



Community BlueSM PPO – Plan 1 Medical Coverage (TEACHERS) Benefits-at-a-Glance for Plymouth-Canton Community Schools 007010262-0011

The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This BAAG is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

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. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

	In-network	Out-of-network *
Member's responsibility (deductibles, copays and dollar maximums)		
Deductibles	\$100 for one member, \$200 for the family (when two or more members are covered under your contract) each calendar year Note: Deductible may be waived if service is performed in a PPO physician's office.	\$250 for one member, \$500 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network deductible amounts also apply toward the in-network deductible.
Flat dollar copays	<ul style="list-style-type: none"> \$20 copay for office visits \$100 copay for emergency room visits 	\$100 copay for emergency room visits
Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.	<ul style="list-style-type: none"> 20% of approved amount for private duty nursing 10% of approved amount for select services See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.	<ul style="list-style-type: none"> 20% of approved amount for private duty nursing 30% of approved amount for most other covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.
Coinsurance maximums – applies to coinsurance amounts for all covered services – including mental health and substance abuse services – but does not apply to deductibles, flat dollar copays, private duty nursing amounts and prescription drug cost sharing amounts	\$500 for one member, \$1,000 for two or more members each calendar year	\$1,500 for one member, \$3,000 for two or more members each calendar year Note: Out-of-network copays also apply toward the in-network maximum.
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays and coinsurance amounts, if applicable	\$6,350 for one member; \$12,700 for two or more members each calendar year	\$12,700 for one member; \$25,400 for two or more members each calendar year Note: Out-of-network cost-sharing amounts also apply toward the in-network out-of-pocket maximum
Lifetime dollar maximum	None	

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* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



In-network

Out-of-network *

Preventive care services

Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay), one per member per calendar year	Not covered
Gynecological exam (including pap smear screening – laboratory and pathology services)	100% (no deductible or copay), one per member per calendar year	Not covered
Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay)	100% after out-of-network deductible
Contraceptive Injections	100% (no deductible or copay)	70% after out-of-network deductible
Voluntary Sterilization for females	100% (no deductible or copay)	70% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay) <ul style="list-style-type: none"> • 6 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 	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay)	Not covered
Fecal occult blood screening	100% (no deductible or copay), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay. One per member per calendar year	70% after out-of-network deductible Note: Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
Colonoscopy – routine or medically necessary	100% (no deductible or copay) for the first billed colonoscopy Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent copay. One per member per calendar year	70% after out-of-network deductible

Physician office services

Office visits/consultations	\$20 copay per office visit	70% after out-of-network deductible, must be medically necessary
Outpatient and home medical care visits	100% after in-network deductible	70% after out-of-network deductible, must be medically necessary
Urgent care visits	\$20 copay per office visit	70% after out-of-network deductible, must be medically necessary

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In-network

Out-of-network *

Emergency medical care

Hospital emergency room	\$100 copay per visit (copay waived if admitted or for an accidental injury)	\$100 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	90% after in-network deductible	90% after in-network deductible

Diagnostic services

Laboratory and pathology services	90% after in-network deductible	70% after out-of-network deductible
Diagnostic tests and x-rays	90% after in-network deductible	70% after out-of-network deductible
Therapeutic radiology	90% after in-network deductible	70% after out-of-network deductible

Maternity services provided by a physician

Prenatal and postnatal care	100% (no deductible or copay) Includes covered services provided by a certified nurse midwife	70% after out-of-network deductible
Delivery and nursery care	90% after in-network deductible Includes covered services provided by a certified nurse midwife	70% after out-of-network deductible

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	90% after in-network deductible	70% after out-of-network deductible
Unlimited days		
Inpatient consultations	90% after in-network deductible	70% after out-of-network deductible
Chemotherapy	90% after in-network deductible	70% after out-of-network deductible

Alternatives to hospital care

Skilled nursing care – must be in a participating skilled nursing facility	90% after in-network deductible	90% after in-network deductible
Limited to a maximum of 730 days per member		
Hospice care	100% (no deductible or copay) Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	100% (no deductible or copay)
Home health care – must be medically necessary and provided by a participating home health care agency	90% after in-network deductible	90% after in-network deductible
Home infusion therapy – must be medically necessary and given by participating home infusion therapy providers	90% after in-network deductible	90% after in-network deductible

Surgical services

Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	90% after in-network deductible	70% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay)	70% after out-of-network deductible
Voluntary sterilization for males	90% after in-network deductible	70% after out-of-network deductible

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In-network

Out-of-network *

Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay)	100% (no deductible or copay) – in designated facilities only
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	90% after in-network deductible	70% after out-of-network deductible
Specified oncology clinical trials	90% after in-network deductible	70% after out-of-network deductible
Kidney, cornea and skin transplants	90% after in-network deductible	70% after out-of-network deductible

Mental health care and substance abuse treatment

Inpatient mental health care	90% after in-network deductible	90% after out-of-network deductible
Inpatient substance abuse treatment	90% after in-network deductible	90% after out-of-network deductible
Outpatient mental health care:	\$15 copay per visit	\$15 copay per visit in participating facilities only
<ul style="list-style-type: none"> • Facility and clinic • Physician's office 	\$15 copay per visit	\$15 copay per visit
Outpatient substance abuse treatment – in approved facilities only	Covered - 90%	Covered – 90%

Other covered services

Outpatient Diabetes Management Program (ODMP) Note: Effective July 1, 2011, when you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	90% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay) for diabetes self-management training	70% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay)	70% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$20 copay per office visit Limited to a combined maximum of 38 visits per member per calendar year	70% after out-of-network deductible
Outpatient physical, speech and occupational therapy – provided for rehabilitation	90% after in-network deductible Limited to a combined maximum of 120 visits per member per calendar year	70% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
Durable medical equipment	90% after in-network deductible	90% after in-network deductible
Prosthetic and orthotic appliances	90% after in-network deductible	90% after in-network deductible
Hair prosthesis and related supplies	80% after in-network deductible	80% after in-network deductible
Private duty nursing	80% after in-network deductible	80% after in-network deductible
Prescription drugs	See separate attachment for details	See separate attachment for details

Additional Included Riders

Rider XVA , excludes voluntary abortions	Excludes benefits for voluntary abortions.
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Plymouth-Canton Community Schools: Plan 1-Teachers



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> ?	\$100 Individual/ \$200 Family	\$250 Individual/ \$500 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 <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)	\$6,350 Individual/ \$12,700 Family	\$12,700 Individual/ \$25,400 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> ?	<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>copay</u> /office visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> / immunization	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)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	May require <u>preauthorization</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	\$10 <u>copay</u> /prescription for retail 30-day supply, \$10 <u>copay</u> /prescription for mail order 90-day supply; <u>deductible</u> does not apply	\$10 <u>copay</u> /prescription plus an additional 25% of BCBSM approved amount for the drug; <u>deductible</u> does not apply	<u>Preauthorization</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. Effective 1/1/2021, select diabetic supplies and devices may be covered under the prescription drug program.
	Preferred brand-name drugs	\$40 <u>copay</u> /prescription for retail 30-day supply, \$40 <u>copay</u> /prescription for mail order 90-day supply; <u>deductible</u> does not apply	\$40 <u>copay</u> /prescription plus an additional 25% of BCBSM approved amount for the drug; <u>deductible</u> does not apply	
	Non-Preferred brand-name drugs	\$40 <u>copay</u> /prescription for retail 30-day supply, \$40 <u>copay</u> /prescription for mail order 90-day supply; <u>deductible</u> does not apply	\$40 <u>copay</u> /prescription plus an additional 25% of BCBSM approved amount for the drug; <u>deductible</u> does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None

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)	
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$100 <u>copay/visit</u> ; <u>deductible</u> does not apply	<u>Copay</u> waived if admitted or for an accidental injury.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Mileage limits apply.
	<u>Urgent care</u>	\$20 <u>copay/visit</u> ; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	Physician/surgeon fee	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	\$15 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$15 <u>copay/visit</u> ; <u>deductible</u> does not apply for Mental Health; No charge; <u>deductible</u> does not apply for substance abuse	Your cost share may be different for services performed in an office setting.
	Inpatient services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	No charge; <u>deductible</u> does not apply	30% <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	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Physician certification required. Unlimited visits.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Physical, Occupational, Speech therapy is limited to a combined maximum of 120 visits per member, per calendar year.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Applied Behavior Analysis (ABA) treatment for Autism – when rendered by Licensed Behavior Analyst (LBA), subject to <u>preauthorization</u> .

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>Skilled nursing care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Preauthorization</u> is required. Limited to lifetime maximum of 730 days with no renewal per member.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	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	Physician certification required. Unlimited visits.
If your child needs dental or eye care	Children's eye exam	No charge; <u>deductible</u> does not apply	30% <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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- 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.)

- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States.
See <http://provider.bcbs.com>
- Hearing Aids
- Non-Emergency care when travelling 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 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>	\$100
■ <u>Specialist copayment</u>	\$20
■ 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>	\$100
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,170

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>	\$100
■ <u>Specialist copayment</u>	\$20
■ 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>	\$100
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,000

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$100
■ <u>Specialist copayment</u>	\$20
■ 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>	\$100
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$350

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.

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تحتاجه مساعدة، ف لديك 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 مشتركاً 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。

بمبعض اللغات، نريد فقط مساعدتك، للحصول 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 مشتركاً بالفعل.

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 고객센터 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, potrzebujesz 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、またはお客様の方の身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>.