

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services



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, visit [www.bcbsm.com](http://www.bcbsm.com) or call the number on the back of your BCBSM ID card. 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](#) or call the SSC Contact Center at 1-866-647-7657 to request a copy.

Important Questions	In-Network	Out-of-Network	Why this Matters:
What is the overall deductible?	\$0	\$0	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 and voluntary sterilization services are covered before you meet your deductible.	Yes. Preventive care and voluntary sterilization services 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 <a href="#">covered preventive services</a> .
Are there other deductibles for specific services?	No.	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan? (May include a coinsurance maximum)	\$3,000 Individual/ \$6,000 Family	\$5,000 Individual/ \$10,000 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, any pharmacy penalty and health care this plan doesn't cover.	Premiums, balance-billing 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.

Important Questions	In-Network	Out-of-Network	Why this Matters:
Will you pay less if you use a network provider?	Yes. See <a href="http://www.bcbsm.com">www.bcbsm.com</a> or call the number on the back of your BCBSM ID card for a list of network providers.	Yes. See <a href="http://www.bcbsm.com">www.bcbsm.com</a> or call the number on the back of your BCBSM ID card 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). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	No.	You can see the specialist you choose without a referral.



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: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay/visit	50% coinsurance	None
If you visit a health care provider's office or clinic	Specialist visit	\$30 copay/visit	50% coinsurance	None
If you visit a health care provider's office or clinic	Preventive care/ screening/ immunization	Covered 100%	Not covered	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)	Covered 100%	50% coinsurance	None
If you have a test	Imaging (CT/PET scans, MRIs)	Covered 100%	50% coinsurance	May require preauthorization
If you need drugs to treat your illness or condition	Generic or select prescribed over-the-counter drugs	N/A	N/A	Prime Therapeutics administers the U of M Prescription Drug Plan. Birdi Pharmacy Services administers mail order services. For more information about prescription drug coverage is available at <a href="#">Prescription Drug Plan</a>

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<b>If you need drugs to treat your illness or condition</b>	Preferred brand-name drugs	N/A	N/A	Prime Therapeutics administers the U of M Prescription Drug Plan. Birdi Pharmacy Services administers mail order services. For more information about prescription drug coverage is available at <a href="#">Prescription Drug Plan</a>
<b>If you need drugs to treat your illness or condition</b>	Nonpreferred brand-name drugs	N/A	N/A	Prime Therapeutics administers the U of M Prescription Drug Plan. Birdi Pharmacy Services administers mail order services. For more information about prescription drug coverage is available at <a href="#">Prescription Drug Plan</a>
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Covered 100%	50% coinsurance	May require preauthorization
<b>If you have outpatient surgery</b>	Physician/surgeon fees	Covered 100%	50% coinsurance	None
<b>If you need immediate medical attention</b>	Emergency room care	\$100 copay/visit	\$100 copay/visit	Copay waived if admitted or for an accidental injury.
<b>If you need immediate medical attention</b>	Emergency medical transportation	Covered 100%	Covered 100%	Mileage limits apply
<b>If you need immediate medical attention</b>	Urgent care	\$25 copay/visit	50% coinsurance	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Covered 100%	50% coinsurance	Preauthorization is required
<b>If you have a hospital stay</b>	Physician/surgeon fee	Covered 100%	50% coinsurance	None
<b>If you need behavioral health services (mental health and substance use disorder)</b>	Outpatient services	\$30 copay/visit	50% coinsurance	Your cost share may be different for services performed in an office setting
<b>If you need behavioral health services (mental health and substance use disorder)</b>	Inpatient services	Covered 100%	50% coinsurance	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<b>If you are pregnant</b>	Office visits	Prenatal / Postnatal: Covered 100%	Prenatal / Postnatal: 50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services cost share may apply. Cost sharing does not apply for preventive services.
<b>If you are pregnant</b>	Childbirth/delivery professional services	Covered 100%	50% coinsurance	None
<b>If you are pregnant</b>	Childbirth/delivery facility services	Covered 100%	50% coinsurance	None
<b>If you need help recovering or have other special health needs</b>	Home health care	Covered 100%	Covered 100%	Physician certification required.
<b>If you need help recovering or have other special health needs</b>	Rehabilitation services	\$25 copay/visit	50% coinsurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
<b>If you need help recovering or have other special health needs</b>	Habilitation services for Autism Spectrum Disorder	\$25 copay/visit	50% coinsurance	Applied behavior analysis (ABA) treatment for Autism - when rendered by an approved licensed behavior analyst - subject to preauthorization.
<b>If you need help recovering or have other special health needs</b>	Skilled nursing care	Covered 100%	Covered 100%	Preauthorization is required. Limited to 120 days per member per calendar year
<b>If you need help recovering or have other special health needs</b>	Durable medical equipment	Covered 100%	Covered 100%	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
<b>If you need help recovering or have other special health needs</b>	Hospice services	Covered 100%	Covered 100%	Physician certification required. Visit limits apply.
<b>If your child needs dental or eye care:</b> For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Covered 100%	50% coinsurance; subject to an annual benefit maximum of \$40	Eye exam limited to 1 per year

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<b>If your child needs dental or eye care:</b> For more information on pediatric vision or dental, contact your plan administrator	Children's glasses	Not covered	Not covered	None
<b>If your child needs dental or eye care:</b> For more information on pediatric vision or dental, contact your plan administrator	Children's dental check-up	Not covered	Not covered	None

**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.)**

- Acupuncture treatment
- Cosmetic surgery
- Long term care
- Routine foot care
- Dental 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
- Gender affirming care
- Hearing aids
- Infertility treatment
- Private-duty nursing
- Non-emergency care when traveling outside the U.S
- [Coverage provided outside the United States](#)

**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 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov) or by calling the number on the back of your BCBSM ID card. 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](http://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 Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card.

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 or [Department of Insurance and Financial Services](http://DepartmentofInsuranceandFinancialServices) or [difs-HICAP@michigan.gov](mailto:difs-HICAP@michigan.gov)

### **Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### **Does this plan meet Minimum Value Standards? Yes**

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. (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: See Addendum**

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*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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ <b>The plan's overall deductible</b>	\$0	■ <b>The plan's overall deductible</b>	\$0	■ <b>The plan's overall deductible</b>	\$0
■ <b>Specialist copayment</b>	\$30	■ <b>Specialist copayment</b>	\$30	■ <b>Specialist copayment</b>	\$30
■ <b>Hospital (facility) copayment</b>	\$0	■ <b>Hospital (facility) copayment</b>	\$0	■ <b>Hospital (facility) copayment</b>	\$0
■ <b>Other copayment</b>	\$0	■ <b>Other copayment</b>	\$0	■ <b>Emergency Room copayment</b>	\$100
<b>This EXAMPLE event includes services like:</b> <u>Specialist office visits (prenatal care)</u> Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests (ultrasounds and blood work)</u> <u>Specialist visit (anesthesia)</u>		<b>This EXAMPLE event includes services like:</b> <u>Specialist physician office visits (including disease education) x2</u> <u>Diagnostic tests (blood work)</u> <u>Prescription drugs</u> <u>Durable medical equipment (glucose meter)</u>		<b>This EXAMPLE event includes services like:</b> <u>Emergency room care (including medical supplies)</u> <u>Diagnostic tests (x-ray)</u> <u>Durable medical equipment (crutches)</u> <u>Rehabilitation services (physical therapy) 4 visits</u>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	<i>Amount</i>	<i>Cost Sharing</i>	<i>Amount</i>	<i>Cost Sharing</i>	<i>Amount</i>
<u>Deductibles</u>	\$0	<u>Deductibles</u>	\$0	<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0	<u>Copayments</u>	\$60	<u>Copayments</u>	\$230
<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	<i>Amount</i>	<i>What isn't covered</i>	<i>Amount</i>	<i>What isn't covered</i>	<i>Amount</i>
Limits or exclusions	\$0	Limits or exclusions	\$60	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$0</b>	<b>The total Joe would pay is</b>	<b>\$60</b>	<b>The total Mia would pay is</b>	<b>\$230</b>

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

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

## We Speak Your Language

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge.

Call 877-469-2583 TTY: 711 or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se ofrecen, sin costo alguno, ayuda y servicios auxiliares adecuados para proporcionar información en formatos accesibles.

Llame al 877-469-2583 TTY: 711 o hable con su proveedor.

تنبيه: إذا كنت تتحدث الإنجليزية، فإن خدمات المساعدة اللغوية المجانية متوفرة لك. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل برقم 877-469-2583 TTY: 711 أو تحدث إلى مزود الخدمة الخاص بك.

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。请致电

877-469-2583 (TTY: 711) 或咨询您的服务提供商。

ማሳሰቢያ: ለእንግሊዝኛ ቋንቋ ለመናገር የሚሰጡ የቋንቋ ማሳደጊያ አገልግሎቶች ከገንዘብ ጋር ሳይወሰዱ ይሰጡታል። ለተጨማሪ መረጃ ወይንም ለአገልግሎት ለመጠየቅ 877-469-2583 ስልክ ወይንም ለገንዘብ ለመጠየቅ 711 ስልክ ይደውሉ።

LU'U Y: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ và dịch vụ phù hợp để cung cấp thông tin bằng các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi số 877-469-2583 TTY: 711 hoặc trao đổi với người cung cấp dịch vụ của bạn.

VËMENDJE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas.

Telefononi 877-469-2583 TTY: 711 ose bisedoni me ofruesin tuaj të shërbimit.

알림: 한국어를 사용하는 경우 언어 지원 서비스를 무료로 이용할 수 있습니다. 정보를 접근 가능한 형식으로 제공받을 수 있는 적절한 보조 기구와 서비스도 무료로 이용할 수 있습니다.

877-469-2583 TTY: 711 번으로 전화하거나 담당 기관에 문의하십시오.

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 877-469-2583 TTY: 711 নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 877-469-2583 TTY: 711 lub porozmawiaj ze swoim usługodawcą.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 877-469-2583 TTY: 711 an oder sprechen Sie mit Ihrem Provider.

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'877-469-2583 TTY: 711 o parla con il tuo fornitore.

注: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。情報をアクセスしやすい形式で提供するための適切な補助器具やサービスも無料でご利用いただけます。877-469-2583 TTY: 711 までお電話いただくか、ご利用の事業者にご相談ください。

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 877-469-2583 TTY: 711 или обратитесь к своему поставщику услуг.

PAŽNJA: Ako govorite srpsko-hrvatski, dostupne su vam besplatne usluge jezične pomoći. Odgovarajuća pomoćna pomagala i usluge za pružanje informacija u pristupačnim formatima također su dostupni besplatno. Nazovite 877-469-2583 TTY: 711 ili razgovarajte sa svojim pružateljem usluga.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na karagdagang tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 877-469-2583 TTY: 711 o makipag-usap sa iyong provider.

### Discrimination is against the law

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 (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex

stereotypes). Blue Cross Blue Shield of Michigan and Blue Care Network does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross Blue Shield of Michigan and Blue Care Network:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provide free language services to people whose primary language is not English, which may include qualified interpreters and information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call the Customer Service number on the back of your card. If you aren't already a member, call 877-469-2583 or, if you're 65 or older, call 888-563-3307, TTY: 711. Here's how you can file a civil right complaint if you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide these 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](mailto: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 website](https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf) <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>, or by mail, phone, or email at:

U.S. Department of Health & Human Services  
200 Independence Ave, SW  
Room 509, HHH Building  
Washington, D.C. 20201  
Phone: 800-368-1019, TTD: 800-537-7697

Email: [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov)

Complaint forms are available on the U.S. Department of Health & Human Services Office for Civil Rights website  
<https://www.hhs.gov/ocr/complaints/index.html>.

[This notice is available at Blue Cross Blue Shield of Michigan and Blue Care Network's website:](https://www.bcbsm.com/important-information/policies-practices/nondiscrimination-notice/)  
<https://www.bcbsm.com/important-information/policies-practices/nondiscrimination-notice/>

**Questions:** Call or visit us at [www.bcbsm.com](http://www.bcbsm.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary to request a copy.