



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. 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/ or call 1-888-288-2738 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall <u>deductible</u>? | \$500 Individual/\$1,000 Family | Generally, you must pay all of the costs from providers 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> , primary care visits, 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | \$1,300 Individual/\$2,600 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 charges</u> , and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u>? | Yes. See http://www.bcbsm.com/index/common/marketplace/preferred-hmo.html 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 plan's <u>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 provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). |
| 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 specialist 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 (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit/Online Visit to treat an injury or illness | \$5/primary care visit No charge /online visit <u>Deductible</u> does not apply | Not covered | Diagnostic services are subject to the plan's <u>deductible</u> and <u>coinsurance</u> . |
| | <u>Specialist</u> visit | \$10/visit <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 subject to the plan's <u>deductible</u> and <u>coinsurance</u> . |
| | <u>Preventive care/screening/immunization</u> | No charge <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 preventive. Ask your <u>provider</u> if the services needed are preventive; then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 5% <u>coinsurance</u> | Not covered | May require prior authorization. The penalty for not having prior authorization is denial of payment. |
| | Imaging (CT/PET scans, MRIs) | 5% <u>coinsurance</u> | Not covered | Prior authorization required. The penalty for not having prior authorization is denial of payment. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------------|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| <p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://www.bcbsm.com/2020selectdruglist</p> | Tier 1-Generic drugs | \$3/prescription-Retail & mail order 30-day supply. <u>Deductible does not apply</u> | Not covered | <p>May require prior authorization & Step Therapy. The penalty for not having prior authorization is denial of payment. No charge for Tier 1A contraceptives. 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.</p> |
| | | \$9/prescription-Retail 84-90-day supply & mail order 31-90-day supply. <u>Deductible does not apply</u> | | |
| | Tier 2-Preferred brand drugs | \$5/prescription-Retail & mail order 30-day supply. <u>Deductible does not apply</u> | Not covered | |
| | | \$15/prescription-Retail 84-90-day supply & mail order 31-90-day supply. <u>Deductible does not apply</u> | | |
| | Tier 3-Non-preferred brand drugs | \$10/prescription-Retail & mail order 30-day supply. <u>Deductible does not apply</u> | Not covered | <p>May require prior authorization & Step Therapy. The penalty for not having prior authorization is denial of payment. <u>Specialty drugs</u> are limited to a 15 or 30-day supply. BCN has contracted with an exclusive pharmacy network 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.</p> |
| | | \$30/prescription-Retail 84-90-day supply & mail order 31-90-day supply. <u>Deductible does not apply</u> | | |
| Tier 4-Preferred <u>Specialty drugs</u> | 40% <u>coinsurance</u> | Not covered | | |
| Tier 5-Non-preferred <u>Specialty drugs</u> | 45% <u>coinsurance</u> | Not covered | | |

*For more information about limitations and exception, see plan or policy document at <http://www.bcbsm.com/index/plans/michigan-health-insurance/2020.html>

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 5% <u>coinsurance</u> | Not covered | May require prior authorization. The penalty for not having prior authorization is denial of payment. Female sterilization covered in full. *See section 8 |
| | Physician/surgeon fees | 50% <u>coinsurance</u> for infertility services, TMJ procedures and weight reduction procedures | | |
| If you need immediate medical attention | <u>Emergency room care</u> | 5% <u>coinsurance</u> | 5% <u>coinsurance</u> | Emergency room visits will be covered at non-participating facilities for medical emergencies and accidental injuries only. |
| | <u>Emergency medical transportation</u> | 5% <u>coinsurance</u> | 5% <u>coinsurance</u> | Includes air and ground transportation. Excludes transportation for convenience. |
| | <u>Urgent care/Retail health center visit</u> | \$25/visit <u>Deductible</u> does not apply | \$25/visit <u>Deductible</u> does not apply | <u>Urgent care/Retail health center</u> visits will be covered at non-participating facilities for medical emergencies and accidental injuries only. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 5% <u>coinsurance</u> | Not covered | Prior authorization required. The penalty for not having prior authorization is denial of payment. Female sterilization covered in full. *See section 8 |
| | Physician/surgeon fees | | | |

*For more information about limitations and exception, see plan or policy document at <http://www.bcbsm.com/index/plans/michigan-health-insurance/2020.html>

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$5 <u>copay</u> /office and online visit <u>Deductible</u> does not apply 5% <u>coinsurance</u> for other outpatient services | Not covered | Prior authorization is not required for outpatient, office and online visits. Prior authorization is required for other outpatient services. The penalty for not having prior authorization is denial of payment. *See section 8 |
| | Inpatient services | 5% <u>coinsurance</u> | Not covered | Prior authorization is required for inpatient services. The penalty for not having prior authorization is denial of payment. *See section 8 |
| If you are pregnant | Office visits | No charge for prenatal visit. <u>Deductible</u> does not apply. \$5/postnatal visit. <u>Deductible</u> does not apply. | Not covered | None. |
| | Childbirth/delivery professional services | 5% <u>coinsurance</u> | Not covered | |
| | Childbirth/delivery facility services | 5% <u>coinsurance</u> | Not covered | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 5% <u>coinsurance</u> | Not covered | Housekeeping services and custodial care are excluded. |
| | <u>Rehabilitation services</u> | 5% <u>coinsurance</u> | Not covered | Prior authorization required. The penalty for not having prior authorization is denial of payment. PT & OT limited to a combined 30 visits per member per calendar year. Speech Therapy limited to 30 visits per member per calendar year. *See section 8 |
| | <u>Habilitation services</u> | 5% <u>coinsurance</u> | Not covered | Prior authorization required. The penalty for not having prior authorization is denial of payment. PT & OT limited to a combined 30 visits per member per calendar year. Speech Therapy limited to 30 visits per member per calendar year. *See section 8 |

*For more information about limitations and exception, see plan or policy document at <http://www.bcbsm.com/index/plans/michigan-health-insurance/2020.html>

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------------|---|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | <u>Skilled nursing care</u> | 5% <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> 5% <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. *See section 8 |
| | <u>Hospice services</u> | No charge | Not covered | Prior authorization required. The penalty for not having prior authorization is denial of payment. BCN participating hospice programs only. *See section 8 |
| If your child needs dental or eye care | Children's eye exam | No charge | Difference between the BCN approved amount and the amount charged by the <u>provider</u> | Limited to once per calendar year through the last day of the year in which the individual turns 19. |
| | Children's glasses | No charge | Difference between the BCN approved amount and the amount charged by the <u>provider</u> | |
| | Children's dental check-up | Not covered | Not covered | Stand-alone dental plans available. |

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"> • Abortion (except in cases of rape, incest or when the life of the mother is endangered) • Acupuncture • Artificial Insemination and In-Vitro Fertilization | <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (adult) • Hearing aids • Long-term care | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the US • Private-duty nursing • Routine eye care (adult) • Routine foot care |
|--|---|---|

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

- | | | |
|--|---|--|
| <ul style="list-style-type: none"> • Bariatric Surgery • Chiropractic Care | <ul style="list-style-type: none"> • Infertility treatment | <ul style="list-style-type: none"> • Weight loss programs |
|--|---|--|

*For more information about limitations and exception, see plan or policy document at <http://www.bcbsm.com/index/plans/michigan-health-insurance/2020.html>

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html>, or Michigan Department of Insurance and Financial Services at michigan.gov/difs or 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 or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Care Network, Appeals and Grievance Unit, MC C248, P.O. Box 248, Southfield, MI 48086 or fax 888-458-0716. For State of Michigan assistance contact the Michigan Department of Insurance and Financial Services, Healthcare Appeals Section, Office of General Council, 611 W. Ottawa St, 3rd Floor, Lansing, MI 48909-7720, michigan.gov/difs or 1-877-999-6442.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP), at 877-999-6442 or DIFS-HICAP@Michigan.gov.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? N/A

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.* —————

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> | \$500 |
| ■ <u>Specialist copayment</u> | \$10 |
| ■ Hospital (facility) <u>coinsurance</u> | 5% |
| ■ Other <u>coinsurance</u> | 5% |

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$500 |
| Copayments | \$20 |
| Coinsurance | \$600 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,180 |

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> | \$500 |
| ■ <u>Specialist copayment</u> | \$10 |
| ■ Hospital (facility) <u>coinsurance</u> | 5% |
| ■ Other <u>coinsurance</u> | 5% |

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$500 |
| Copayments | \$200 |
| Coinsurance | \$90 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Joe would pay is | \$850 |

Mia's Simple Fracture

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

| | |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$500 |
| ■ <u>Specialist copayment</u> | \$10 |
| ■ Hospital (facility) <u>coinsurance</u> | 5% |
| ■ Other <u>coinsurance</u> | 5% |

This EXAMPLE event includes services like:

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

| | |
|---------------------------|----------------|
| Total Example Cost | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$500 |
| Copayments | \$30 |
| Coinsurance | \$100 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$630 |

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

