MICHIGAN CATHOLIC CONFERENCE

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 01/01/2015
Coverage for: Individual/Family **Plan Type:** PPO1

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsm.com or by calling the number on the back of your BCBSM ID card.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$250 Individual/ $500 Family	$500 Individual/ $1,000 Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.		You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses? (Deductibles and copays apply to out of pocket)	$1,250 Individual/ $2,500 Family	$3,500 Individual/ $7,000 Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.		The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.bcbsm.com or call the number on the back of your BCBSM ID card.		If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.		You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.		Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Group Number 007001434-

Questions: Call the number on the back of your BCBSM ID card or visit us at www.bcbsm.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the number on the back of your BCBSM ID card to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-pay	40% co-insurance after deductible	None, except the plan will not cover any medical expense which would violate the tenets of the Catholic Church. See the (*) in the Excluded Services section below for more information.
	Specialist visit	$25 co-pay	40% co-insurance after deductible	---none--- (*)
	Other practitioner office visit	$25 co-pay for chiropractic and osteopathic manipulative therapy	40% co-insurance after deductible for chiropractic and osteopathic manipulative therapy	Coverage is limited to a combined maximum of 24 visits per member per calendar year.
	Preventive care/ screening/immunization	No Charge	Not Covered	---none--- (*)
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance after deductible	40% co-insurance after deductible	---none--- (*)
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible	40% co-insurance after deductible	---none---
If you need drugs to treat your illness or condition For more information about prescription drug coverage, call 877.798.8454	Generic or select prescribed over-the-counter drugs	Not covered	Not covered	Generally covered with a 30 day supply retail or 90 day supply mail order. Please contact Express Scripts for more information (*)
	Preferred brand-name drugs	Not covered	Not covered	Specific limitations and exceptions may apply. Please contact Express Scripts for more information (*)
	Non-preferred brand-name drugs	Not covered	Not covered	Specific limitations and exceptions may apply. Please contact Express Scripts for more information (*)

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	40% co-insurance after deductible	---none--- (*)
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	---none--- (*)
If you need immediate medical attention	Emergency room services	$100 co-pay	$100 co-pay	Co-pay waived if admitted or for an accidental injury. (*)
	Emergency medical transportation	20% co-insurance after deductible	20% co-insurance after deductible	---none--- (*)
	Urgent care	$50 co-pay	40% co-insurance after deductible	---none--- (*)
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible	40% co-insurance after deductible	Unlimited days (*)
	Physician/surgeon fee	20% co-insurance after deductible	40% co-insurance after deductible	Unlimited days (*)
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	Unlimited visits (*)
	Mental/Behavioral health inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	Unlimited days (*)
	Substance use disorder outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	Unlimited visits (*)
	Substance use disorder inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	Unlimited days (*)
If you are pregnant	Prenatal and postnatal care	No Charge	40% co-insurance after deductible	Includes covered services provided by a certified nurse midwife. (*)
	Delivery and all inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	Includes covered services provided by a certified nurse midwife. (*)
If you need help recovering or have other special health needs	Home health care	20% co-insurance after deductible	20% co-insurance after deductible	---none---
	Rehabilitation services	20% co-insurance after deductible	40% co-insurance after deductible	Coverage for Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year. (*)

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
	Habilitation services	20% co-insurance after deductible for Applied Behavioral Analysis; 20% co-insurance after deductible for Physical, Speech and Occupational Therapy	20% co-insurance after deductible for Applied Behavioral Analysis; 40% co-insurance after deductible for Physical, Speech and Occupational Therapy	---none--- (*)
	Skilled nursing care	20% co-insurance after deductible	20% co-insurance after deductible	Limited to a maximum of 120 days per member, per calendar year. (*)
	Durable medical equipment	20% co-insurance after deductible	20% co-insurance after deductible	---none--- (*)
	Hospice service	No Charge	No Charge	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day-periods-provided through a participating hospice program only. (*)
If you or your child needs dental or eye care For more information on vision, contact your plan administrator	Routine Vision Exam	$25 co-pay	Not Covered	Coverage for preventative eye exam only. (*)
	Glasses	Not Covered	Not Covered	Discounts Offered (*)
	Dental check-up	Not Covered	Not Covered	---none--- (*)

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- (*) Any medical expense which would violate the tenets of the Catholic Church, specifically including medical expenses relating to sterilizations, abortions and/or birth control devices
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery
- Chiropractic Care
- Coverage provided outside the United States. See http://provider.bcbs.com
- Hearing aids
- Non-Emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at the number on the back of your BCBSM ID card. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Blue Cross®and Blue Shield®of Michigan by calling the number on the back of your BCBSM ID card. Or, you can contact Michigan Office of Financial and Insurance Regulation at **www.michigan.gov/ofir** or 1-877-999-6442. For group health coverage subject to ERISA, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Please note: Coverage examples are calculated based on individual coverage and calculations may not include a coinsurance maximum.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,390
- **Patient pays** $1,150

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$250
Co-pays	$0
Co-insurance	$750
Limits or exclusions	$150
Total	**$1,150**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,350 ■ **Patient pays** $1,050

Sample care costs:

Prescriptions (through Express Scripts)	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$250
Co-pays	$280
Co-insurance	$440
Limits or exclusions	$80
Total	**$1,050**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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