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 **www.michiganbac.org**, or call the number on the back of your BCBSM ID card or the Fund Office at 1-800-531-2244. 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 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 Individual/$1000 Family for in-network; $1,000 Individual/ $2,000 Family for out-of-network	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, primary care and COVID-19 and related services as a result of the National Public Health Emergency, are covered before you meet your deductible. Additionally, office visit services are also not subject to the deductible but are subject to a copayment.	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.	There are no other deductibles.
What is the out-of-pocket limit for this plan?	$7,900 Individual/$15,800 Family **Note**: Within the out-of-pocket limit there is a $2,000 annual coinsurance in-network family maximum	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?	Copayments for certain services, 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.

Important Questions	Answers	Why This Matters:
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. Note: A referral for an out-of-network provider is required to avoid additional out-of-pocket expenses.

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	$40 copay/office visit; deductible/coinsurance does not apply	40% coinsurance after deductible	Copayment/Coinsurance is waived for emergency/accidental care at an office or clinic. During the COVID-19 Public Health Emergency, COVID-19 diagnostic tests and certain related services are covered with no cost sharing by In-Network or Out-of-Network Providers. COVID-19 related telehealth copays are waived.
	Specialist visit	$40 copay/visit; deductible/coinsurance does not apply	40% coinsurance after deductible	None. During the COVID-19 Public Health Emergency, COVID-19 diagnostic tests and certain related services are covered with no cost sharing by In-Network or Out-of-Network Providers. COVID-19 related Telehealth copays are waived.
	Preventive care/screening/ Immunization and COVID-19 services	Covered; no charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. During the COVID-19 Public Health Emergency, COVID-19 diagnostic tests and certain related services are covered with no cost sharing by In-Network or Out-of-Network Providers. COVID-19 related telehealth copays are waived.

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 a test	Diagnostic test (x-ray, blood work) including COVID-19 testing	20% coinsurance after deductible	40% coinsurance after deductible	Out-of-network providers may balance bill. During the COVID-19 Public Health Emergency there is no charge for a COVID-19 test or diagnostic test that result in COVID-19 testing at an In-network or Out-of-network provider.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	May require preauthorization. Out-of-network provider may balance bill.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com	Generic drugs	$5 copay (retail & Express Scripts mail order) 30-day supply; 90-day supply must be from Walgreens Retail Pharmacy ($10 copay) or Express Scripts Mail Order ($0 copay)	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. Select preventive drugs, supplements and vitamins required by PPACA may be covered in full. Ninety-day (90-day) supply for prescriptions are not covered for retail or mail order out-of-network providers. Effective April 1, 2021, Manufacturer Coupon Program is mandatory for Participants with prescription drugs that cost $400 or more and a manufacturer's coupon is available. Health Advocacy Program will contact the Participant. If Manufacturer coupon is not used, the Participant's cost sharing is 50% of the cost of the prescription drug.
	Brand drugs	30% coinsurance at any BCBSM Participating Retail Pharmacy or Express Scripts mail order for 30-day supply; 90-day supply is twice the cost of 30 day supply based on the 30% coinsurance amount and must be from Walgreens Retail Pharmacy or Express Scripts Mail Order	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
	Specialty Drug Generic and Brand are limited to 30-day supply	**Generic** $5 copay; **Brand** 30%. Both must be filled at Walgreens Retail Pharmacy or AllianceRx Prime Mail Order	Specialty drugs are not payable Out-of-Network	

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)	20% coinsurance after deductible	40% coinsurance after deductible	Non-participating facilities are not covered.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	Out-of-network providers may balance bill.
If you need immediate medical attention	Emergency room care	$250 copay/visit; deductible does not apply	$250 copay/visit; deductible does not apply	Copayment waived if admitted or for an accidental injury. During the COVID-19 Public Health Emergency, cost-sharing is waived for medically appropriate COVID-19 diagnostic tests, treatment and certain related items and/or services.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Mileage limits may apply. Out-of-network providers may balance bill.
	Urgent care	$40 copay/visit; deductible/coinsurance does not apply	40% coinsurance after deductible	Deductible/ Copayment /Coinsurance does not apply to accidental or medical emergencies. During the COVID-19 Public Health Emergency, cost-sharing is waived for medically appropriate COVID-19 diagnostic tests, treatment and certain related items and/or services
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization may be required. Non-participating facilities are not covered except for emergency.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	Out-of-network providers may balance bill.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Your cost share may be different for services performed in an office setting. Non-participating mental health providers/clinics are not covered. Waiver for telehealth for COVID-19 related mental health services
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required. Non-participating facilities are not covered.

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 are pregnant	Office visits	Prenatal and Postnatal: Covered; deductible/ copay does not apply	Prenatal and Postnatal: 40% coinsurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	Out-of-network providers may balance bill.
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	Out-of-network providers may balance bill.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	20% coinsurance after deductible	Preauthorization is required. Non-participating facilities are not covered.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Physical, Speech and Occupational Therapy is limited to a combined (in-network/out-of-network) maximum of 60 visits per individual, per calendar year. Non-participating providers/clinics are not covered.
	Habilitation services	Not covered for Applied Behavioral Analysis; 20% coinsurance after deductible for Physical, Speech and Occupational Therapy habilitative services required by PPACA	Not covered for Applied Behavioral Analysis; 40% coinsurance after deductible for Physical, Speech and Occupational Therapy habilitative services required by PPACA	Services are limited to a combined (in-network/out-of-network) maximum of 60 visits per individual, per calendar year including rehabilitation services. Non-participating providers/clinics are not covered.
	Skilled nursing care	20% coinsurance after deductible	20% coinsurance after deductible	Preauthorization is required. Limited to 120 days per individual per calendar year. Non-participating facilities are not covered.
	Durable medical equipment	20% coinsurance after deductible	Not covered	Excludes bath, exercise and deluxe equipment and comfort and convenience items. A prescription is required. Non-participating providers are not covered.
	Hospice services	Covered; deductible/ copay does not apply	Covered; deductible/ copay does not apply	Preauthorization is required. Visit limits may apply. Must use a participating hospice care provider.

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	Covered; $5 copay eye exam	Covered; provider may bill for difference between approved amount and provider's charge; $5 copay for exam applies	Vision benefits are covered once each 24 months. You may choose between prescription glasses (lenses and frames) or contact lenses but not both.
	Children's glasses	Covered; $7.50 copay for frames/lenses; $7.50 copay for medically necessary contact lenses	Covered; provider may bill for difference between approved amount and provider's charge; $7.50 copay for lenses/frames applies	
	Children's dental check-up	Covered; 50% co-insurance for preventive services (Class I, II, III)	Covered; provider may bill for difference between approved amount and provider's charge; 50% coinsurance applies	$500 maximum per individual per calendar year; orthodontics not covered.

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.)

- Acupuncture
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

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
- Dental care (Adult)
- Hearing aids
- Private-duty nursing
- Routine eye care (Adult)

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, 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 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 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: Blue Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card.

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? 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:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-531-2244

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-531-2244

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-531-2244

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-531-2244

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

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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** **$500**
- **Specialist copayment** **$40**
- **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	$500
Copayments	$200
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,500**

Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$40**
- **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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$500
Copayments	$800
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,460**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$40**
- **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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$500
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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

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