



**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 1-888-288-2738 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 [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-888-288-2738 to request a copy.

| Important Questions                                                | Answers                                                                                                                                                      | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | In-network providers, \$6,800 individual / \$13,600 family<br>Out-of-network providers, \$13,600 individual / \$27,200 family                                | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.                                                                                                                         |
| <b>Are there services covered before you meet your deductible?</b> | Yes. Preventive services are covered before you meet your deductible.                                                                                        | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services 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 deductibles for specific services.                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>What is the out-of-pocket limit for this plan?</b>              | In-network providers, \$11,700 individual / \$23,400 family<br>Out-of-network providers, \$23,400 individual / \$46,800 family                               | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.                                                                                                                                                                                                                         |
| <b>What is not included in the out-of-pocket limit?</b>            | Premiums, balance billing charges, and health care this plan doesn't cover.                                                                                  | Even though you pay these expenses, they don't count toward the out-of-pocket limit.                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="https://www.bcbsm.com/marketplace/ppo/">https://www.bcbsm.com/marketplace/ppo/</a> or call 1-888-288-2738 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| <b>Do you need a referral to see a specialist?</b>                 | No.                                                                                                                                                          | You can see the specialist you choose without a referral.                                                                                                                                                                                                                                                                                                                                                                                                            |

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

| Common Medical Event                                                                                                                                                                                                                                                   | Services You May Need                            | What You Will Pay                                                                                                                                                                                                                                                   |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                        |                                                  | 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 visit to treat an injury or illness | \$40 <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.                            | 50% <u>coinsurance</u>                             | Diagnostic and laboratory services are not included in the office visit <u>copayment</u> . These services are subject to the plan's <u>deductible</u> and <u>coinsurance</u> .<br><br>No charge for 24/7 medical virtual visits when performed through the BCBSM selected vendor app.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                                                        | <u>Specialist</u> visit                          | \$80 <u>copayment</u> /visit<br><u>Deductible</u> does not apply.                                                                                                                                                                                                   | 50% <u>coinsurance</u>                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                        | <u>Preventive care/screening/immunization</u>    | No charge<br><u>Deductible</u> does not apply.                                                                                                                                                                                                                      | 50% <u>coinsurance</u>                             | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>If you have a test</b>                                                                                                                                                                                                                                              | <u>Diagnostic test</u> (x-ray, blood work)       | \$125 <u>copayment</u> for x-rays<br>\$55 <u>copayment</u> for lab services.<br><u>Deductible</u> does not apply                                                                                                                                                    | 50% <u>coinsurance</u>                             | None.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                                                        | Imaging (CT/PET scans, MRIs)                     | 30% <u>coinsurance</u>                                                                                                                                                                                                                                              | 50% <u>coinsurance</u>                             | Prior authorization required. The penalty for not having prior authorization is denial of payment.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <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/2027-essential-select-druglist">https://www.bcbsm.com/2027-essential-select-druglist</a> | Generic drugs                                    | Retail <u>copayment</u> per prescription:<br>\$0 for 1-30 day supply<br>\$0 for 84-90 day supply<br>Mail order <u>copayment</u> per prescription: \$0 for 1-30 day supply<br>\$0 for 31-60 day supply \$0 for 61-90 day supply<br><u>Deductible</u> does not apply. | Not covered                                        | Opioid-containing medications are limited to no more than a 30-day supply per fill and first fills of select opioid containing medications will be limited to a 5-day supply. Prior authorization, step therapy and quantity limits may apply to select drugs. 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. 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> . For <u>out-of-network</u> providers, member must pay the full cost of the drug and submit to BCBSM for reimbursement. |

\* For more information about limitations and exceptions, see the plan or policy document at <https://www.bcbsm.com/individuals/plans/>

| 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/2027-essential-select-druglist">https://www.bcbsm.com/2027-essential-select-druglist</a> | Preferred brand drugs                                                        | Retail <u>copayment</u> per prescription:<br>\$40 for 1-30 day supply<br>\$120 for 84-90 day supply<br>Mail order <u>copayment</u> per prescription: \$40 for 1-30 day supply \$80 for 31-60 day supply \$120 for 61-90 day supply<br><u>Deductible</u> does not apply. | Not covered                                        | Opioid-containing medications are limited to no more than a 30-day supply per fill and first fills of select opioid containing medications will be limited to a 5-day supply. Prior authorization, step therapy and quantity limits may apply to select drugs. 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. 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> .<br>For <u>out-of-network providers</u> , member must pay the full cost of the drug and submit to BCBSM for reimbursement.                                                                           |
|                                                                                                                                                                                                                                                                        | Non-preferred brand drugs                                                    | Retail <u>copayment</u> per prescription:<br>\$80 for 1-30 day supply<br>\$240 for 84-90 day supply<br>Mail order <u>copayment</u> per prescription: \$80 for 1-30 day supply \$160 for 31-60 day supply \$240 for 61-90 day supply                                     | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                        | Preferred <u>specialty drugs</u><br><br>Non-preferred <u>specialty drugs</u> | Retail and mail order <u>coinsurance</u> per prescription:<br>45% for 1-30 day supply<br><br>50% for 1-30 day supply                                                                                                                                                    | 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. BCBSM 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.<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> . |

\* For more information about limitations and exceptions, see the plan or policy document at <https://www.bcbsm.com/individuals/plans/>

| 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 have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center) | \$400 <u>copayment</u>                                                                                                                                                               | 50% <u>coinsurance</u>                             | Excludes cosmetic surgery, corrective eye surgery, investigational and experimental procedures. These services may require prior authorization. The penalty for not having prior authorization is denial of payment.                                                                                                                    |
|                                                                           | Physician/surgeon fees                         | \$400 <u>copayment</u>                                                                                                                                                               | 50% <u>coinsurance</u>                             | 50% <u>coinsurance</u> for infertility, temporomandibular joint dysfunction (TMJ) and weight reduction procedures. Weight reduction procedures limited to one per lifetime.                                                                                                                                                             |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                     | \$600 <u>copayment</u>                                                                                                                                                               | \$600 <u>copayment</u>                             | Emergency room visits will be covered at non-participating facilities for medical emergencies and accidental injuries only.                                                                                                                                                                                                             |
|                                                                           | <u>Emergency medical transportation</u>        | 30% <u>coinsurance</u>                                                                                                                                                               | 30% <u>coinsurance</u>                             | Includes air and ground transportation. Excludes transportation for convenience.                                                                                                                                                                                                                                                        |
|                                                                           | <u>Urgent care</u>                             | \$75 <u>copayment</u> /visit<br><u>Deductible</u> does not apply.                                                                                                                    | 50% <u>coinsurance</u>                             | When the <u>urgent care</u> visit is for an emergency or accidental injury, <u>in-network cost sharing</u> applies.                                                                                                                                                                                                                     |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)             | 30% <u>coinsurance</u>                                                                                                                                                               | 50% <u>coinsurance</u>                             | BCBSM participating hospitals only. These services require prior authorization. The penalty for not having prior authorization is denial of payment.<br><br>50% <u>coinsurance</u> for infertility, temporomandibular joint dysfunction (TMJ) and weight reduction procedures. Weight reduction procedures limited to one per lifetime. |
|                                                                           | Physician/surgeon fees                         | 30% <u>coinsurance</u>                                                                                                                                                               | 50% <u>coinsurance</u>                             |                                                                                                                                                                                                                                                                                                                                         |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                            | \$40 <u>copayment</u> /office visit and applied behavior analysis (ABA) treatment.<br><u>Deductible</u> does not apply.<br><br>30% <u>coinsurance</u> for other outpatient services. | 50% <u>coinsurance</u>                             | <u>Copayment</u> applies to <u>provider's</u> office, virtual visit by participating BCBSM <u>provider</u> and Blue Cross virtual care visit from BCBSM selected vendor app only. Additional services are subject to the <u>plan's deductible and coinsurance</u> . BCBSM approved facilities only.                                     |

\* For more information about limitations and exceptions, see the plan or policy document at <https://www.bcbsm.com/individuals/plans/>

| 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 mental health, behavioral health, or substance abuse services</b> | Inpatient services                        | 30% <u>coinsurance</u>                                            | 30% <u>coinsurance</u> for substance abuse<br><br>50% <u>coinsurance</u> for other inpatient services | BCBSM approved facilities only. These services require prior authorization. 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.                    | 50% <u>coinsurance</u>                                                                                | <u>Cost sharing</u> does not apply for <u>preventive services</u> with a <u>network provider</u> . 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 | 30% <u>coinsurance</u>                                            | 50% <u>coinsurance</u>                                                                                | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                  | Childbirth/delivery facility services     | 30% <u>coinsurance</u>                                            | 50% <u>coinsurance</u>                                                                                | BCBSM participating hospitals only. These services require prior authorization. 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>                   | 30% <u>coinsurance</u>                                            | 30% <u>coinsurance</u>                                                                                | BCBSM participating agencies only. Excludes housekeeping and custodial services.                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                  | <u>Rehabilitation services</u>            | \$40 <u>copayment</u> /visit.<br><u>Deductible</u> does not apply | 50% <u>coinsurance</u>                                                                                | <u>Plan's coinsurance</u> and <u>deductible</u> will apply to chiropractic, osteopathic manipulative therapy and cardiac/pulmonary visits.<br>Physical, occupational, chiropractic and osteopathic manipulative therapy limited to a combined maximum of 30 visits per member per calendar year.<br><br>Speech therapy limited to a maximum of 30 visits per member per calendar year.<br><br>Cardiac/pulmonary visits limited to a maximum of 30 visits per member per calendar year. |

\* For more information about limitations and exceptions, see the plan or policy document at <https://www.bcbsm.com/individuals/plans/>

| 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 need help recovering or have other special health needs | <u>Habilitation services</u>     | \$40 <u>copayment</u> /visit<br><u>Deductible</u> does not apply. | 50% <u>coinsurance</u>                             | Physical and occupational therapy limited to a combined maximum of 30 visits per member per calendar year.<br><br>Speech therapy limited to a maximum of 30 visits per member per calendar year.                                             |
|                                                                | <u>Skilled nursing care</u>      | 30% <u>coinsurance</u>                                            | 50% <u>coinsurance</u>                             | Limited to a maximum of 45 days per member per calendar year. BCBSM participating facilities only. Excludes custodial care. These services require prior authorization. The penalty for not having prior authorization is denial of payment. |
|                                                                | <u>Durable medical equipment</u> | 50% <u>coinsurance</u>                                            | 70% <u>coinsurance</u>                             | 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                                                         | No charge                                          | Coverage includes inpatient and outpatient hospice care. BCBSM approved hospice programs only. Excludes housekeeping services.                                                                                                               |
| If your child needs dental or eye care                         | Children's eye exam              | No charge<br><u>Deductible</u> does not apply.                    | No charge<br><u>Deductible</u> does not apply.     | 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.                    | No charge<br><u>Deductible</u> does not apply.     | 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 <https://www.bcbsm.com/individuals/plans/>

## 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 eye care (Adult)</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></ul>                                                        | <ul style="list-style-type: none"><li>• Infertility treatment</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

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 888-288-2738 uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 888-288-2738.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 888-288-2738.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 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 <https://www.bcbsm.com/individuals/plans/>

## 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> | \$6,800 |
| ■ <u>Specialist copayment</u>                 | \$80    |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%     |
| ■ Other <u>coinsurance</u>                    | 30%     |

**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>  | \$6,800 |
| <u>Copayments</u>   | \$800   |
| <u>Coinsurance</u>  | \$1,300 |

| <i>What isn't covered</i> |      |
|---------------------------|------|
| Limits or exclusions      | \$60 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Peg would pay is</b> | <b>\$8,960</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> | \$6,800 |
| ■ <u>Specialist copayment</u>                 | \$80    |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%     |
| ■ Other <u>coinsurance</u>                    | 30%     |

**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>  | \$800 |
| <u>Copayments</u>   | \$600 |
| <u>Coinsurance</u>  | \$0   |

| <i>What isn't covered</i> |      |
|---------------------------|------|
| Limits or exclusions      | \$20 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Joe would pay is</b> | <b>\$1,420</b> |
|-----------------------------------|----------------|

### Mia's Simple Fracture

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

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$6,800 |
| ■ <u>Specialist copayment</u>                 | \$80    |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%     |
| ■ Other <u>coinsurance</u>                    | 30%     |

**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>  | \$2,000 |
| <u>Copayments</u>   | \$500   |
| <u>Coinsurance</u>  | \$0     |

| <i>What isn't covered</i> |     |
|---------------------------|-----|
| Limits or exclusions      | \$0 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Mia would pay is</b> | <b>\$2,500</b> |
|-----------------------------------|----------------|

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

