Blue Cross Blue Shield of Michigan

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

Blue Cross® Premier PPO Silver

Coverage Period: 01/01/2017 – 12/31/17

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual / Family| **Plan Type:** PPO

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/member or by calling 1-888-288-2738.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	**$1,800 Individual /$3,600 Family,** Does not apply to preventive care	**$3,600 Individual /$7,200 Family,** Does not apply to preventive 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 Common Medical Event 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**	**No**	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	**Yes, $7,150 Individual /$14,300 Family**	**Yes, $14,300 Individual /$28,600 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 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 Common Medical Event 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 in-network providers, see www.bcbsm.com or call 1-888-288-2738.		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 Common Medical Events 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 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-888-288-2738 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 1-888-288-2738 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 a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit/Retail health center visit to treat an injury or illness	$30 copay	40% coinsurance	After deductible. Prior authorization may be required for select drugs covered under the medical benefit.
	Specialist visit	$50 copay	40% coinsurance	After deductible. Prior authorization may be required for select drugs covered under the medical benefit.
	Other practitioner office visit/Online visit	$30 copay/ $10 copay	40% coinsurance	After deductible. Prior authorization may be required for select drugs covered under the medical benefit. In-network Online visits not subject to deductible.
	Preventive care/screening/ immunization	No Charge before deductible	40% coinsurance after deductible	Prior authorization may be required for select drugs covered under the medical benefit.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	After deductible.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	After deductible. To be eligible for coverage, these services require approval before they are provided.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/2017selectdruglistppo	Generic drugs	$15 copay	BCBSM will reimburse 80% of the BCBSM-approved amount for covered drugs, less the copay and the difference between the out-of-network pharmacy's charge and the BCBSM-approved amount for the drug. For out of network providers, member must pay full cost of drug and submit to BCBSM for reimbursement.	After in-network integrated medical and prescription drug deductible. Mail order: 31-60 days apply 2 copays, 61 to 90 days apply 3 copays and 90 day retail network pharmacies: 84-90 days apply 3 copays.
	Preferred brand drugs	25% coinsurance		After in-network integrated medical and prescription drug deductible, Retail and mail 30 days: $40 minimum and $100 maximum copay, Mail 31-60 days: $80 minimum and $200 maximum copay, Retail 84-90 days & Mail 61-90 days: $120 minimum and $300 maximum copay.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
	Non-preferred brand drugs	50% coinsurance		After in-network integrated medical and prescription drug deductible, Retail and mail 30 days: $80 minimum and $100 maximum copay, Mail 31-60 days: $160 minimum and $200 maximum copay, Retail 84-90 days & Mail 61-90 days: $240 minimum and $300 maximum copay.
	Specialty drugs (e.g., chemotherapy)	20% coinsurance Preferred 25% coinsurance Nonpreferred		After in-network integrated medical and prescription drug deductible. Specialty drugs limited to a 15 or 30-day supply per fill.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	After deductible
	Physician/surgeon fees	20% coinsurance	40% coinsurance	After deductible
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	After in-network deductible plus $250 copay. (copay waived if admitted)
	Emergency medical transportation	20% coinsurance	20% coinsurance	After in-network deductible
	Urgent care	20% coinsurance	40% coinsurance	After deductible plus $75 copay. When the urgent care visit is for an emergency or accidental injury then in-network cost-sharing applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	After deductible, semi-private room. To be eligible for coverage, these services require approval before they are provided. BCBSM participating facilities only.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	After deductible
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay	40% coinsurance	After deductible. Copayment applies to office visit only. Additional services are subject to the plan's deductible and coinsurance.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	After deductible, semi-private room. To be eligible for coverage, these services require approval before they are provided. BCBSM participating facilities only.
	Substance use disorder outpatient services	$30 copay	$30 copay	After deductible. Copayment applies to office visit only. Additional services are subject to the plan's deductible and coinsurance. BCBSM approved clinics and facilities only.
	Substance use disorder inpatient services	20% coinsurance	20% coinsurance	After deductible, semi-private room. To be eligible for coverage, these services require approval before they are provided. BCBSM approved facilities only.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you are pregnant	Prenatal and postnatal care	Prenatal visits no charge Postnatal visits $30 copay after deductible	Prenatal and postnatal visits 40% coinsurance after deductible.	Diagnostic and laboratory services are subject to the deductible and coinsurance.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	After deductible.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	After deductible. BCBSM participating agencies only.
	Rehabilitation services	20% coinsurance	40% coinsurance	After deductible. Physical, occupational, chiropractic and osteopathic manipulative therapy limited to a combined maximum of 30 visits per member per calendar year. Speech therapy limited to a maximum of 30 visits per member per calendar year.
	Habilitation services	20% coinsurance	40% coinsurance	After deductible. Applied behavioral analysis services must be preauthorized by BCBSM. Physical and occupational therapy limited to a combined maximum of 30 visits per member per calendar year. Speech therapy limited to a maximum of 30 visits per member per calendar year.
	Skilled nursing care	20% coinsurance	40% coinsurance	After deductible. Limited to a maximum of 45 days per member per calendar year. BCBSM participating facilities only.
	Durable medical equipment	50% coinsurance	70% coinsurance	After deductible.
	Hospice service	No Charge	No Charge	After deductible. BCBSM participating hospice programs only.
If your child needs dental or eye care	Eye exam	No Charge	No Charge	Limited to once in a calendar year for members through the last day of the year in which they turn age 19.
	Glasses	No Charge	No Charge	Frames (chosen from a select collection) and lenses are covered once in a calendar year for members through the last day of the year in which they turn age 19.
	Dental check-up	Not Covered	Not Covered	Stand-alone dental plans available.

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 (child & adult)
- Glasses (adult)
- Hearing Aids
- Long-Term Care
- Private-duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Termination of pregnancy, except in limited circumstances

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
- Coverage provided outside the United States excluding non-emergency care. See www.bcbs.com/bluecardworldwide
- 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 insurer at 1-888-288-2738. You may also contact Department of Insurance and Financial Services at **michigan.gov/difs** at 1-877-999-6442.

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 1-888-288-2738. Or, you can contact Michigan Department of Insurance and Financial Services at **michigan.gov/difs** or 1-877-999-6442.

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.

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 insurance 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 also will be different.

See the next page for important information about these examples.

Please Note: Coverage Examples are calculated based on individual coverage.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,550
- **Plan pays** $4,760
- **You pay** $2,790

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	$50
Total	**$7,550**

Patient pays:

Deductibles	$1,800
Co-pays	$50
Co-insurance	$790
Limits or exclusions	$150
Total	**$2,790**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,410
- **You pay** $2,990

Sample care costs:

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

Patient pays:

Deductibles	$1,800
Co-pays	$610
Co-insurance	$540
Limits or exclusions	$40
Total	**$2,990**

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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2017SBC19

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 کڕیاران بکە کە لەسەر پشتەوەی کارتەکەتە، یان 877-469-2583 TTY:711 بکە ئەگەر 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*