

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call the number on the back of your BCBSM ID card. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call the number on the back of your BCBSM ID card to request a copy.

| Important Questions | Answers | | Why This Matters: |
|---|---|---|--|
| | In-Network | Out-of-Network | |
| What is the overall <u>deductible</u> ? | \$1,000 Individual/ \$2,000 Family | \$2,000 Individual/ \$4,000 Family | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> . | | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <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</u> limit 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</u> limit 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</u> limits until the overall family <u>out-of-pocket</u> limit has been met. |
| What is not included in the <u>out-of-pocket</u> limit? | Premiums, <u>balance-billing</u> charges, any <u>pharmacy</u> penalty and health care this <u>plan</u> doesn't cover. | | Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit. |
| Will you pay less if you use a <u>network</u> provider? | Yes. See (http://www.bcbsm.com) or call the number on the back of your BCBSM ID card for a list of <u>network</u> providers. | | This <u>plan</u> uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network</u> <u>provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network</u> <u>provider</u> might use an <u>out-of-network</u> <u>provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |

| Important Questions | Answers | | Why This Matters: |
|--|------------|----------------|--|
| | In-Network | Out-of-Network | |
| 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 | \$10 <u>copay</u> /office visit; <u>deductible</u> does not apply | 20% <u>coinsurance</u> | None |
| | <u>Specialist</u> visit | \$10 <u>copay</u> /visit; <u>deductible</u> does not apply | 20% <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 you need 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) | No Charge | 20% <u>coinsurance</u> | None |
| | Imaging (CT/PET scans, MRIs) | No Charge | 20% <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 select prescribed over-the-counter drugs | \$10 <u>copay</u> for retail 30-day supply; \$20 <u>copay</u> for retail or mail order 90-day supply; <u>deductible</u> does not apply | In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply | Preauthorization, step therapy and quantity limits may apply to select drugs. <u>Preventive</u> drugs covered in full. 90-day supply not covered out of network. |
| | Preferred brand-name drugs | \$40 <u>copay</u> for retail 30-day supply; \$80 <u>copay</u> for retail or mail order 90-day supply; <u>deductible</u> does not apply | In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply | |
| | Non preferred brand-name drugs | \$80 <u>copay</u> for retail 30-day supply; \$160 <u>copay</u> for retail or mail order 90-day supply; <u>deductible</u> does not apply | In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply | |

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|--|--|--|--|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No Charge | 20% <u>coinsurance</u> | None |
| | Physician/surgeon fees | No Charge | 20% <u>coinsurance</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> | \$50 <u>copay/visit</u> ; <u>deductible</u> does not apply | \$50 <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> | No Charge | No Charge | Mileage limits apply |
| | <u>Urgent care</u> | \$10 <u>copay/visit</u> ; <u>deductible</u> does not apply | 20% <u>coinsurance</u> | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No Charge | 20% <u>coinsurance</u> | <u>Preauthorization</u> may be required |
| | Physician/surgeon fee | No Charge | 20% <u>coinsurance</u> | None |
| If you need mental health, behavioral health, or substance use disorder services | Outpatient services | No Charge; <u>deductible</u> does not apply | No Charge; <u>deductible</u> does not apply | Your cost share may be different for services performed in an office setting |
| | Inpatient services | No Charge | 20% <u>coinsurance</u> | <u>Preauthorization</u> is required. |
| If you are pregnant | Office visits | No Charge; <u>deductible</u> does not apply | 20% <u>coinsurance</u> | Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. <u>Cost sharing</u> does not apply to certain maternity services considered to be <u>preventive</u> . |
| | Childbirth/delivery professional services | No Charge | 20% <u>coinsurance</u> | None |
| | Childbirth/delivery facility services | No Charge | 20% <u>coinsurance</u> | None |
| If you need help recovering or have other special health needs | <u>Home health care</u> | No Charge | No Charge | <u>Preauthorization</u> is required. |
| | <u>Rehabilitation services</u> | No Charge | 20% <u>coinsurance</u> | 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 | 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>Habilitation services</u> | No Charge for Applied Behavioral Analysis; No Charge for Physical, Speech and Occupational Therapy | No Charge for Applied Behavioral Analysis; 20% <u>coinsurance</u> for Physical, Speech and Occupational Therapy | Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to <u>preauthorization</u> . |
| | <u>Skilled nursing care</u> | No Charge | No Charge | <u>Preauthorization</u> is required. Limited to 120 days per member per calendar year |
| | <u>Durable medical equipment</u> | No Charge | No Charge | 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 | <u>Preauthorization</u> is required. Visit limits apply. |
| If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator | Children's eye exam | Not covered | Not covered | None |
| | 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 treatment
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- 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>
- 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, co-payments, or co-insurance, or benefits not otherwise covered
- Non-emergency care when traveling outside the U.S
- Private duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor’s Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling the number on the back of your BCBSM ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or <http://www.michigan.gov/difs> or difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? Yes

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 <u>deductible</u> | \$1,000 |
| ■ <u>Specialist copayment</u> | \$10 |
| ■ Hospital (facility) <u>coinsurance</u> | 0% |
| ■ Other <u>coinsurance</u> | 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 | \$1,000 |
| Copayments | \$50 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,110 |

Managing Joe's Type 2 Diabetes

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

| | |
|--|---------|
| ■ The plan's overall <u>deductible</u> | \$1,000 |
| ■ <u>Specialist copayment</u> | \$10 |
| ■ Hospital (facility) <u>coinsurance</u> | 0% |
| ■ Other <u>coinsurance</u> | 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 | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,000 |
| Copayments | \$900 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Joe would pay is | \$1,960 |

Mia's Simple Fracture

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

| | |
|--|---------|
| ■ The plan's overall <u>deductible</u> | \$1,000 |
| ■ <u>Specialist copayment</u> | \$10 |
| ■ Hospital (facility) <u>coinsurance</u> | 0% |
| ■ Other <u>coinsurance</u> | 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 | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,000 |
| Copayments | \$30 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,030 |

