HSA Plan (Health Savings Account)

Flexible Blue℠ Plan 2 Medical Coverage with Preventive Care, Mammography and RX Benefits Benefits-at-a-Glance for Holland Public Schools #37459-001

This is intended as an easy-to-read summary. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

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

Note: Services without a PPO network and emergency services are covered at the in-network level. **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.** 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
Deductibles **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.	$1,250 for a one-person contract or $2,500 for a family contract (2 or more members) each calendar year (**no 4th 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 4th quarter carry-over**)
	Deductibles are based on amounts defined annually by the federal government for Flexible Blue-related health plans. Please call your customer service center for an annual update.	
Copays • Fixed dollar copays	None	None
• Percent copays	20% of approved amount	40% of approved amount
Copay dollar maximums • Fixed dollar copays	Not applicable	Not applicable
• Percent copays	$1,000 for a one-person contract or $2,000 for a family contract (2 or more members) each calendar year	$2,000 for a one-person contract or $4,000 for a family contract (2 or more members) each calendar year
Dollar maximums	$1 million lifetime per covered specified human organ transplant type and a **separate** $5 million lifetime per member for all other covered services and as noted above for individual services	

Preventive care services – *Payment for preventive services is limited to a combined maximum of $500 per member per calendar year

	In-network	Out-of-network
Health maintenance exam – includes chest X-ray, EKG, cholesterol screening and other select lab procedures	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Gynecological exam	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Well-baby and child care	Covered – 100% (no deductible or copay) * • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Not covered
Childhood immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics	Covered – 100% (no deductible or copay)*	Not covered
Fecal occult blood screening	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered

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	In-network	Out-of-network
Preventive care services, *continued*		
Flexible sigmoidoscopy exam	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Mammography		
Mammography screening	Covered – 100% (no deductible or copay)	Covered – 60% after out-of-network deductible
	One per member per calendar year, no age restriction	
Physician office services		
Office visits	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Outpatient and home medical care visits	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Office consultations	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Urgent care visits	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Emergency medical care		
Hospital emergency room	Covered – 80% after in-network deductible	Covered – 80% after in-network deductible
Ambulance services – must be medically necessary	Covered – 80% after in-network deductible	Covered – 80% after in-network deductible
Diagnostic services		
Laboratory and pathology services	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Diagnostic tests and x-rays	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Therapeutic radiology	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Maternity services provided by a physician		
Prenatal and postnatal care	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
	Includes care provided by a certified nurse midwife	
Delivery and nursery care	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
	Includes delivery 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.	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
	Unlimited days	
Inpatient consultations	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Chemotherapy	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible

	In-network	Out-of-network
Alternatives to hospital care		
Skilled nursing care	Covered – 80% after in-network deductible, in **participating** skilled nursing facilities **only** Limited to 90 days per member per calendar year	
Hospice care	Covered – 80% after in-network deductible, through a **participating** hospice program **only** Limited to dollar maximum that is reviewed and adjusted periodically	
Home health care – must be medically necessary	Covered – 80% after in-network deductible, by a **participating** home health care agency **only**	
Home infusion therapy – must be medically necessary	Covered – 80% after in-network deductible, by **participating** providers **only**	
Surgical services		
Surgery – includes presurgical consultations, related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Colonoscopy	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
	One per member per calendar year	
Voluntary sterilization	Covered – 80% after in-network deductible	Covered – 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 (800-242-3504)	Covered – 80% after in-network deductible, in designated facilities **only,** limited to $1 million **lifetime** maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Specified oncology clinical trials	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Kidney, cornea and skin transplants	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Mental health care and substance abuse treatment		
Inpatient mental health care and inpatient substance abuse treatment	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
	Limited to a **combined** maximum of 60 days per calendar year with 120 days lifetime per member	
Outpatient mental health care	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible, in participating facilities **only**
	Limited to a **combined** maximum of 120 visits per member per calendar year	
Outpatient substance abuse treatment – in approved facilities **only**	Covered – 80% after in-network deductible	Covered – 80% after in-network deductible, in approved facilities **only**
	Limited to annual state-dollar amount (that combines outpatient and residential substance abuse)	
Other covered services		
Outpatient Diabetes Management Program (ODMP)	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Allergy testing and therapy	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible
Chiropractic and Osteopathic manipulative therapy	Covered – 80% after in-network deductible up to 24 visits per member per year	Covered – 60% after in-network deductible up to 24 visits per calendar year

	In-network	Out-of-network

Other covered services, *continued*

Service	In-network	Out-of-network
Outpatient physical, speech and occupational therapy services – provided for rehabilitation	Covered – 80% after in-network deductible	Covered – 60% after out-of-network deductible **Note:** Outpatient physical therapy is **not** covered at nonparticipating facilities.
	Limited to a **combined** maximum of 60 visits per member per calendar year	
Durable medical equipment	Covered – 80% after in-network deductible	Covered – 80% after in-network deductible
Prosthetic and orthotic appliances	Covered – 80% after in-network deductible	Covered – 80% after in-network deductible
Private duty nursing services	Covered – 80% after in-network deductible	Covered – 80% after in-network deductible

Prescription drug coverage

Your Flexible Blue prescription drug benefits, including mail order drugs, are subject to the same deductible, copay, out-of-pocket copay maximum and lifetime dollar maximum required under your Flexible Blue medical coverage.

Benefits are **not** payable until after you have met the Flexible Blue annual deductible.

Note: Effective October 1, 2006, the mail order pharmacy for **specialty drugs** changed to Option Care, 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. Option Care 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 Blue members.) A list of specialty drugs is available on our Web site at **bcbsm.com**. Log in under "I am a Member." If you have any questions, please call Option Care customer service at 866-515-1355.

	Network pharmacy: 80% of approved amount after Flexible Blue medical coverage deductible **Note:** If you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber has not indicated "Dispensed as Written" (DAW) on the prescription, you must pay the difference in cost between the brand name drug dispensed and the maximum allowable cost for the generic, **plus** your copay, if applicable. This cost difference will **not** be applied toward your in-network deductible, nor your out-of-pocket or lifetime maximums, if applicable. **Non-network pharmacy**: 60% of approved amount after Flexible Blue medical coverage deductible (The 20% out-of-network copay will **not** be applied toward your annual Flexible Blue deductible, out-of-pocket copay maximum or lifetime dollar maximum.)

Note: A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a MedImpact pharmacy outside Michigan. MedImpact is an independent company providing pharmacy benefit services for Blue members. A **non-network** pharmacy is a pharmacy NOT in the Preferred Rx or MedImpact networks.

Features of your prescription drug plan

Feature	Description
Drug interchange and generic copay waiver	Certain drugs may not be covered for a second prescription if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at **bcbsm.com**. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at **bcbsm.com**.

Selected riders

Rider CI, Rider PCD2 and Rider PD-CM	Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and IUDs, and Rx only oral or injectable contraceptive medications. **Note**: These riders are only available as a "prescription drug package" with the Flexible Blue Prescription Drug Plan. Riders CI and PCD2 are part of your medical-surgical coverage and Rider PD-CM is part of your prescription drug coverage.
Rider PD-XED	Excludes coverage for elective drugs. **Note**: Elective drugs are lifestyle drugs such as those that treat sexual impotency or infertility, 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.
Rider XVA	Excludes benefits for voluntary abortions.