



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:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | \$5,800 Individual/\$11,600 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, primary care visits, lab, and <u>urgent care</u> 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                            |
| Are there other <u>deductibles</u> for specific services?           | No.                                                                                                                                                                                | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | \$7,650 Individual/\$15,300 Family                                                                                                                                                 | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                     |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , <u>balance billing</u> charges, and health care this <u>plan</u> doesn't cover.                                                                                  | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Will you pay less if you use a <u>network provider</u> ?            | Yes. See <a href="https://www.bcbsm.com/marketplace/select-hmo/">https://www.bcbsm.com/marketplace/select-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</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | Yes.                                                                                                                                                                               | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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                                                                                                                                                                                                                                        |
|--------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                        |                                                  | Network Provider<br>(You will pay the least)                                                                                                                                                                                             | Out-of-Network Provider<br>(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 | \$60 <u>copayment</u> /primary care office and virtual visits, retail health clinic visit, and medical evaluation at an affiliated immunization pharmacy. No charge 24/7 medical virtual visit.<br><br><u>Deductible</u> does not apply. | Not covered                                        | Diagnostic services are not included in the office visit <u>copayment</u> . These services are subject to the <u>plan's deductible</u> and <u>coinsurance</u> . No charge for 24/7 medical virtual visits when performed through the BCN selected vendor app.                                 |
|                                                        | <u>Specialist</u> visit                          | \$110 <u>copayment</u> /visit<br><u>Deductible</u> does not apply.                                                                                                                                                                       | Not covered                                        | <u>Referral</u> required. The penalty for not having a <u>referral</u> is denial of payment. Diagnostic services are not included in the office visit <u>copayment</u> . These services are subject to the <u>plan's deductible</u> and <u>coinsurance</u> .                                  |
|                                                        | <u>Preventive care/screening/immunization</u>    | No charge<br><u>Deductible</u> does not apply.                                                                                                                                                                                           | Not covered                                        | May require prior authorization. The penalty for not having prior authorization is denial of payment. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| If you have a test                                     | <u>Diagnostic test</u> (x-ray, blood work)       | 35% <u>coinsurance</u><br><br>No charge for lab services.<br><u>Deductible</u> does not apply for lab services.                                                                                                                          | Not covered                                        | May require prior authorization. The penalty for not having prior authorization is denial of payment.                                                                                                                                                                                         |
|                                                        | Imaging (CT/PET scans, MRIs)                     | 35% <u>coinsurance</u>                                                                                                                                                                                                                   | 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/2026.html](http://www.bcbsm.com/index/plans/michigan-health-insurance/2026.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>prescription drug coverage</b> is available at <a href="https://www.bcbsm.com/2026-select-hmo-druglist">https://www.bcbsm.com/2026-select-hmo-druglist</a> | Preferred generic drugs     | \$4 <u>copayment</u> /prescription-Retail & mail order 30-day supply.<br><br>\$12 <u>copayment</u> /prescription-Retail 84-90-day supply & mail order 31-90-day supply.      | Not covered                                        | May require prior authorization & Step Therapy. The penalty for not having prior authorization is denial of payment. <u>Preventive</u> drugs are covered with no out-of-pocket-costs when health care reform requirements are met. 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. Any coupon, rebate, or other credits received directly or indirectly from an assistance program or the drug manufacturer may not be applied to a consumer's <u>deductible</u> , <u>cost-sharing</u> or <u>out of pocket maximum</u> .        |
|                                                                                                                                                                                                                                                     | Non-preferred generic drugs | \$20 <u>copayment</u> /prescription-Retail & mail order 30-day supply.<br><br>\$60 <u>copayment</u> /prescription-Retail 84-90-day supply & mail order 31-90-day supply.     | Not covered                                        | May require prior authorization & Step Therapy. The penalty for not having prior authorization is denial of payment. <u>Preventive</u> drugs are covered with no out-of-pocket-costs when health care reform requirements are met. 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.<br><br>Any coupon, rebate, or other credits received directly or indirectly from an assistance program or the drug manufacturer may not be applied to a consumer's <u>deductible</u> , <u>cost-sharing</u> or <u>out of pocket maximum</u> . |
|                                                                                                                                                                                                                                                     | Preferred brand drugs       | \$100 <u>copayment</u> /prescription-Retail & mail order 30-day supply.<br><br>\$300 <u>copayment</u> /prescription - Retail 84-90-day supply & mail order 31-90-day supply. | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                     | Non-preferred brand drugs   | \$150 <u>copayment</u> /prescription-Retail & mail order 30-day supply.<br><br>\$450 <u>copayment</u> /prescription - Retail 84-90-day supply & mail order 31-90-day supply. | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsm.com/index/plans/michigan-health-insurance/2026.html](https://www.bcbsm.com/index/plans/michigan-health-insurance/2026.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/2026-select-hmo-druglist">https://www.bcbsm.com/2026-select-hmo-druglist</a> | Preferred <u>specialty drugs</u>               | 40% <u>coinsurance</u>                                     | Not covered                                                | <p><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.</p> <p>Any coupon, rebate, or other credits received directly or indirectly from an assistance program or the drug manufacturer may not be applied to a consumer's <u>deductible</u>, <u>cost-sharing</u> or <u>out of pocket maximum</u>.</p> |
|                                                                                                                                                                                                                                                            | Non-preferred <u>specialty drugs</u>           | 45% <u>coinsurance</u>                                     | Not covered                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                      | Facility fee (e.g., ambulatory surgery center) | 35% <u>coinsurance</u>                                     | Not covered                                                | <p>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.</p> <p>50% <u>coinsurance</u> for infertility, temporomandibular joint dysfunction (TMJ) and weight reduction procedures. Weight reduction procedures limited to one per lifetime.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                            | Physician/surgeon fees                         | 35% <u>coinsurance</u>                                     | Not covered                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                                             | <u>Emergency room care</u>                     | \$250 <u>copayment</u> / visit then 35% <u>coinsurance</u> | \$250 <u>copayment</u> / visit then 35% <u>coinsurance</u> | Emergency room visits will be covered at non-participating facilities for medical emergencies and accidental injuries only. <u>Copayment</u> waived if admitted inpatient into the hospital.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                                            | <u>Emergency medical transportation</u>        | 35% <u>coinsurance</u>                                     | 35% <u>coinsurance</u>                                     | Includes air and ground transportation. Excludes transportation for convenience.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                            | <u>Urgent care</u>                             | \$45 <u>copayment</u><br><u>Deductible</u> does not apply. | \$45 <u>copayment</u><br><u>Deductible</u> does not apply. | <u>Urgent care</u> visits will be covered at non-participating <u>providers</u> for medical emergencies and accidental injuries only.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsm.com/index/plans/michigan-health-insurance/2026.html](http://www.bcbsm.com/index/plans/michigan-health-insurance/2026.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 have a hospital stay</b>                                               | Facility fee (e.g., hospital room)        | 35% <u>coinsurance</u>                                                                                                                                                               | Not covered                                        | Prior authorization required. The penalty for not having prior authorization is denial of payment.<br>50% <u>coinsurance</u> for infertility, temporomandibular joint dysfunction (TMJ) and weight reduction procedures.<br>Weight reduction procedures limited to one per lifetime.                                                                                                                                                                                                                 |
|                                                                                  | Physician/surgeon fees                    | 35% <u>coinsurance</u>                                                                                                                                                               | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$60 <u>copayment</u> /office visit and applied behavior analysis (ABA) treatment.<br><u>Deductible</u> does not apply.<br><br>35% <u>coinsurance</u> for other outpatient services. | Not covered                                        | <u>Copayment</u> applies to <u>provider's</u> office, virtual visit by participating BCN <u>provider</u> and Blue Cross virtual care visit from BCN selected vendor app only. Additional services are subject to the <u>plan's deductible</u> and <u>coinsurance</u> .<br>Prior authorization is not required for outpatient, office, virtual and online visits. Prior authorization is required for other outpatient services. The penalty for not having prior authorization is denial of payment. |
|                                                                                  | Inpatient services                        | 35% <u>coinsurance</u>                                                                                                                                                               | Not covered                                        | Prior authorization is required for inpatient services. The penalty for not having prior authorization is denial of payment.                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you are pregnant</b>                                                       | Office visits                             | No charge<br><u>Deductible</u> does not apply.                                                                                                                                       | Not covered                                        | <u>Cost sharing</u> does not apply for <u>preventive services</u> .<br><br>Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).                                                                                                                                                                                                             |
|                                                                                  | Childbirth/delivery professional services | 35% <u>coinsurance</u>                                                                                                                                                               | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                  | Childbirth/delivery facility services     | 35% <u>coinsurance</u>                                                                                                                                                               | Not covered                                        | Prior authorization is required for inpatient services. The penalty for not having prior authorization is denial of payment.                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you need help recovering or have other special health needs</b>            | <u>Home health care</u>                   | 35% <u>coinsurance</u>                                                                                                                                                               | Not covered                                        | Excludes housekeeping and custodial services.                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsm.com/index/plans/michigan-health-insurance/2026.html](http://www.bcbsm.com/index/plans/michigan-health-insurance/2026.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>Rehabilitation services</u>   | 35% <u>coinsurance</u> / visit                                                      | Not covered                                        | Prior authorization required. The penalty for not having prior authorization is denial of payment.                                                                                                                                                                                                                       |
|                                                                       | <u>Habilitation services</u>     | 35% <u>coinsurance</u> / visit                                                      | Not covered                                        | Physical and occupational therapy are limited to a combined 30 visits per member per calendar year.<br><br>Speech therapy is limited to 30 visits per member per calendar year.                                                                                                                                          |
|                                                                       | <u>Skilled nursing care</u>      | 35% <u>coinsurance</u>                                                              | 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> | 50% <u>coinsurance</u><br><br>35% <u>coinsurance</u> for diabetic testing supplies. | 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<br><u>Deductible</u> does not apply.                                      | Not covered                                        | Limited to once in a calendar year. A child is defined as a member up to the age of 19. <u>Out-of-network</u> is paid up to the <u>allowed amount</u> .                                                                                                                                                                  |
|                                                                       | Children's glasses               | No charge<br><u>Deductible</u> does not apply.                                      | 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. <u>Out-of-network</u> 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.                                                                                                                                                                                                                                                                               |

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsm.com/index/plans/michigan-health-insurance/2026.html](http://www.bcbsm.com/index/plans/michigan-health-insurance/2026.html)

## 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.)                                            |                                                                                                                       |                                                                                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)</li><li>• Acupuncture</li><li>• Cosmetic Surgery</li></ul> | <ul style="list-style-type: none"><li>• Dental care (Adult)</li><li>• Hearing aids</li><li>• Long-term care</li></ul> | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing</li><li>• Routine foot care</li></ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)                                                                |                                                                                                                       |                                                                                                                                                                 |
| <ul style="list-style-type: none"><li>• Bariatric surgery</li></ul>                                                                                                                         | <ul style="list-style-type: none"><li>• Chiropractic</li><li>• Infertility treatment</li></ul>                        | <ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Weight loss programs</li></ul>                                                       |

**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.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsm.com/index/plans/michigan-health-insurance/2026.html](http://www.bcbsm.com/index/plans/michigan-health-insurance/2026.html)

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$5,800 |
| ■ <u>Specialist copayment</u>                 | \$110   |
| ■ Hospital (facility) <u>coinsurance</u>      | 35%     |
| ■ Other <u>coinsurance</u>                    | 35%     |

**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>                | \$5,800        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$1,900        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$7,710</b> |

### Managing Joe's Type 2 Diabetes

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

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$5,800 |
| ■ <u>Specialist copayment</u>                 | \$110   |
| ■ Hospital (facility) <u>coinsurance</u>      | 35%     |
| ■ Other <u>coinsurance</u>                    | 35%     |

**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>                | \$4,300        |
| <u>Copayments</u>                 | \$700          |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$5,020</b> |

### Mia's Simple Fracture

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

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$5,800 |
| ■ <u>Specialist copayment</u>                 | \$110   |
| ■ Hospital (facility) <u>coinsurance</u>      | 35%     |
| ■ Other <u>coinsurance</u>                    | 35%     |

**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>                | \$2,500        |
| <u>Copayments</u>                 | \$300          |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,800</b> |

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

