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| image2 | **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, visit [www.bcbsm.com](http://www.bcbsm.com) or call the number on the back of your BCBSM ID card. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call the number on the back of your BCBSM ID card to request a copy. | |

| **Important Questions** | **Answers** | | **Why this Matters:** |
| --- | --- | --- | --- |
| **In-Network** | **Out-of-Network** |
| **What is the overall deductible?** | $250 Individual/ $500 Family | $500 Individual/ $1,000 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. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care 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 <https://www.healthcare.gov/coverage/preventive-care-benefits/>. |
| **Are there other deductibles for specific services?** | No. | | You don’t have to meet deductibles for specific services. |
|  |  | |  |
| **What is the out-of-pocket limit for this plan?**  (May include a coinsurance maximum) | $6,350 Individual/ $12,700 Family | $12,700 Individual/ $25,400 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. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn’t cover. | | Even though you pay these expenses, they don’t count toward the out–of–pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See [www.bcbsm.com](https://www.bcbsm.com) or call the number on the back of your BCBSM ID card 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. |
| **Do you need a referral to see a specialist?** | No. | | You can see the specialist you choose without a referral. |

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| image3 | 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** |
| --- | --- | --- | --- | --- |
| **In-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 to treat an injury or illness | $20 copay/office visit; deductible does not apply | 40% coinsurance | None |
| Specialist visit | $20 copay/visit; deductible does not apply | 40% coinsurance | None |
| Preventive care/ screening/ immunization | No Charge; deductible does not apply | Not covered | You may have to pay for services that aren’t preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | None |
| Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | May require preauthorization |
| **If you need drugs to treat your illness or condition**  More information about **prescription drug coverage** is available at [www.bcbsm.com/druglists](http://www.bcbsm.com/druglists) | Generic or select prescribed over-the-counter drugs | $7 copay/prescription for retail 30-day supply; $7 copay/prescription for retail or mail order 90-day supply; deductible does not apply | In-Network copay plus an additional 25% of the approved amount; deductible does not apply | Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not covered out of network. |
| Preferred brand-name drugs | $35 copay/prescription for retail 30-day supply; $35 copay/prescription for retail or mail order 90-day supply; deductible does not apply | In-Network copay plus an additional 25% of the approved amount; deductible does not apply |
| Non preferred brand-name drugs | $70 copay/prescription for retail 30-day supply; $70 copay/prescription for retail or mail order 90-day supply; deductible does not apply | In-Network copay plus an additional 25% of the approved amount; deductible does not apply |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | None |
| Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $250 copay/visit; deductible does not apply | $250 copay/visit; deductible does not apply | Copay waived if admitted or for an accidental injury. |
| Emergency medical transportation | 20% coinsurance | 20% coinsurance | Mileage limits apply |
| Urgent care | $20 copay/visit; deductible does not apply | 40% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Preauthorization may be required |
| Physician/surgeon fee | 20% coinsurance | 40% coinsurance | None |
| **If you need mental health, behavioral health, or substance use disorder services** | Outpatient services | 20% coinsurance | 20% coinsurance | Your cost share may be different for services performed in an office setting |
| Inpatient services | 20% coinsurance | 40% coinsurance | Preauthorization is required. |
| **If you are pregnant** | Office visits | Prenatal: No Charge; deductible does not apply Postnatal: No Charge; deductible does not apply | Prenatal: 40% coinsurance Postnatal: 40% coinsurance | Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. Cost sharing does not apply to certain maternity services considered to be preventive. |
| Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | None |
| Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | None |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 20% coinsurance | Preauthorization is required. |
| Rehabilitation services | 20% coinsurance | 40% coinsurance | Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year. |
| Habilitation services | Not covered for Applied Behavioral Analysis; Not covered for Physical, Speech and Occupational Therapy | Not covered for Applied Behavioral Analysis; Not covered for Physical, Speech and Occupational Therapy | None |
| Skilled nursing care | 20% coinsurance | 20% coinsurance | Preauthorization is required. Limited to 120 days per member per calendar year |
| Durable medical equipment | 20% coinsurance | 20% coinsurance | Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required. |
| Hospice services | No Charge; deductible does not apply | No Charge; deductible does not apply | Preauthorization is required. Visit limits apply. |
| **If your child needs dental or eye care**  For more information on pediatric vision or dental, contact your plan administrator | Children’s eye exam | Not Covered | Not Covered | None |
| Children’s glasses | Not Covered | Not Covered | None |
| Children’s dental check-up | Not Covered | Not Covered | None |

**Excluded Services & Other Covered Services:**

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| **Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)** | | |
| * Acupuncture treatment * Cosmetic surgery * Dental care (Adult) | * Hearing aids * Infertility treatment * Long term care | * Routine eye care (Adult) * Routine foot care * Weight loss programs |

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| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)** | | |
| * Bariatric surgery * Chiropractic care | * Coverage provided outside the United States. See http://provider.bcbs.com * If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses - like the deductible, co-payments, or co-insurance, or benefits not otherwise covered | * Non-emergency care when traveling outside the U.S * Private-duty nursing |

**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 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or[www.cciio.cms.gov](http://www.cciio.cms.gov/) or by calling the number on the back of your BCBSM ID card. 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 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 Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or <http://www.michigan.gov/difs> or [difs-HICAP@michigan.gov](mailto: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 Minimum Value Standards? Yes**

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.

(IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

**Language Access Services: See Addendum**

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

**About these Coverage Examples:**

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| image4 | **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. |

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| |  | | --- | | **Peg is Having a Baby** (9 months of in-network pre-natal care  and a hospital delivery) |  |  |  | | --- | --- | |  **The plan’s overall deductible** | **$250** | |  **Specialist copayment** | **$20** | |  **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** |   **In this example, Peg would pay:**   |  |  | | --- | --- | | *Cost Sharing* | | | Deductibles | $250 | | Copayments | $70 | | Coinsurance | $2,000 | | *What isn’t covered* | | | Limits or exclusions | $60 | | **The total Peg would pay is** | **$2,380** | |  | |  | | --- | | **Managing Joe’s Type 2 Diabetes** (a year of routine in-network care of a well-controlled condition) |  |  |  | | --- | --- | |  **The plan’s overall deductible** | **$250** | |  **Specialist copayment** | **$20** | |  **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** |   **In this example, Joe would pay:**   |  |  | | --- | --- | | *Cost Sharing* | | | Deductibles | $250 | | Copayments | $800 | | Coinsurance | $300 | | *What isn’t covered* | | | Limits or exclusions | $60 | | **The total Joe would pay is** | **$1,410** | |  | |  | | --- | | **Mia’s Simple Fracture** **(**in-network emergency room visit and  follow up care) |  |  |  | | --- | --- | |  **The plan’s overall deductible** | **$250** | |  **Specialist copayment** | **$20** | |  **Hospital (facility) coinsurance** | **20%** | |  **Other coinsurance** | **20%** |     **This EXAMPLE event includes services like:**  Emergency room care(*including medical*   *supplies)*  Diagnostic tests (*x-ray*)  Durable medical equipment (*crutches*)  Rehabilitation services (*physical therapy*)   |  |  | | --- | --- | | **Total Example Cost** | **$1,900** |   **In this example, Mia would pay:**   |  |  | | --- | --- | | *Cost Sharing* | | | Deductibles | $250 | | Copayments | $60 | | Coinsurance | $200 | | *What isn’t covered* | | | Limits or exclusions | $0 | | **The total Mia would pay is** | **$510** | |

