


Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services



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 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 ?	\$1,350 Individual /\$2,700 Family	\$2,700 Individual /\$5,400 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 policy, the overall family deductible must be met before the plan begins to pay.
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)	\$2,250 Individual /\$4,500 Family	\$4,500 Individual /\$9,000 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 , the overall family out-of-pocket limit must be 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 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 .

 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 to treat an injury or illness	No charge	20% coinsurance	None
	Specialist visit	No charge	20% 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)	No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% 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	Generic or prescribed over-the-counter drugs	\$10 copay for retail 30-day supply; \$20 copay for retail or mail order 90-day supply	\$10 copay plus 20% of approved amount	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	\$40 copay for retail 30-day supply; \$80 copay for retail or mail order 90-day supply	\$40 copay plus 20% of approved amount	
	Non-Preferred brand-name drugs	\$80 for 30-day supply; \$160 for retail or mail order 90-day supply	\$80 copay plus 20% of approved amount	
	Generic and preferred brand-name Specialty drugs	Standard tiered copays apply	Standard tiered copays apply	15 or 30-day supply per fill. Preauthorization is required.
	Nonpreferred brand-name Specialty drugs	Standard tiered copays apply	Standard tiered copays apply	15 or 30-day supply per fill. Preauthorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	None
	Physician/surgeon fees	No charge	20% coinsurance	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	Emergency room care	No charge	No charge	None
	Emergency medical transportation	No charge	No charge	Mileage limits apply
	Urgent care	No charge	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Preauthorization may be required
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	No charge	20% coinsurance	None
	Inpatient services	No charge	20% coinsurance	Preauthorization is required
If you are pregnant	Office visits	No charge; deductible does not apply	20% 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	No charge	20% coinsurance	None
	Childbirth/delivery facility services	No charge	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Preauthorization is required
	Rehabilitation services	No charge	20% coinsurance	Physical, Speech, and Occupational Therapy is limited to a combined maximum of 30 visits per member per calendar year
	Habilitation services	No charge for Applied Behavioral Analysis; No charge for Physical Speech and Occupational Therapy	20% coinsurance for Applied Behavioral Analysis; 20% coinsurance for Physical Speech and Occupational Therapy	Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified analyst - is covered through age 18, subject to preauthorization .
	Skilled nursing care	No charge	No charge	Preauthorization is required. Limited to 120 days per member per calendar year
	Durable medical equipment	No charge	No charge	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No charge	No charge	Preauthorization is required. Visit limits apply.

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 your child needs dental or eye care	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:

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"> • Acupuncture • Cosmetic surgery • Dental Care (Adult) 	<ul style="list-style-type: none"> • Hearing aids • Infertility treatment • Long term care 	<ul style="list-style-type: none"> • 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.)

<ul style="list-style-type: none"> • Bariatric surgery • Chiropractic care 	<ul style="list-style-type: none"> • Non-Emergency care when traveling outside the U.S. • Coverage outside of the U.S., see http://provider.bcbs.com 	<ul style="list-style-type: none"> • Private-duty nursing
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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](tel:1-866-444-3272) or 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](tel:1-877-267-2323) [x61565](tel:1-877-267-2323) or www.cciio.cms.gov or by calling [1-800-752-1455](tel:1-800-752-1455). 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 Cross® and Blue Shield® of Michigan by calling [1-800-752-1455](tel:1-800-752-1455).

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

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](#).

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:



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	\$1,350
■ Specialist coinsurance	0 %
■ Hospital (facility) coinsurance	0 %
■ Other coinsurance	0 %

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:

Cost Sharing	
Deductibles	\$1,350
Copayments	\$30
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,440

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1,350
■ Specialist coinsurance	0 %
■ Hospital (facility) coinsurance	0 %
■ Other coinsurance	0 %

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:

Cost Sharing	
Deductibles*	\$1,350
Copayments	\$700
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$2,110

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,350
■ Specialist coinsurance	0 %
■ Hospital (facility) coinsurance	0 %
■ Other coinsurance	0 %

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:

Cost Sharing	
Deductibles*	\$1,350
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,350

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.

