
 **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, call 1-888-227-2345 or go online to [www.bcbsm.com](http://www.bcbsm.com). 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 1-888-227-2345 to request a copy.

| Important Questions                                                 | Answers                                                                                                                                                                                  | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                              | \$0                                                                                                                                                                                      | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Are there services covered before you meet your deductible?</b>  | Yes. <u>Preventive care</u> , primary care visits, lab, and <u>urgent care</u> are covered before you meet your deductible.                                                              | 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                           |
| <b>Are there other deductibles for specific services?</b>           | No                                                                                                                                                                                       | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b> | Not Applicable                                                                                                                                                                           | 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.                                                                                                                                                                                                                                                                                    |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>      | <u>Premiums</u> , <u>balance billing charges</u> , 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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Will you pay less if you use a <u>network provider</u>?</b>      | Yes. See <a href="https://www.bcbsm.com/marketplace/preferred-hmo/">https://www.bcbsm.com/marketplace/preferred-hmo/</a> or call 1-888-227-2345 for a list of <u>network providers</u> . | 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 charge</u> 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. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>    | Yes                                                                                                                                                                                      | This <u>plan</u> will pay some or all of the costs to see a specialist for covered services but only if you have a <u>referral</u> before you see the specialist.                                                                                                                                                                                                                                                                                                                                                                                            |

 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                                                                                                                                                                                                                               |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|----------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                                                                       | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                      |
| <b>If you visit a health care provider's office or clinic</b> | Primary care/<br>Virtual/ Retail health clinic/<br>Medical online visit to treat an injury or illness | No charge                                    | Not covered                                        | Medical online visits when performed by a BCN selected vendor.                                                                                                                                                                                                                       |
|                                                               | <u>Specialist</u> visit                                                                               | No charge                                    | Not covered                                        | <u>Referral</u> required. The penalty for not having a <u>referral</u> is denial of payment.                                                                                                                                                                                         |
|                                                               | <u>Preventive care/ screening/ Immunization</u>                                                       | No charge                                    | Not covered                                        | May require prior authorization. The penalty for not having prior authorization is denial of payment.<br><br>You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| <b>If you have a test</b>                                     | <u>Diagnostic test</u><br>(x-ray, blood work)                                                         | No charge                                    | Not covered                                        | May require prior authorization. The penalty for not having prior authorization is denial of payment.                                                                                                                                                                                |
|                                                               | Imaging (CT/PET scans, MRIs)                                                                          | No charge                                    | Not covered                                        | Prior authorization required. The penalty for not having prior authorization is denial of payment.                                                                                                                                                                                   |

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsm.com/index/plans/michigan-health-insurance/2023.html](http://www.bcbsm.com/index/plans/michigan-health-insurance/2023.html)

| Common Medical Event                                                                                                                                                                                                                                       | Services You May Need                | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|----------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                            |                                      | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="https://www.bcbsm.com/2023-select-hmo-druglist">https://www.bcbsm.com/2023-select-hmo-druglist</a> | Preferred generic drugs              | No charge                                    | Not covered                                        | May require prior authorization & Step Therapy. The penalty for not having prior authorization is denial of payment. No charge for preferred generic contraceptives.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                            | Non-preferred generic drugs          | No charge                                    | Not covered                                        | Retail & mail order 30-day supply. Retail 84-90-day supply & mail order 31-90-day supply.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                                            | Preferred brand drugs                | No charge                                    | Not covered                                        | Opioid containing medications are limited to no more than a 30-day supply per fill. First fills of select opioid containing medications will be limited to a 5-day supply.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                            | Non-preferred brand drugs            | No charge                                    | Not covered                                        | Any coupon, rebate, or other credits received directly or indirectly from the drug manufacturer may not be applied to a consumer's <u>deductible</u> , <u>cost-sharing</u> or out of pocket maximum.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                            | Preferred <u>Specialty drugs</u>     | No charge                                    | Not covered                                        | <u>Specialty drugs</u> are limited to a 30-day supply per fill, however some may be limited to a 15-day supply fill, depending on the medication. BCN has contracted with an exclusive pharmacy <u>network</u> for <u>specialty drugs</u> . Call the customer service phone number on the back of your ID card for the pharmacy's phone number or location nearest to you. If you obtain your <u>specialty drugs</u> from any other pharmacy, you are responsible for the total cost. Prior authorization, step therapy and quantity limits may apply to select drugs. The penalty for not having prior authorization is denial of payment. Any coupon, rebate, or other credits received directly or indirectly from the drug manufacturer may not be applied to a consumer's <u>deductible</u> , <u>cost-sharing</u> or out of pocket maximum. |
|                                                                                                                                                                                                                                                            | Non-Preferred <u>Specialty drugs</u> | No charge                                    | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

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| Common Medical Event                                                             | Services You May Need                          | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                                | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>If you have outpatient surgery</b>                                            | Facility fee (e.g., ambulatory surgery center) | No charge                                    | Not covered                                        | These services may require prior authorization. The penalty for not having prior authorization is denial of payment. Excludes cosmetic surgery, corrective eye surgery, investigational and experimental procedures.<br><br>Weight reduction procedures limited to one per lifetime.                                                                                                                                                              |
|                                                                                  | Physician/surgeon fees                         | No charge                                    | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>If you need immediate medical attention</b>                                   | <u>Emergency room care</u>                     | No charge                                    | No charge                                          | Emergency room visits will be covered at non-participating facilities for medical emergencies and accidental injuries only.                                                                                                                                                                                                                                                                                                                       |
|                                                                                  | <u>Emergency medical transportation</u>        | No charge                                    | No charge                                          | Includes air and ground transportation. Excludes transportation for convenience.                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                  | <u>Urgent care</u>                             | No charge                                    | No charge                                          | <u>Urgent care</u> visits will be covered at non-participating <u>providers</u> for medical emergencies and accidental injuries only.                                                                                                                                                                                                                                                                                                             |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)             | No charge                                    | Not covered                                        | Prior authorization required. The penalty for not having prior authorization is denial of payment.<br><br>Weight reduction procedures limited to one per lifetime.                                                                                                                                                                                                                                                                                |
|                                                                                  | Physician/surgeon fees                         | No charge                                    | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                            | No charge                                    | Not covered                                        | Prior authorization is not required for outpatient, office, virtual visit by participating BCN <u>provider</u> and Blue Cross online visit from BCN selected vendor only. Prior authorization is required for other outpatient services. The penalty for not having prior authorization is denial of payment.<br><br>Prior authorization is required for inpatient services. The penalty for not having prior authorization is denial of payment. |
|                                                                                  | Inpatient services                             | No charge                                    | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

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| Common Medical Event                                           | Services You May Need                     | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                            |
|----------------------------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                   |
| If you are pregnant                                            | Office visits                             | No charge                                    | Not covered                                        | None                                                                                                                                                                                                                                                                              |
|                                                                | Childbirth/delivery professional services | No charge                                    | Not covered                                        | None                                                                                                                                                                                                                                                                              |
|                                                                | Childbirth/delivery facility services     | No charge                                    | Not covered                                        | Prior authorization is required for inpatient services. The penalty for not having prior authorization is denial of payment.                                                                                                                                                      |
| If you need help recovering or have other special health needs | <u>Home health care</u>                   | No charge                                    | Not covered                                        | Excludes housekeeping and custodial services.                                                                                                                                                                                                                                     |
|                                                                | <u>Rehabilitation services</u>            | No charge                                    | Not covered                                        | Prior authorization required. The penalty for not having prior authorization is denial of payment.<br>Physical and occupational therapy are limited to a combined 30 visits per member per calendar year. Speech therapy is limited to 30 visits per member per calendar year.    |
|                                                                | <u>Habilitation services</u>              | No charge                                    | Not covered                                        | Prior authorization required. The penalty for not having prior authorization is denial of payment.<br>Physical and occupational therapy are limited to a combined 30 visits per member per calendar year.<br>Speech therapy is limited to 30 visits per member per calendar year. |

\* For more information about limitations and exceptions, see the [plan](http://www.bcbsm.com/index/plans/michigan-health-insurance/2023.html) or policy document at [www.bcbsm.com/index/plans/michigan-health-insurance/2023.html](http://www.bcbsm.com/index/plans/michigan-health-insurance/2023.html)

| Common Medical Event                                                  | Services You May Need            | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                   |
|-----------------------------------------------------------------------|----------------------------------|----------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                  | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                          |
| <b>If you need help recovering or have other special health needs</b> | <u>Skilled nursing care</u>      | No charge                                    | Not covered                                        | Prior authorization required. The penalty for not having prior authorization is denial of payment. Limited to 45 days per calendar year. Custodial care is excluded.                                                                                                                                                     |
|                                                                       | <u>Durable medical equipment</u> | No charge                                    | Not covered                                        | Prior authorization required. The penalty for not having prior authorization is denial of payment. Breast pumps are covered in full when preauthorized.<br><br>Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription is required. Rental and purchase limited to basic equipment. |
|                                                                       | <u>Hospice services</u>          | No charge                                    | Not covered                                        | Prior authorization required. The penalty for not having prior authorization is denial of payment. Coverage includes inpatient and outpatient hospice care. BCN participating hospice programs only. Excludes housekeeping services.                                                                                     |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam              | No charge                                    | Not covered                                        | Limited to once in a calendar year. A child is defined as a member up to the age of 19. Out-of-network is paid up to the <u>allowed amount</u> .                                                                                                                                                                         |
|                                                                       | Children's glasses               | No charge                                    | Not covered                                        | Frames (chosen from a select collection) and lenses are covered once in a calendar year. A child is defined as a member up to the age of 19. Out-of-network is paid up to the <u>allowed amount</u> .                                                                                                                    |
|                                                                       | Children's dental check-up       | Not covered                                  | Not covered                                        | Stand-alone dental <u>plans</u> available.                                                                                                                                                                                                                                                                               |

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## 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.)

- Abortion (except in the case of when the life of the mother is endangered). See section 5 in the plan's certificate.
- Acupuncture
- Cosmetic Surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic
- Infertility treatment
- Weight loss programs

**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: Michigan Department of Insurance and Financial Services at [www.michigan.gov/difs](http://www.michigan.gov/difs) at 1-877-999-6442. 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](http://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 on how 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: Michigan Department of Insurance and Financial Services at [michigan.gov/difs](http://michigan.gov/difs) at 1-877-999-6442.

### 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 the Minimum Value Standards? Not Applicable

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.

### Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 888-288-2738.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-288-2738.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 888-288-2738.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 888-288-2738.]

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

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## 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 overall deductible</u>   | \$0 |
| ■ <u>Specialist copayment</u>            | \$0 |
| ■ 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <i>Cost Sharing</i>               |             |
|-----------------------------------|-------------|
| <u>Deductibles</u>                | \$0         |
| <u>Copayments</u>                 | \$0         |
| <u>Coinsurance</u>                | \$0         |
| <i>What isn't covered</i>         |             |
| Limits or exclusions              | \$60        |
| <b>The total Peg would pay is</b> | <b>\$60</b> |

### Managing Joe's Type 2 Diabetes

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

|                                          |     |
|------------------------------------------|-----|
| ■ The <u>plan's overall deductible</u>   | \$0 |
| ■ <u>Specialist copayment</u>            | \$0 |
| ■ 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <i>Cost Sharing</i>               |             |
|-----------------------------------|-------------|
| <u>Deductibles</u>                | \$0         |
| <u>Copayments</u>                 | \$0         |
| <u>Coinsurance</u>                | \$0         |
| <i>What isn't covered</i>         |             |
| Limits or exclusions              | \$20        |
| <b>The total Joe would pay is</b> | <b>\$20</b> |

### Mia's Simple Fracture

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

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

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| <i>Cost Sharing</i>               |            |
|-----------------------------------|------------|
| <u>Deductibles</u>                | \$0        |
| <u>Copayments</u>                 | \$0        |
| <u>Coinsurance</u>                | \$0        |
| <i>What isn't covered</i>         |            |
| Limits or exclusions              | \$0        |
| <b>The total Mia would pay is</b> | <b>\$0</b> |

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



