



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

Plymouth-Canton Community Schools

Group Number: 71711 Package Code(s): 031, 032

Division Code(s): 3000, 3100

PPO - HDHP1A, RX7, Hearing11

Effective Date: 01/01/2025

Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Note: A list of services that require approval **before** they are provided is available online at (<https://www.bcbsm.com/importantinfo>). Select **Approving covered Services**.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract.	\$2,000 per member \$4,000 per family	\$4,000 per member \$8,000 per family
Copays • Fixed Dollar Copays	No Copay	No Copay
Coinsurance • Percent Coinsurance	20%	40% Note: Services without a network are covered at the in-network level.
Annual out-of-pocket maximums The full family out of pocket maximum must be met before it is considered satisfied.	\$3,000 per member \$6,000 per family Includes Deductible, Coinsurance and Copays	\$6,000 per member \$12,000 per family Includes Deductible and Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered

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Benefits	In-Network	Out-of-Network
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 60% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 60% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services		
Benefits	In-Network	Out-of-Network
Office Visits	Covered - 80% after deductible	Covered - 60% after deductible
Telemedicine Visits	Covered - 80% after deductible	Covered - 60% after deductible
Virtual Care - Online Medical Visits Note: Online Medical visits by a non-BCBSM selected vendor are not covered.	Covered - 80% after deductible	Not Covered
Office Consultations	Covered - 80% after deductible	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 100% after deductible	Covered - 60% after deductible

Emergency Medical Care		
Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 80% after deductible	Covered - 80% after deductible
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Facility Urgent Care Services	Covered - 80% after deductible	Covered - 60% after deductible
Physician Urgent Care Services	Covered - 80% after deductible	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

Diagnostic Services		
Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 60% after deductible

Maternity Services Provided by a Physician		
Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 60% after deductible

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Benefits	In-Network	Out-of-Network
Delivery and Nursery Care	Covered - 80% after deductible	Covered - 60% after deductible

Hospital Care		
Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible	Covered - 60% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 60% after deductible

Alternatives to Hospital Care		
Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 100% after deductible	Covered - 100% after deductible
Home Health Care	Covered - 80% after deductible	Covered - 80% after deductible
Skilled Nursing Limited to 90 days per benefit period	Covered - 80% after deductible	Covered - 80% after deductible

Surgical Services		
Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Bariatric Surgery	Covered - 80% after deductible	Not Covered
Sterilization - male reproductive organs excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - female reproductive organs excludes reversal sterilization	Covered - 100%	Covered - 60% after deductible
Expanded Abortion Services	Not Covered	Not Covered
Note: Abortions are not covered if rendered in a location where abortions are not legal.		

Human Organ Transplants		
Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100% after deductible	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 60% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)		
Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Telemedicine Mental Health Care	Covered - 80% after deductible	Covered - 60% after deductible

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Benefits	In-Network	Out-of-Network
Virtual Care - Online Mental Health Visits Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered.	Covered - 80% after deductible	Not Covered

Autism Spectrum Disorders, Diagnoses and Treatment		
Benefits	In-Network	Out-of-Network
Applied Behavior Analysis (ABA) Prior authorization required Note: Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).	Covered - 80% after deductible	Covered - 60% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 80% after deductible	Covered - 60% after deductible
Nutritional Counseling	Covered - 80% after deductible	Covered - 60% after deductible

Other Covered Services		
Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation Services Limited to a maximum of 24 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 60% after deductible
Private Duty Nursing Care	Covered - 50% after deductible	Covered - 50% after deductible
Allergy Testing and Therapy	Covered - 100% after deductible	Covered - 60% after deductible
Facility Clinic Visit	Covered - 80% after deductible	Covered - 60% after deductible

Therapy Services		
Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible



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Plymouth-Canton Community Schools

Group Number: 71711 Package Code(s): 031, 032

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Hearing Care Coverage

Effective Date: 01/01/2025

Benefits-at-a-glance

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Member's responsibility (deductible and coinsurance)

Benefits	Participating Provider	Non-Participating Provider
Deductible	\$2,000 per member \$4,000 per family	Not Covered
Coinsurance	20%	Not Covered

Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

Benefits	Participating Provider	Non-Participating Provider
Frequency Limitation	Once every 36 months	
Audiometric Exam	Covered - 80% after deductible	Not Covered
Hearing Aid Evaluation	Covered - 80% after deductible	Not Covered
Hearing Aid	Covered - 80% after deductible	Not Covered
Limited to a maximum of \$1,890 age 19 and over		
Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.		
Hearing Aid Conformity Test	Covered - 80% after deductible	Not Covered

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Prescription Drugs
Effective Date: 01/01/2025
Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)	
Benefits	Coverage
Deductible	\$2,000 per member \$4,000 per family
Retail - 30-day supply	\$15 copay after deductible - Generic drugs \$50 copay after deductible - Preferred brand drugs 50% coinsurance after deductible - Non-Preferred brand drugs \$70 minimum, \$100 maximum Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Mail Order - 90-day supply	\$30 copay after deductible - Generic drugs \$100 copay after deductible - Preferred brand drugs 50% coinsurance after deductible - Non-Preferred brand drugs \$140 minimum, \$200 maximum
Specialty Drugs	Retail 30-day: \$15 copay after deductible - Generic drugs \$50 copay after deductible - Preferred brand drugs 50% coinsurance after deductible - Non-Preferred brand drugs \$70 minimum, \$100 maximum Members are restricted to a 30-day supply and certain specialty drugs are limited to only a 15-day supply for each fill.
High-Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum. Note - Adjustments may be required to accurately reflect your annual out-of-pocket maximum with your true out-of-pocket costs.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%

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Benefits	Coverage
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance
Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered
Diabetic Supplies	Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs. • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement. • "Preferred" devices will be covered at 100% of our approved amount. "Nonpreferred" devices will be subject to your nonpreferred brand-name drugs cost-share requirement. • If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies.

Features of your prescription drug plan	
Preferred Therapy Program	A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications before prescribing a more expensive brand-name drug. It applies only to prescriptions being filled for the first time of a targeted medication. Before filling your initial prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at bcbsm.com/pharmacy, along with the preferred medications. If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect all targeted brand- name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.
Maximum allowable cost drugs	For maximum allowable cost (MAC) drugs, if you have a prescription filled by an in-network pharmacy, and the pharmacist fills it with a generic equivalent drug, you are required to pay only the copayment and/or deductible, if applicable. If you obtain a brand name drug when a generic equivalent drug is available, you must pay the difference between the maximum allowable cost and the Blue Cross approved amount for the brand name drug plus your copayment and/or deductible, if applicable. Note: If your physician requests and receives authorization for a brand name drug from Blue Cross Pharmacy Services Department and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your copayment and/or deductible, if applicable.

Plymouth-Canton Community Schools

Coverage for: Individual/Family | Plan Type: PPO

Plan 7 HDHP



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 1-800-752-1455. 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 1-800-752-1455 to request a copy.

Important Questions	Answers		Why This Matters:
	In-Network	Out-of-Network	
What is the overall <u>deductible</u> ?	\$2,000 Individual/ \$4,000 Family	\$4,000 Individual/ \$8,000 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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
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 <u>preventive services</u> 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)	\$3,000 Individual/ \$6,000 Family	\$6,000 Individual/ \$12,000 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> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <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. For a list of <u>network providers</u> see www.bcbsm.com or call 1-800-752-1455		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.
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 (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 to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care/ screening/ immunization</u>	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)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	May require <u>prior authorization</u> .
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbsm.com/druglists	Generic or prescribed over-the-counter drugs	\$15 <u>copay</u> /prescription for retail 30-day supply, \$30 <u>copay</u> /prescription for mail order 90-day supply	\$15 <u>copay</u> /prescription for retail 30-day supply plus an additional 25% of BCBSM approved amount for the drug	Prior <u>authorization</u> , step therapy and quantity limits may apply to select drugs. <u>Preventive</u> drugs covered in full. Mail order drugs are not covered out-of-network. Select diabetic supplies and devices may be covered under the prescription drug program.
	Preferred brand-name drugs	\$50 <u>copay</u> /prescription for retail 30-day supply, \$100 <u>copay</u> /prescription for mail order 90-day supply	\$50 <u>copay</u> /prescription for retail 30-day supply plus an additional 25% of BCBSM approved amount for the drug	
	Non-Preferred brand-name drugs	50% <u>coinsurance</u> with \$70 min and \$100 max for retail 30-day supply, 50% <u>coinsurance</u> with \$140 min and \$200 max for mail order 90-day supply	50% <u>coinsurance</u> with \$70 min and \$100 max for retail 30-day supply plus an additional 25% of BCBSM approved amount for the drug	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Mileage limits apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior authorization</u> is required.
	Physician/surgeon fee	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Your cost share may be different for services performed in an office setting.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior authorization</u> is required.
If you are pregnant	Office visits	Prenatal: No charge; <u>deductible</u> does not apply Postnatal: No charge; <u>deductible</u> does not apply	Prenatal: 40% <u>coinsurance</u> Postnatal: 40% <u>coinsurance</u>	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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Physician certification required. Unlimited visits.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Physical, Occupational and Speech Therapy are limited to a combined maximum of 60 visits per member, per calendar year.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Applied Behavior Analysis (ABA) treatment for Autism – when rendered by Licensed Behavior Analyst (LBA), subject to <u>prior authorization</u> .
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prior authorization</u> is required. Limited to a maximum of 120 days per member, per calendar year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	<u>Hospice services</u>	No charge	No charge	Physician certification required. Unlimited visits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Limited to a maximum of one exam per member, per 12 months.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
• Acupuncture	• Infertility treatment	• Routine foot care
• Cosmetic surgery	• Long-term care	• Weight Loss programs
• Dental care (Adult)	• Routine eye care (Adult)	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
• Bariatric surgery	• Coverage provided outside the United States. See http://provider.bcbs.com	• Non-Emergency care when travelling outside the U.S.
• Chiropractic care	• Hearing Aids	• 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 1-800-752-1455. 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 1-800-752-1455.

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>	\$2,000
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,000
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

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>	\$2,000
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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>	\$2,000
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$200
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,720

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,200

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.

