Blue Cross® Preferred HMO Silver Saver

Coverage Period: 1/1/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family **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 **(888) 227-2345**.

Important Questions	Answers: Member / Family	Why this Matters:
What is the overall deductible?	$4,500 Individual/$9,000 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?	Yes. $5,500 Individual/$11,000 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 and healthcare this plan does not 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 (888)227-2345	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 (888) 227-2345 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 (888) 227-2345 to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) 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/Online Visit to treat an injury or illness	$30 copay/visit	Not covered	No deductible
	Specialist visit	$50 copay/visit	Not covered	Requires referral/30% co-insurance for allergy testing, serum and injections/Deductible applies
	Other practitioner office visit	$30 copay/visit	Not covered	Requires referral/30% co-insurance applies to spinal manipulations limited to 30 visits/calendar year/Deductible applies
	Preventive care/screening/immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	May require prior authorization/Deductible applies to non-preventive services/Deductible does not apply to lab
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	Requires prior authorization/Deductible applies
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/customselectdruglist	Tier 1A - Value Generics	$4/30 days	Not covered	Prior-auth & step therapy apply to select drugs/Drugs for treatment of sexual dysfunction, weight loss, cough & cold, infertility & compounds are not covered/No charge for Tier 1A contraceptives. Any overall deductible/out-of-pocket maxes apply. 84-90 day retail & 31-90 day mail order co-pays are 3x the 30-day co-pay.
	Tier 1B - Generics	$20/30 days	Not covered	
	Tier 2 - Preferred Brand	25% co-insurance $40 min-$100 max/30 days	Not covered	
	Tier 3 - Non-Preferred Brand	50% co-insurance $80 min-$100 max/30 days	Not covered	
	Tier 4 - Preferred Specialty	20% co-insurance	Not covered	Limited to a 30 day supply
	Tier 5 - Non-Preferred Specialty	25% co-insurance	Not covered	

Common Medical Event	Services You May Need	Your cost if you use Providers:		Limitations & Exceptions
		In Network	Out of Network	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	May require prior authorization/Female sterilization covered in full/50% coinsurance for infertility counseling & treatment, TMJ, weight reduction procedures/ Deductible applies
	Physician/surgeon fees	30% coinsurance	Not covered	See "Outpatient surgery facility fee"
If you need immediate medical attention	Emergency room services	$250 copay then 30% coinsurance	$250 copay then 30% coinsurance	Copay waived if admitted to the hospital as in inpatient (non-observation stay)/Deductible applies
	Emergency medical transportation	30% coinsurance	30% coinsurance	Services provided by an emergency responder that does not provide transportation are not covered/Deductible applies
	Urgent Care/Retail Health Center Visit	$40 copay/visit	$40 copay/visit	No deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	May require prior authorization/Female sterilization covered in full/50% coinsurance for infertility counseling/ treatment, TMJ, weight reduction procedures/Deductible applies
	Physician/surgeon fee	30% coinsurance	Not covered	See "Hospital Stay Facility Fee"
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% coinsurance	Not covered	Requires prior authorization/Deductible applies
	Mental/Behavioral health inpatient services	30% coinsurance	Not covered	Requires prior authorization/Deductible applies
	Substance use disorder outpatient services	30% coinsurance	Not covered	Requires prior authorization/Deductible applies
	Substance use disorder inpatient services	30% coinsurance	Not covered	Requires prior authorization/Deductible applies
If you are pregnant	Prenatal and postnatal care	$30 copay/visit	Not covered	Prenatal covered in full/Deductible applies to postnatal
	Delivery and all inpatient services	30% coinsurance	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	30% coinsurance	Not covered	Deductible applies
	Rehabilitation services	30% coinsurance	Not covered	May require authorization/ PT/OT combined limit-30 visits/member/calendar year. Speech Therapy-30 visits/member/calendar year. Deductible applies
	Habilitation services	30% coinsurance	Not covered	Requires authorization/Combined 30 visits/ calendar year for PT/OT. 30 visits/ calendar year for speech therapy. Deductible applies.
	Skilled nursing care	30% coinsurance	Not covered	Requires prior authorization/Limited to 45 days per calendar year/Deductible applies
	Durable medical equipment	50% coinsurance	Not covered	Equipment must be authorized and obtained from a BCN supplier/Deductible applies / Breast pumps are covered in full when preauthorized/Diabetic supplies covered with 30% co-insurance
	Hospice service	No charge	Not covered	Preauthorization is required/Deductible applies
If your child needs dental or eye care	Eye exam	No Charge	Difference between the BCN approved amount and the amount charged by the provider	Limited to once per calendar year through the last day of the year in which the individual turns age 19.
	Glasses	No Charge	Difference between the BCN approved amount and the amount charged by the provider	Frames (chosen from a select collection) and lenses are covered once per calendar year through the last day of the year in which the individual turns age 19.
	Dental check-up	Not covered	Not covered	Not covered

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
- Artificial Insemination and in-vitro fertilization
- Cosmetic surgery
- Dental Care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Voluntary Abortion

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
- Habilitation Services
- Infertility Treatment
- Weight loss programs

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the plan at (888) 227-2345. 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?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 888-288-2738.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-288-2738.]
[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 888-288-2738.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-288-2738.]

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** $2,210
- **Patient pays** $5,330

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	$4,500
Co-pays	$10
Co-insurance	$670
Limits or exclusions	$150
Total	**$5,330**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $710
- **Patient pays** $4,690

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	$4,500
Co-pays	$30
Co-insurance	$80
Limits or exclusions	$80
Total	**$4,690**

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.

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.

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ئەگەر تۆ، یان کەسێک کە یارمەتی دەدەیت، پێویستی بە یارمەتی هەیە، مافی ئەوەت هەیە بە بێ هیچ تێچوونێک یارمەتی و زانیاری بە زمانەکەت وەربگریت. بۆ قسەکردن لەگەڵ وەرگێڕ، پەیوەندی بە ژمارەی خزمەتگوزاری بەکارهێنەرانەوە بکە کە لەپشت کارتەکەتەوەیە، یان 877-469-2583 TTY:711 ئەگەر ئێستا ئەندام نیت.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号 (メンバーでない方は877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at*http://www.hhs.gov/ocr/office/file/index.html*.