-of-network deductible
Outpatient physical, speech and occupational therapy - provided for rehabilitation	100% after in-network deductible Limited to a <b>combined</b> 60-visits maximum per member per calendar year	100% after out-of-network deductible <b>Note:</b> Services at nonparticipating outpatient physical therapy facilities are not covered.
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
Prescription drugs	Not covered	Not covered

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