



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> ?	For <u>in-network providers</u> , \$2,100 individual / \$4,200 family For <u>out-of-network providers</u> , \$4,200 individual / \$8,400 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 services</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> ?	For <u>in-network providers</u> , \$6,400 individual / \$12,800 family For <u>out-of-network providers</u> , \$12,800 individual / \$25,600 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/commarketplace/ppo.html or call 1-888-288-2738 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit/ Retail health clinic/ online visit to treat an injury or illness	\$30 <u>copayment</u> /visit No charge /online visit. <u>Deductible</u> does not apply to online visits.	40% <u>coinsurance</u>	Diagnostic and laboratory 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>Specialist</u> visit	\$50 <u>copayment</u> /visit	40% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	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)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization required. The penalty for not having prior authorization is denial of payment.
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	Generic drugs	Retail <u>copayment</u> per prescription: \$15 for 1-30 day supply \$45 for 84-90 day supply Mail order <u>copayment</u> per prescription: \$15 for 1-30 day supply \$30 for 31-60 day supply \$45 for 61-90 day supply	BCBSM will reimburse 80% of the BCBSM-approved amount for covered drugs, less the <u>copayment</u> and the difference between the out-of-network pharmacy's charge and the BCBSM-approved amount for the drug. For <u>out-of-network providers</u> , member must pay the full cost of the drug and submit to BCBSM for reimbursement.	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.
	Preferred brand drugs	Retail <u>coinsurance</u> per prescription: 25% for 1-30 day supply 25% for 84-90 day supply Mail order <u>coinsurance</u> per prescription: 25% for 1-30 day supply 25% for 31-60 day supply 25% for 61-90 day supply		

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</p> <p>More information about prescription drug coverage is available at http://www.bcbsm.com/2020selectdruglist</p>	Non-preferred brand drugs	Retail <u>coinsurance</u> per prescription: 50% for 1-30 day supply 50% for 84-90 day supply Mail order <u>coinsurance</u> per prescription: 50% for 1-30 day supply 50% for 31-60 day supply 50% for 61-90 day supply	BCBSM will reimburse 80% of the BCBSM-approved amount for covered drugs, less the <u>copayment</u> and the difference between the out-of-network pharmacy's charge and the BCBSM-approved amount for the drug. For <u>out-of-network providers</u> , member must pay the full cost of the drug and submit to BCBSM for reimbursement.	Minimum and maximum dollar amounts per prescription will apply, see policy document at: www.bcbsm.com/index/plans/michigan-health-insurance/2020.html . 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>Specialty drugs</u>	Retail and mail order <u>coinsurance</u> per prescription: 40% for 1-30 day supply for Preferred Specialty 45% for 1-30 day supply for Non-Preferred Specialty	Not covered	The first <u>specialty drug</u> fill will be limited to a 15 day supply. Subsequent fills limited to a 15 or 30 day supply per fill, depending on the medication. BCBSM 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. Prior authorization, step therapy and quantity limits may apply to select drugs. The penalty for not having prior authorization is denial of payment.
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

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 immediate medical attention	<u>Emergency room care</u>	\$250 <u>copayment</u> / visit then 20% <u>coinsurance</u>	\$250 <u>copayment</u> / visit then 20% <u>coinsurance</u>	<u>Copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Includes air and ground transportation. Excludes transportation for convenience.
	<u>Urgent care</u>	\$75 <u>copayment</u> / visit then 20% <u>coinsurance</u>	\$75 <u>copayment</u> / visit then 40% <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)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	BCBSM participating hospitals only. These services require prior authorization. The penalty for not having prior authorization is denial of payment.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copayment</u> / visit	40% <u>coinsurance</u>	<u>Copayment</u> applies to <u>provider's</u> office and online visit only. Additional services are subject to the <u>plan's deductible</u> and <u>coinsurance</u> . BCBSM approved facilities only.
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u> for substance abuse 40% <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.
If you are pregnant	Office visits	Prenatal visits: No charge. <u>Deductible</u> does not apply. Postnatal visits: \$30 <u>copayment</u> / visit	Prenatal and postnatal visits: 40% <u>coinsurance</u>	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	BCBSM participating hospitals only. These services require prior authorization. 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)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	BCBSM participating agencies only. Excludes housekeeping and custodial services.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Physical, occupational, chiropractic and osteopathic manipulative therapy limited to a combined maximum of 30 visits per member per calendar year. Speech therapy limited to a maximum of 30 visits per member per calendar year. Cardiac/pulmonary visits limited to a maximum of 30 visits per member per calendar year.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Physical and occupational therapy limited to a combined maximum of 30 visits per member per calendar year. Speech therapy limited to a maximum of 30 visits per member per calendar year.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <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	BCBSM approved hospice programs only. Excludes housekeeping services.
If your child needs dental or eye care	Children's eye exam	No charge. <u>Deductible</u> does not apply.	No charge. <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. Out-of-network is paid up to the <u>allowed amount</u> .
	Children's glasses	No charge. <u>Deductible</u> does not apply.	No charge. <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. Out-of-network is paid up to the <u>allowed amount</u> .
	Children's dental check-up	Not covered	Not covered	Stand-alone dental <u>plans</u> available.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

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

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Michigan Department of Insurance and Financial Services at 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 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: Michigan Department of Insurance and Financial Services at michigan.gov/difs at 1-877-999-6442.

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 plan's overall deductible \$2,100
- Specialist copayment \$50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,100
Copayments	\$100
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,760

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$2,100
- Specialist copayment \$50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,100
Copayments	\$800
Coinsurance	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$4,260

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$2,100
- Specialist copayment \$50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,400
Copayments	\$200
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

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

