

STATE OF MICHIGAN

Actives

Coverage Period: 10/11/2015

Coverage for: Individual/Family

Plan Type: PPO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsm.com or by calling the number on the back of your BCBSM ID card.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible ?	\$400 Individual/ \$800 Family	\$800 Individual/ \$1,600 Family	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses? (May include a co-insurance maximum)	\$2,000 Individual/ \$4,000 Family	\$3,000 Individual/ \$6,000 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Premiums, balance-billed charges, any pharmacy penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.		The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes. For a list of in-network providers, see www.bcbsm.com or call the number on the back of your BCBSM ID card.		If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No.		You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.		Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Questions: Call the number on the back of your BCBSM ID card or visit us at www.bcbsm.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call the number on the back of your BCBSM ID card to request a copy.



- **Co-payments** are fixed dollar amounts (for example, \$20) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 co-pay	20% co-insurance after deductible	---none---
	Specialist visit	\$20 co-pay	20% co-insurance after deductible	---none---
	Other practitioner office visit	\$20 co-pay for chiropractic and osteopathic manipulative therapy	20% co-insurance after deductible for chiropractic and osteopathic manipulative therapy	Limited to a maximum of 24 visits per member per calendar year for chiropractic manipulation.
	Allergy testing and therapy(non-injection)/ Allergy injections	10% co-insurance after deductible	20% co-insurance after deductible	
	Preventive care/ screening/immunization	No Charge	Limited services – 20% co-insurance after deductible	Out-of-network services limited to colonoscopy, double contrast barium enema, flu shot, and mammography. Childhood immunizations 20% co-insurance, deductible not applicable.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance after deductible	20% co-insurance after deductible	---none---
	Imaging (CT/PET scans, MRIs)	10% co-insurance after deductible	20% co-insurance after deductible	---none---
If you need drugs to treat your illness or condition More information about	Generic drugs *Includes generic Specialty drugs	\$10 (1- 34 day supply) \$20 (35-90 day supply through Mail Order only)	100% out of pocket	You can find specific limitations and exceptions by utilizing the formulary link on our website or by contacting Medimpact Customer Service at 877-403-6034

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
prescription drug coverage is available at https://mp.medimpact.com/som	Preferred brand drugs *Includes Preferred brand Specialty drugs	\$30 (1- 34 day supply) \$60 (35-90 day supply through Mail Order only)	100% out of pocket	You can find specific limitations and exceptions by utilizing the formulary link on our website or by contacting Medimpact Customer Service at 877-403-6034
	Non-preferred brand drugs *Includes Non-preferred Specialty drugs	\$60 (1- 34 day supply) \$120 (35-90 day supply through Mail Order only)	100% out of pocket	You can find specific limitations and exceptions by utilizing the formulary link on our website or by contacting Medimpact Customer Service at 877-403-6034
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance after deductible	20% co-insurance after deductible	---none---
	Physician/surgeon fees	10% co-insurance after deductible	20% co-insurance after deductible	---none---
If you need immediate medical attention	Emergency room services	\$200 co-pay	\$200 co-pay	Co-pay waived if admitted as inpatient
	Emergency medical transportation	10% co-insurance after deductible	10% co-insurance after deductible	---none---
	Urgent care	\$20 co-pay	20% co-insurance after deductible	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance after deductible	20% co-insurance after deductible	You are not covered, if you choose to go to a nonparticipating hospital when you have adequate access to a network hospital.
	Physician/surgeon fee	10% co-insurance after deductible	20% co-insurance after deductible	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10%	50% of provider charges	Deductible applies to Applied Behavioral Analysis (ABA); ABA Out-of-network: your cost is 20%.
	Mental/Behavioral health inpatient services	0%	50%	
	Substance use disorder outpatient services	10%	50% of provider charges	Annual maximum \$3,500

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
	Substance use disorder inpatient services	0%	50%	Up to two 28-day admissions per year (must be at least 60 days between admissions).
If you are pregnant	Prenatal and postnatal care, Delivery and nursery care	No Charge for prenatal care, 10% co-insurance after deductible	20% co-insurance after deductible	---none---
	Delivery and all inpatient services	10% co-insurance after deductible	20% co-insurance after deductible	---none---
If you need help recovering or have other special health needs	Home health care	10% co-insurance after deductible	10% co-insurance after deductible	Not covered for services rendered by a nonparticipating provider.
	Rehabilitation services	10% co-insurance after deductible	20% co-insurance after deductible	Physical, Speech and Occupational Therapy is limited to a combined maximum of 90 visits per member, per calendar year. Benefit maximum does not apply for developmental speech therapy for children through 6 years.
	Habilitation services	Not Covered	Not Covered	---none---
	Skilled nursing care	10% co-insurance after deductible	10% co-insurance after deductible	Must be a BCBSM-approved skilled nursing facility. Limited to a maximum of 120 days per member per benefit period.
	Durable medical equipment	No Charge	20% of the approved amount plus the difference between charge and approved amount	---none---
	Hospice service	No Charge	No Charge	No charge for BCBSM or Medicare certified hospice program. Not covered for services rendered by a nonparticipating provider.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Eye exam	Not Covered	Not Covered	Routine eye exam is covered under the State Vision Plan
	Glasses	Not Covered	Not Covered	Routine eye exam is covered under the State Vision Plan
	Dental check-up	Not Covered	Not Covered	Dental is covered under the State Dental Plan

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) | <ul style="list-style-type: none"> • Infertility treatment • Long-term care | <ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care |
|---|---|---|

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|--|---|--|
| <ul style="list-style-type: none"> • Bariatric surgery • Chiropractic Care | <ul style="list-style-type: none"> • Coverage provided outside the United States for emergency and unexpected illnesses for residents of the United States traveling in foreign countries. See https://www.bluecardworldwide.com/ | <ul style="list-style-type: none"> • Private Duty Nursing |
|--|---|--|

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at the number on the back of your BCBSM ID card. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Blue Cross[®] and Blue Shield[®] of Michigan by calling the number on the back of your BCBSM ID card. Or, you can contact Michigan Office of Financial and Insurance Regulation at www.michigan.gov/ofir or 1-877-999-6442. For group health coverage subject to ERISA, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides. (**IMPORTANT:** Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services

For assistance in a language below please call the number on the back of your BCBSM ID card.

SPANISH (Español): Para ayuda en español, llame al número de servicio al cliente que se encuentra en este aviso ó en el reverso de su tarjeta de identificación.

TAGALOG (Tagalog): Para sa tulong sa wikang Tagalog, mangyaring tumawag sa numero ng serbisyo sa mamimili na nakalagay sa likod ng iyong pagkakakilanlan kard o sa paunawang ito.

CHINESE (中文): 要获取中文帮助，请致电您的身份识别卡背面或本通知提供的客户服务号码。

NAVAJO (Dine): Taa'dineji'keego shii'kaa'ahdool'wool ninizin'goo, beesh behane'e naal'tsoos bikii sin'dahiigii binii'deehgo eeh'doodago di'naaltsoo bikaiigii bichi'hoodillnii.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Please note: Coverage examples are calculated based on individual coverage and calculations may not include a coinsurance maximum.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,630
- Patient pays \$910

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$250
Co-pays	\$0
Co-insurance	\$490
Limits or exclusions	\$170
Total	\$910

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$1,900
- Patient pays \$3,500

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$250
Co-pays	\$200
Co-insurance	\$120
Limits or exclusions	\$2,930
Total	\$3,500

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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