Blue Care Network of Michigan

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

BCN1LG

State Of Michigan Retirees **Coverage Period:** 10/1/2015-9/30/2016 **Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for:** All Contract Types **Plan Type:** HMO

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 **(800) 662-6667**.

Important Questions	Answers: Member / Family	Why this Matters:
What is the overall deductible?	$125/$250 Doesn't apply to lab, preventive care, DME/P&O, services with a fixed dollar co-pay. Deductible applies to chiropractic and home health care.	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?	Yes. $2000/$4000	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, balanced billed charges 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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of BCN providers, see www.BCBSM.com or call (800) 662-6667	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?	Yes, in-network only. Paper or electronic.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
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 (800) 662-6667 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 (800) 662-6667 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 Providers:		Limitations & Exceptions
		In Network	Out of Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay/visit	Not covered	——————none——————
	Specialist visit	$20 co-pay/visit	Not covered	Requires Referral/Deductible applies to allergy testing
	Other practitioner office visit	$20 co-pay/visit	Not covered	Requires Referral/Deductible applies to chiropractic care
	Preventive care/screening/immunization	$20 co-pay/visit	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	May require prior authorization/Deductible applies except for lab services
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Prior authorization/Deductible applies
	Allergy testing and therapy	No charge	Not covered	Deductible applies
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available www.bcbsm.com	Tier 1 - Formulary Preferred(Mostly Generic)	$10/30 days	Not covered	Prior-authorization & step-therapy apply to select drugs.
	Tier 2 - Formulary Brand	$30/30 days	Not covered	
	Tier 3 - Non-Formulary	$60/30 days	Not covered	90 day mail order and retail co-pays are 2x the standard retail co-pays.
	Specialty drugs	Tiered co-pays listed above apply	Not covered	Limited to a 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	May require prior authorization/no charge for elective abortion/Deductible applies
	Physician/surgeon fees	No charge	Not covered	See "Outpatient surgery facility fee"

Common Medical Event	Services You May Need	Your cost if you use Providers:		Limitations & Exceptions
		In Network	Out of Network	
If you need immediate medical attention	Emergency room services	$200 co-pay/visit	$200 co-pay/visit	Copay waived if admitted
	Emergency medical transportation	No charge	No charge	Non-emergent transport is covered when authorized/Deductible applies
	Urgent care	$20 co-pay/visit	$20 co-pay/visit	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Requires prior authorization/no charge for elective abortion/Deductible applies
	Physician/surgeon fee	No charge	Not covered	See "Hospital stay facility fee"
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	Not covered	Requires prior authorization/Deductible applies
	Mental/Behavioral health inpatient services	No charge	Not covered	Requires prior authorization/Deductible applies
	Substance use disorder outpatient services	No charge	Not covered	Requires prior authorization/Deductible applies
	Substance use disorder inpatient services	No charge	Not covered	Requires prior authorization/Deductible applies
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	Postnatal and non-routine prenatal office visits-$20 copay. The deductible does not apply to routine maternity care.
	Delivery and all inpatient services	No charge	Not covered	Deductible applies

Common Medical Event	Services You May Need	Your cost if you use Providers:		Limitations & Exceptions
		In Network	Out of Network	
If you need help recovering or have other special health needs	Home health care	$20 co-pay/visit	Not covered	Deductible applies
	Rehabilitation services	$20 co-pay/visit	Not covered	Limited to 90 visits for any combination of therapies per benefit year
	Habilitation services	No charge for ABA	Not covered	Requires prior authorization./Deductible applies
	Skilled nursing care	No charge	Not covered	Requires prior authorization/120 days each benefit period/Deductible applies/No charge for private duty nursing
	Durable medical equipment	No charge	Not covered	Must be authorized and obtained from a BCN supplier/Diabetic supplies covered in full/Unattached shoe insert covered/Hair prosthesis covered with limits
	Hospice service	No charge	Not covered	Inpatient care requires authorization/Deductible applies
If your child needs dental or eye care	Eye exam	No charge	Not covered	Vision exam covered for children through the age of 17
	Glasses	Not covered	Not covered	Contact your benefit administrator for coverage information.
	Dental check-up	Not covered	Not covered	Contact your benefit administrator for coverage information.

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.)**

- Acupuncture
- Cosmetic surgery
- Dental Care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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.)**

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment

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 (800) 662-6667. 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 Care Network, Appeals and Grievance Unit, MC C248, P.O. Box 284, Southfield, MI 48086 or fax 1-888-458-0716.

For state of Michigan assistance contact the Department of Insurance and Financial Services, Healthcare Appeals Section, Office of General Counsel, 611 Ottawa, 3rd Floor, P. O. Box 30220, Lansing, MI 48909-7720**,** michigan.gov/difs; call 1-877-999-6442 or fax: 517-241-4168.

For Department of Labor assistance contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP), Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720, michigan.gov/difs; Ofir-hicap@michigan.gov.

Translation available

To get help reading in your language call the customer service number on the back of your ID card.

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 Care Network of Michigan is assuming that your coverage provides for all Essential Health Benefits (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 for specific EHB categories, for example prescription drugs, through another carrier**.)**

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.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,220
- **Patient pays** $320

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	$120
Co-pays	$50
Co-insurance	$0
Limits or exclusions	$150
Total	**$320**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,540
- **Patient pays** $860

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	$120
Co-pays	$660
Co-insurance	$0
Limits or exclusions	$80
Total	**$860**

If you are also covered by an account-type plan such as an integrated health reimbursement arrangement (HRA), and/or an health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses-like deductible, co-payments, or co-insurance or benefits not otherwise covered.

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.
- Coverage examples are calculated based on individual coverage.
- The Coverage examples assume you have a combined medical and pharmacy out-of-pocket maximum.
- The coverage calculator examples do not include the co-insurance maximum if applicable to your coverage.

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.