

U-M HEALTH – Silver Health Plan

Community BlueSM PPO ASC

Coverage for: Individual/Family | Plan Type: PPO



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 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 at <https://www.healthcare.gov/sbc-glossary> or call the number on the back of your BCBSM ID card to request a copy.

Important Questions	Answers			Why this Matters:
	In-Network		Out-of-Network	
	Tier 1	Tier 2		
What is the overall <u>deductible</u> ?	\$500 Individual/ \$1,000 Family	\$1,500 Individual/ \$3,000 Family	\$3,000 Individual/ \$6,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .			This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.			You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? (May include a <u>coinsurance</u> maximum)	\$2,000 Individual/ \$4,000 Family	\$6,000 Individual/ \$12,000 Family	\$10,000 Individual/ \$15,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, <u>balance-billing</u> charges, any <u>pharmacy</u> penalty and health care this <u>plan</u> doesn't cover.			Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbsm.com or call the number on the back of your BCBSM ID card for a list of <u>network providers</u> .			This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Important Questions	Answers		Why this Matters:	
	In-Network			Out-of-Network
	Tier 1	Tier 2		
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.		You can see the <u>specialist</u> you choose without a <u>referral</u> .	



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
		In-Network Provider		Out-of-Network Provider (You will pay the most)	
		Tier 1 (You will pay the least)	Tier 2 (You will pay more)		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /office visit; <u>deductible</u> does not apply	\$45 <u>copay</u> /office visit; <u>deductible</u> does not apply	Not covered	None
	<u>Specialist</u> visit	\$40 <u>copay</u> /office visit; <u>deductible</u> does not apply	\$65 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	None
	<u>Preventive care</u> / <u>screening</u> / immunization	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	90% <u>coinsurance</u> for laboratory test, \$75 <u>copay</u> ; <u>deductible</u> does not apply for X-rays	30% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$75 <u>copay</u> ; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Not covered	May require <u>prior authorization</u>
If you need drugs to treat your illness or condition More information about <u>prescription drug</u>	Generic or select prescribed over-the-counter drugs	Not covered	Not covered	Not covered	None
	Preferred brand-name drugs	Not covered	Not covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Tier 1 (You will pay the least)	Tier 2 (You will pay more)		
<u>coverage</u> is available at www.bcbsm.com/druglists	Nonpreferred brand-name drugs	Not covered	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit; <u>deductible</u> does not apply	\$250 <u>copay</u> /visit; <u>deductible</u> does not apply	\$250 <u>copay</u> /visit; <u>deductible</u> does not apply	<u>Copay</u> waived if admitted or for an accidental injury.
	<u>Emergency medical transportation</u>	\$250 <u>copay</u> /trip; <u>deductible</u> does not apply	\$250 <u>copay</u> /trip; <u>deductible</u> does not apply	\$250 <u>copay</u> /trip; <u>deductible</u> does not apply	Mileage limits apply
	<u>Urgent care</u>	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	\$75 <u>copay</u> /visit; <u>deductible</u> does not apply	\$75 <u>copay</u> /visit; <u>deductible</u> does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Facility services are covered in participating facilities only. <u>Prior authorization</u> is required
	Physician/surgeon fee	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	\$25 <u>copay</u> ; <u>deductible</u> does not apply	\$30 <u>copay</u> ; <u>deductible</u> does not apply	Not covered	Facility services are covered in participating facilities only. Your cost share may be different for services performed in an office setting
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Facility services are covered in participating facilities only. <u>Prior authorization</u> is required.

Common Medical Event	Services You May Need	What You Will Pay		Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Tier 1 (You will pay the least)	Tier 2 (You will pay more)		
If you are pregnant	Office visits	Prenatal: No Charge; <u>deductible</u> does not apply Prenatal: No Charge; <u>deductible</u> does not apply	Prenatal: No Charge; <u>deductible</u> does not apply Postnatal: No Charge; <u>deductible</u> does not apply	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services <u>cost share</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Facility services are covered in participating facilities only.
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	Physician certification required.
	<u>Rehabilitation services</u>	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	\$65 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	<u>Habilitation services</u>	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply for Applied Behavior Analysis; 10% <u>coinsurance</u> for Physical, Speech and Occupational Therapy	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply for Applied Behavior Analysis; 30% <u>coinsurance</u> for Physical, Speech and Occupational Therapy	Not covered for Applied Behavior Analysis; Not covered for Physical, Speech and Occupational Therapy	Prior authorization is required for applied behavior analysis (ABA).
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	Facility services are covered in participating facilities only. <u>Prior authorization</u> is required. Limited to 120 days per member per calendar year
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	<u>Hospice services</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	Not covered	Physician certification required. Visit limits apply.
If your child needs	Children's eye exam	Not covered	Not covered	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Provider		Out-of-Network Provider (You will pay the most)	
		Tier 1 (You will pay the least)	Tier 2 (You will pay more)		
dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children’s glasses	Not covered	Not covered	Not covered	None
	Children’s dental check-up	Not covered	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.)

- Cosmetic surgery
- Dental care (Adult)
- Long term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Acupuncture treatment
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States.
See <http://provider.bcbs.com>
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S
- Private-duty nursing

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, 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 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 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 <http://www.michigan.gov/difs> or 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

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 <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$900
<u>What isn't covered</u>	
Limits or exclusions	\$70
The total Peg would pay is	\$1,470

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$40
<u>What isn't covered</u>	
Limits or exclusions	\$3,500
The total Joe would pay is	\$4,240

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This **EXAMPLE** event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$10
<u>What isn't covered</u>	
Limits or exclusions	\$10
The total Mia would pay is	\$920

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.

