Blue Care Network of Michigan

Blue Cross® Metro Detroit HMO Silver Saver **Coverage for:** Individual/Family | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-227-2345 or go online to www.bcbsm.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-888-288-2738 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,700 Individual/$7,400 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, primary care visits, lab, and urgent care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7,500 Individual/$15,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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.
Will you pay less if you use a network provider?	Yes. See http://www.bcbsm.com/index/common/marketplace/metro-detroit-hmo.html or call 1-888-227-2345 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit/Online Visit to treat an injury or illness	$30/primary care visit No charge /online visit Deductible does not apply	Not covered	Diagnostic services are subject to the plan's deductible and coinsurance.
	Specialist visit	$50/visit	Not covered	Referral required. The penalty for not having a referral is denial of payment. Diagnostic services are subject to the plan's deductible and coinsurance.
	Preventive care/screening/ immunization	No charge Deductible does not apply	Not covered	May require prior authorization. The penalty for not having prior authorization is denial of payment. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive; then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance No charge for lab services Deductible does not apply for lab services	Not covered	May require prior authorization. The penalty for not having prior authorization is denial of payment.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.bcbsm.com/2020selectdruglist	Tier 1A-Preferred generic drugs	$4/prescription-Retail & mail order 30-day supply. $12/prescription-Retail 84-90-day supply & mail order 31-90-day supply.	Not covered	May require prior authorization & Step Therapy. The penalty for not having prior authorization is denial of payment. No charge for Tier 1A contraceptives. Opioid containing medications are limited to no more than a 30-day supply per fill. First fills of select opioid containing medications will be limited to a 5-day supply.
	Tier 1B-Generics	$20/prescription-Retail & mail order 30-day supply. $60/prescription-Retail 84-90-day supply & mail order 31-90-day supply.	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.bcbsm.com/2020selectdruglist	Tier 2-Preferred brand drugs	25% coinsurance-$40 minimum and $100 copay maximum. Retail & mail order 30-day supply. 25% coinsurance-$120 minimum/ $300 maximum copay. Retail 84-90-day supply & mail order 31-90-day supply.	Not covered	May require prior authorization & Step Therapy. The penalty for not having prior authorization is denial of payment. No charge for Tier 1A contraceptives. Opioid containing medications are limited to no more than a 30-day supply per fill. First fills of select opioid containing medications will be limited to a 5-day supply.
	Tier 3-Non-preferred brand drugs	50% coinsurance-$80 minimum and $150 copay maximum. Retail & mail order 30-day supply. 50% coinsurance-$240 minimum/ $450 maximum copay. Retail 84-90-day supply & mail order 31-90-day supply.	Not covered	
	Tier 4-Preferred Specialty drugs	40% coinsurance	Not covered	May require prior authorization & Step Therapy. The penalty for not having prior authorization is denial of payment. Specialty drugs are limited to a 15 or 30-day supply. BCN has contracted with an exclusive pharmacy network for specialty drugs. Call the customer service phone number on the back of your ID card for the pharmacy's phone number or location nearest to you. If you obtain your specialty drugs from any other pharmacy, you are responsible for the total cost.
	Tier 5-Non-Preferred Specialty drugs	45% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance 50% coinsurance for infertility services, TMJ procedures and weight reduction procedures	Not covered	May require prior authorization. The penalty for not having prior authorization is denial of payment. Female sterilization covered in full. *See section 8
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$250 copayment then 30% coinsurance	$250 copayment then 30% coinsurance	Emergency room visits will be covered at non-participating facilities for medical emergencies and accidental injuries only.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Includes air and ground transportation. Excludes transportation for convenience.
	Urgent care/Retail health center visit	$40/visit Deductible does not apply	$40/visit Deductible does not apply	Urgent care/Retail health center visits will be covered at non-participating facilities for medical emergencies and accidental injuries only.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance 50% coinsurance for infertility services, TMJ procedures and weight reduction procedures	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment. Female sterilization covered in full. *See section 8
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office and online visit Deductible does not apply 30% coinsurance for other outpatient services	Not covered	Prior authorization is not required for outpatient, office and online visits. Prior authorization is required for other outpatient services. The penalty for not having prior authorization is denial of payment. *See section 8
	Inpatient services	30% coinsurance	Not covered	Prior authorization is required for inpatient services. The penalty for not having prior authorization is denial of payment. *See section 8
If you are pregnant	Office visits	No charge for prenatal visit. Deductible does not apply. $30/postnatal visit.	Not covered	None.
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	Housekeeping services and custodial care are excluded.
	Rehabilitation services	30% coinsurance	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment. PT & OT limited to a combined 30 visits per member per calendar year. Speech Therapy limited to 30 visits per member per calendar year. *See section 8
	Habilitation services	30% coinsurance	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment. PT & OT limited to a combined 30 visits per member per calendar year. Speech Therapy limited to 30 visits per member per calendar year. *See section 8

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Skilled nursing care	30% coinsurance	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment. Limited to 45 days per calendar year. Custodial care is excluded.
	Durable medical equipment	50% coinsurance 30% coinsurance for diabetic testing supplies	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment. Breast pumps are covered in full when preauthorized. *See section 8
	Hospice services	No charge	Not covered	Prior authorization required. The penalty for not having prior authorization is denial of payment. BCN participating hospice programs only. *See section 8
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	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 19.
	Children's glasses	No charge. Deductible does not apply.	Difference between the BCN approved amount and the amount charged by the provider	
	Children's dental check-up	Not covered	Not covered	Stand-alone dental plans available.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (except in cases of rape, incest or when the life of the mother is endangered)
- Acupuncture
- Artificial Insemination and In-Vitro Fertilization
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the US
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Infertility treatment
- Weight loss programs

*For more information about limitations and exception, see plan or policy document at http://www.bcbsm.com/index/plans/michigan-health-insurance/2020.html

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html, or Michigan Department of Insurance and Financial Services at michigan.gov/difs or 1-877-999-6442. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Care Network, Appeals and Grievance Unit, MC C248, P.O. Box 248, Southfield, MI 48086 or fax 888-458-0716.
For State of Michigan assistance contact the Michigan Department of Insurance and Financial Services, Healthcare Appeals Section, Office of General Council, 611 W. Ottawa St, 3rd Floor, Lansing, MI 48909-7720, michigan.gov/difs or 1-877-999-6442.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP), at 877-999-6442 or DIFS-HICAP@Michigan.gov.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **N/A**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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 section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$3,700**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,700
Copayments	$100
Coinsurance	$3,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,360**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$3,700**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,700
Copayments	$1,000
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$6,160**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$3,700**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$400
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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。

ܐܢ ܐܢܬܘܢ، ܝܢ ܚܕ ܦܪܨܘܦܐ ܕܩܐ ܥܕܪܘܬܘܢ ، ܣܢܝܩ ܝܠܗ ܥܘܕܪܢܐ،
ܐܝܬܠܘܟܘܢ ܙܕܩܘܬܐ ܕܩܒܠܝܬܘܢ ܥܘܕܪܢܐ ܘܡܘܕܥܢܘܬܐ
ܒܠܫܢܘܟܘܢ ܕܠܐ ܡܦܩܬܐ. ܠܡܡܠܠܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘܢ ܥܠ
ܡܢܝܢܐ ܕܚܠܡܬ ܣܥܘܪܐ ܕܐܝܬܠܗ ܥܠ ܚܨܐ ܕܟܪܛܝܣܘܟܘܢ ܝܢ 877-469-2583
TTY:711 ܐܢ ܠܐ ܗܘܝܬܘܢ ܗܕܡܐ.

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*.