HOUSE of REPRESENTATIVES
STATE OF MICHIGAN

MEDICAL COVERAGE OPTIONS: January 1, 2025 to December 31, 2025

	COMMUNITY BLUE P.P.O. #1		COMMUNITY BLUE P.P.O. #2		SIMPLY BLUE Health Savings Account	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Costs						
Premium	Single - $8,953 Two Person - $20,764 Family - $26,861		Single - $8,188 Two Person - $18,455 Family - $24,564		Single - $5,788 Two Person - $13,895 Family - $17,367	
Employee Premium Contribution	20%		10%		5%	
Deductible: Annual	• $250 for one member • $500 for the family (when two or more members are covered under your contract) each calendar year	• $500 for one member • $1,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible	• $500 for one member • $1,000 for the family (when two or more members are covered under your contract) each calendar year	• $1,000 for one member • $2,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible	• $2,000 for a one-person contract • $4,000 for a family contract (2 or more members) each calendar year	• $4,000 for a one-person contract • $8,000 for a family contract (2 or more members) each calendar year
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing care • 0% coinsurance for most other covered services	• 50% of approved amount for private duty nursing care • 40% of approved amount for mental health and substance abuse treatment • 40% of approved amount for most other covered services	• 50% of approved amount for private duty nursing care • 10% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)	• 50% of approved amount for private duty nursing care • 40% of approved amount for mental health and substance abuse treatment • 40% of approved amount for most other covered services	20% of approved amount for most covered services	40% of approved amount for most covered services

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Coinsurance Maximum	$0 for most covered services	• $3,000 for one member • $6,000 for two or more members each calendar year **Note:** Out-of-network cost sharing amounts also apply toward the in-network out-of-pocket maximum.	• $1,000 for one member • $2,000 for two or more members each calendar year	• $3,000 for one member • $6,000 for two or more members each calendar year **Note:** Out-of-network cost sharing amounts also apply toward the in-network out-of-pocket maximum.	• $500 for a one-person • $1,000 for a family contract (2 or more members) each calendar year	• $1,000 for a one-person • $2,000 for a family contract (2 or more members) each calendar year
Flat dollar copays	• $10 copay for office visits and office consultations • $10 copay for chiropractic services and osteopathic manipulative therapy • $100 copay for emergency room visits	$100 copay for emergency room visits	• $20 copay for office visits and office consultations • $20 copay for chiropractic services and osteopathic manipulative therapy • $100 copay for emergency room visits	$100 copay for emergency room visits	See "Prescription Drugs" section	See "Prescription Drugs" section
Annual out-of-pocket maximums - applies to deductibles, copays and coinsurance amounts for all covered services - including cost sharing amounts for prescription drugs.	• $6,350 for one member • $12,700 for two or more members each calendar year	• $12,700 for one member • $25,400 for two or more members each calendar year **Note:** Out-of-network cost sharing amounts also apply toward the in-network out-of-pocket maximum.	• $6,350 for one member • $12,700 for two or more members each calendar year	• $12,700 for one member • $25,400 for two or more members each calendar year **Note:** Out-of-network cost sharing amounts also apply toward the in-network out-of-pocket maximum.	• $2,500 for a one-person • $5,000 for a family contract (2 or more members) each calendar year	• $5,000 for a one-person • $10,000 for a family contract (2 or more members) each calendar year
Lifetime dollar maximum	None		None		None	

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventative Care Services One per Member per calendar year						
Health Maintenance Exam -- includes chest x-ray, EKG, cholesterol screening and other select lab procedures	Covered - 100%	Not Covered	Covered - 100%	Not Covered	Covered - 100%	Not Covered
Gynecological Exam	Covered - 100%	Not Covered	Covered - 100%	Not Covered	Covered - 100%	Not Covered
Pap Smear Screening - laboratory and pathology services	Covered - 100%	Not Covered	Covered - 100%	Not Covered	Covered - 100%	Not Covered
Voluntary Sterilizations for females	Covered - 100%	Covered - 60% after deductible	Covered - 100%	Covered - 60% after deductible	Covered - 100%	Covered - 60% after deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	Covered - 100%	Covered - 100% after deductible	Covered - 100%	Covered - 100% after deductible	Covered - 100%	Covered - 60% after deductible
Contraceptive injections	Covered - 100%	Covered - 60% after deductible	Covered - 100%	Covered - 60% after deductible	Covered - 100%	Covered - 60% after deductible
Well-Baby and Child Care	Covered - 100%	Not Covered	Covered - 100%	Not Covered	Covered - 100%	Not Covered

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventative Care Services cont.						
Immunizations - Adult and childhood immunizations as recommended by the Advisory Committee on Immunization practices. **Note**: Immunizations for travel to foreign countries are not covered.	Covered - 100%	Not Covered	Covered - 100%	Not Covered	Covered - 100%	Not Covered
Fecal Occult Blood Screening	Covered - 100%	Not Covered	Covered - 100%	Not Covered	Covered - 100%	Not Covered
Flexible Sigmoidoscopy Exam	Covered - 100%	Not Covered	Covered - 100%	Not Covered	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) Screening	Covered - 100%	Not Covered	Covered - 100%	Not Covered	Covered - 100%	Not Covered
Routine mammogram and related reading	Covered - 100% **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	Covered - 60% after deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by a in-network provider.	Covered - 100% **Note**: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	Covered - 60% after deductible **Note**: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by a in-network provider.	Covered - 100% **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	Covered - 60% after deductible **Note**: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by a in-network provider.

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventative Care Services cont.						
Colonoscopy - routine	Covered - 100% once annually **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	Covered - 60% after deductible	Covered - 100% once annually **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	Covered - 60% after deductible	Covered - 100% once annually	Covered - 60% after deductible
Physician Services						
Office Visits	Covered - $10 copay	Covered - 60% after deductible	Covered - $20 copay	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Outpatient and Home Visits	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Office Consultations	Covered - $10 copay	Covered - 60% after deductible	Covered - $20 copay	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Urgent Care Visits	Covered - $10 copay	Covered - 60% after deductible	Covered - $20 copay	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Medical Care						
Hospital Emergency Room	Covered - $100 copay, waived if admitted or for an accidental injury	Covered - $100 copay, waived if admitted or for an accidental injury	Covered - $100 copay, waived if admitted or for an accidental injury	Covered - $100 copay, waived if admitted or for an accidental injury	Covered - 80% after deductible	Covered - 80% after deductible
Ambulance Services - medically necessary	Covered - 100% after deductible	Covered - 100% after deductible	Covered - 90% after deductible	Covered - 90% after deductible	Covered - 80% after deductible	Covered - 80% after deductible
Diagnostic Services						
Laboratory and Pathology Tests	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests and X-rays	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Therapeutic Radiology	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Maternity Services						
Prenatal care visits	Covered - 100%	Covered - 60% after deductible	Covered - 100%	Covered - 60% after deductible	Covered - 100% after deductible	Covered - 60% after deductible
Postnatal care visit	Covered - 100%	Covered - 60% after deductible	Covered - 100%	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Maternity Services cont.						
Delivery and Nursery Care - Includes covered services provided by a certified nurse midwife.	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Hospital Services						
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies, Specialty Care Units **Note:** Unlimited Days	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Inpatient Consultations	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Chemotherapy	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Surgical Services						
Surgery	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Presurgical consultations	Covered - 100%	Covered - 60% after deductible	Covered - 100%	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Surgical Services cont.						
Voluntary sterilization for males	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Alternatives to Hospital Care						
Skilled Nursing Facility - Combined 120 days per calendar year	Covered - 100% after deductible	Covered - 100% after deductible	Covered - 90% after deductible	Covered - 90% after deductible	Covered - 80% after deductible - 90 days annual max.	Covered - 80% after deductible - 90 days annual max.
Home Health Care	Covered - 100% after deductible	Covered - 100% after deductible	Covered - 90% after deductible	Covered - 90% after deductible	Covered - 80% after deductible	Covered - 80% after deductible
Home Infusion Therapy -- must be medically necessary	Covered - 100% after deductible	Covered - 100% after deductible	Covered - 90% after deductible	Covered - 90% after deductible	Covered - 80% after deductible	Covered - 80% after deductible
Hospice Care	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 80% after deductible	Covered - 80% after deductible
Note: Up to 28 pre-hospice counseling visits before electing hospice services; when elected, for 90 day periods--provided through a participating hospice program only; limited to the dollar maximum that is reviewed and adjusted periodically.						
Human Organ Transplants						
Specified human organ transplants when coordinated through the BCBSM Human Organ Transplant Program in an approved facility.	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 80% after deductible	Covered - 80% after deductible

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Human Organ Transplants cont.						
Bone marrow transplants--when coordinated through the BCBSM Human Organ Transplant Program	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Kidney, cornea and skin transplant	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Specified oncology clinical trials	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Mental Health & Substance Abuse						
Inpatient mental health care, unlimited days	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Inpatient substance abuse care, unlimited days	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Outpatient mental health care	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 80% after deductible
Physician's office	$10 copay per visit	Covered - 60% after deductible	$20 copay per visit	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Facility and Clinic	Covered - 100% after deductible	Not Covered	Covered - 90% after deductible	Not Covered	Covered - 80% after deductible	Covered - 80% after deductible

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Mental Health & Substance Abuse cont.						
Outpatient substance abuse treatment in an approved facilities only	$10 copay per visit	Covered - 60% after deductible	$20 copay per visit	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Other Services						
Hearing Aid Testing & Treatment	Covered - copays apply (every 36 months)	Not Covered	Covered - copays apply (every 36 months)	Not Covered	Covered - 80% after deductible	Not Covered
Allergy Testing and Therapy	Covered - 100%	Covered - 60%	Covered - 100%	Covered - 60%	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic manipulation treatment and osteopathic manipulation treatment - Up to a combined maximum of 24 visits per member per calendar year	Covered- $10 copay	Covered - 60% after deductible	Covered- $20 copay	Covered - 60% after deductible	Not Covered	Covered - 60% after deductible
Outpatient Physical, Speech and Occupational Therapy - Limited to a combined maximum of 60 visits per member per calendar year	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Durable Medical Equipment	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 80% after deductible
Prosthetic and Orthotic Appliances	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 80% after deductible

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Other Services cont.						
Private Duty Nursing	Covered - 50% after deductible	Covered - 50% after deductible	Covered - 50% after deductible	Covered - 50% after deductible	Covered - 80% after deductible	Covered - 80% after deductible
Outpatient Diabetes Management Program (ODMP)	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Fertility Treatment -Artificial insemination and Assisted Reproductive Technology (ART)	Covered - 100% after deductible	Covered - 60% after deductible	Covered - 90% after deductible	Covered - 60% after deductible	Covered - 80% after deductible	Covered - 80% after deductible
Lifetime dollar maximum: $**25,000 for fertility treatment per contract.** This lifetime dollar maximum is for professional medical services only and does not apply to facility services, or services related to the treatment of underlying causes of infertility.						
Prescription Drugs, included with medical coverage	$15/generic $30/brand name $50/Non-formulary		$15/generic $30/brand name $50/Non-formulary		$10/generic $60/brand name Co-pays apply after deductible	
Vision	Not Covered separate vision plan needed		Not Covered separate vision plan needed		Not Covered separate vision plan needed	
** Simply Blue - H.S.A. House Contribution (Annual)	*Single - $1.000 *Family - $2,000 *Prorated for new employees					