County of Oakland

Medicare Sup CMM, Rx5, Hearing 1

Coverage for: Individual/Family | **Plan Type:** Supplemental

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 1-877-752-1233. 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 1-877-752-1233 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Medicare approved expenses.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the medical out-of-pocket limit for this plan? (May include a coinsurance maximum)	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is the out-of-pocket limit for this prescription plan?	$3,775 Individual / $5,550 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Not Applicable	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
		Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not Covered	None
	Online visits	No charge	Online Medical visits by a non-BCBSM selected vendor are not covered.
	Specialist visit	Not Covered	None
	Preventive care/screening /immunization	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	None
	Imaging (CT/PET scans, MRIs)	No charge	May require prior authorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/druglists	Generic or prescribed over-the-counter drugs	$10 copay/prescription for retail 30-day supply, $10 copay/prescription for retail or mail order 90-day supply	Prior authorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. Mail order drugs are not covered out-of-network. Effective 1/1/2021, selective diabetic supplies and devices may be covered under the prescription drug program. Covers up to a 90-day supply (retail or up to a 90-day supply mail order). Specific criteria may need to be met in order for some high-cost medications to be covered.
	Preferred brand-name drugs	$30 copay/prescription for retail 30-day supply, $30 copay/prescription for retail or mail order 90-day supply	
	Non-Preferred brand-name drugs	$50 copay/prescription for retail 30-day supply, $50 copay/prescription for retail or mail order 90-day supply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	None
	Physician/surgeon fees	No charge	None
If you need immediate medical attention	Emergency room care	$100 copay/visit	Copay waived if admitted.
	Emergency medical transportation	No charge	Mileage limits apply.
	Urgent care	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
		Participating Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Prior authorization is required.
	Physician/surgeon fee	No charge	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	No charge	Office visit coverage is excluded.
	Inpatient services	No charge	Prior authorization is required (excludes office visits).
If you are pregnant	Office visits	No charge	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services cost share may apply. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	None
	Childbirth/delivery facility services	No charge	None
If you need help recovering or have other special health needs	Home health care	No charge	Physician certification required. Limited to a maximum of 100 visits per member, per calendar year.
	Rehabilitation services	No charge	None
	Habilitation services	Not Covered	Applied Behavior Analysis (ABA) treatment for Autism – when rendered by Licensed Behavior Analyst (LBA), subject to prior authorization.
	Skilled nursing care	No charge	Prior authorization is required. Limited to a maximum of 100 days per member, per calendar year.
	Durable medical equipment	No charge	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No charge	Physician certification required. Limited to a Lifetime maximum of 30 days per member.
If your child needs dental or eye care	Children's eye exam	Not Covered	For more information about vision coverage visit www.heritagevisionplans.com or www.oakgov.com/benefits.
	Children's glasses	Not Covered	
	Children's dental check-up	Not Covered	For more information about dental coverage visit www.deltadentalmi.com or www.oakgov.com/benefits.

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	• Dental care (Adult)	• Routine eye care (Adult)
• Chiropractic care	• Infertility treatment	• Weight Loss programs
• Cosmetic surgery	• Long-term care	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Hearing Aids	• Private-duty nursing
• Coverage provided outside the United States. See http://provider.bcbs.com	• Non-Emergency care when travelling outside the U.S.	• Routine foot care

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 1-877-752-1233. 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 1-877-752-1233.

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 plan's overall deductible** — **$0**
- **Specialist coinsurance** — **100%**
- **Hospital (facility) coinsurance** — **0%**
- **Other coinsurance** — **0%**

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** — **$0**
- **Specialist coinsurance** — **100%**
- **Hospital (facility) coinsurance** — **0%**
- **Other coinsurance** — **0%**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$800
The total Joe would pay is	**$1,300**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** — **$0**
- **Specialist coinsurance** — **100%**
- **Hospital (facility) coinsurance** — **0%**
- **Other coinsurance** — **0%**

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Mia would pay is	**$300**

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

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

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 تساعده بحاجة لمساعدة، فلديك 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 مشتركا 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。

ܐܢ ܐܚܬܘܢ، ܐܘ ܚܕ ܦܪܨܘܦܐ ܕܡܥܕܪܝܬܘܢ ، ܣܢܝܩ ܝܗܘܐ ܠܥܘܕܪܢܐ، ܐܚܬܘܢ ܐܝܬܠܟܘܢ ܙܕܩܘܬܐ ܕܩܒܠܝܬܘܢ ܥܘܕܪܢܐ ܘܡܘܕܥܢܘܬܐ ܠܠܫܢܟܘܢ ܕܠܐ ܦܘܪܥܢܐ. ܠܡܡܠܠܬܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘ ܠܡ ܡܢܝܢܐ ܕܚܠܡܬܐ ܕܒܥܡܝܠܐ ܥܠ ܒܣܪܐ ܕܟܪܛܝܣܟܘܢ ܝܢ 877-469-2583 TTY:711 ܐܢ ܠܐ ܗܘܝܬܘܢ ܗܕܡܐ.

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 고객 서비스 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, potrzebujecie 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、またはお客様の身の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*.