, revised 5/1/2023

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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. | | | | | |
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| **Important Questions** | | **Answers** | | **Why this Matters:** |
| **In-Network** | **Out-of-Network** |
| **What is the overall deductible?** | | $100 Individual/ $200 Family | $250 Individual/ $500 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, most outpatient physician services (e.g. primary care, urgent care, specialist visits, telemedicine e-visits), most chiropractic care, emergency room care and prescription drug coverage 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. |
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| **What is the out-of-pocket limit for this plan?**  (May include a coinsurance maximum) | | The out-of-pocket limits for medical coinsurance are $500/individual and $1,000 family. The total out-of-pocket limits for medical services are $4,125/individual and $10,250/family. These figures include medical deductible, coinsurance and copays. The out-of-pocket limit for prescription drugs are $3,775/individual and $5,550/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?** | | Deductible and copayments are not include in the out-of-pocket limits applicable to medical coinsurance. Amounts attributed to the total out-of-pocket limits for medical services are not include in the out-of-pocket limits for prescription cots. In general, out-of-pocket limits do not include premiums, balance-billing charges, any 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 | 30% coinsurance | None |
| Online visits | $20 copay/office visit; deductible does not apply | 30% coinsurance | By physician or BCBSM selected vendor must be medically necessary |
| Specialist visit | $20 copay/visit; deductible does not apply | 30% 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 needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | 30% coinsurance | None |
| Imaging (CT/PET scans, MRIs) | 10% coinsurance | 30% coinsurance | May require preauthorization |
| **If you need drugs to treat your illness or condition**  More information about **prescription drug coverage** is available at [www.navitus.com](http://www.navitus.com). Also refer to [www.oakgov.com/benefits](http://www.oakgov.com/benefits). | Tier 1-Rx Formulary: This is your lowest cost option, including many generic medications and a few brand name drugs | $5 copay/prescription (retail or mail order) | Paid at the in-network cost, less $5 copay | Covers up to a 90-day supply (retail or up to a 90-day supply mail order). Specific criteria may need to be met in order for some high-cost medications to be covered.  Effective 4/1/2023: When you fill certain specialty drugs that are dispensed through the specialty pharmacy, Lumicera will contact you to assist you with enrollment in the Copay Max PLUS Program. Under this program, your specialty drugs are subject to a coinsurance of 40% (retail or mail order). Your total payment for a specialty drug will be capped at $0. You will be **required** to enroll in the Navitus program to obtain manufacturer assistance, including copay assistance. Amounts paid by drug manufacturers on your behalf (along with other payments from drug manufacturers, such as manufacturer coupons) will not count toward your annual out-of-pocket limits. Instead, only those payments made directly by you will count toward your out-of-pocket limit. Your copay will default to the Rx formulary’s current tiered copay if a specialty drug does not quality or is removed from the program. |
| Tier 2-Rx Formulary: This drug tier offers more brand name options, including Preferred brands and some generics | $20 copay/prescription (retail or mail order) | Paid at the in-network cost, less $20 copay |
| Tier 3-Rx Formulary: This is your most costly option with Non-Preferred products (could include both brand and generic products) | $40 copay/prescription (retail or mail order) | Paid at the in-network cost, less $40 copay |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance | None |
| Physician/surgeon fees | 10% coinsurance | 30% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $100 copay/visit; deductible does not apply | $100 copay/visit; deductible does not apply | Copay waived if admitted or for an accidental injury. |
| Emergency medical transportation | 10% coinsurance | 10% coinsurance | Mileage limits apply; Must be medically necessary |
| Urgent care | $20 copay/visit; deductible does not apply | 30% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., semi-private hospital room) | 10% coinsurance | 30% coinsurance | Preauthorization is required; Nonemergency services must be rendered in a participating hospital |
| Physician/surgeon fee | 10% coinsurance | 30% coinsurance | None |
| **If you need behavioral health services (mental health and substance use disorder)** | Outpatient services | 10% coinsurance | 10% coinsurance for mental health; 30% coinsurance for substance use disorder | Your cost share may be different for services performed in an office setting |
| Inpatient services | 10% coinsurance | 30% coinsurance | Preauthorization is required; Nonemergency services must be rendered in a participating hospital |
| **If you are pregnant** | Office visits | Prenatal: No Charge; deductible does not apply Postnatal: No Charge; deductible does not apply | Prenatal: 30% coinsurance Postnatal: 30% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services cost share may apply. Cost sharing does not apply for preventive services. |
| Childbirth/delivery professional services | 10% coinsurance | 30% coinsurance | None |
| Childbirth/delivery facility services | 10% coinsurance | 30% coinsurance | None |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 10% coinsurance | Physician certification required. |
| Rehabilitation services | 10% coinsurance | 30% coinsurance | Physical, Speech and Occupational Therapy is limited to a combined maximum of 180 visits per member, per calendar year. |
| Habilitation services | 10% coinsurance for Applied Behavior Analysis | 10% coinsurance for Applied Behavior Analysis | Applied behavior analysis (ABA) treatment for Autism - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization.  Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment. |
| Skilled nursing care | 10% coinsurance | 10% coinsurance | Preauthorization is required. Limited to 120 days per member per calendar year |
| Durable medical equipment | 10% coinsurance | 10% coinsurance | Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.  Note; DME items required under the preventive drug benefit provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of preventive DME items that PPACA requires to be covered at 100%, call BCBSM. |
| Hospice services | No Charge; deductible and coinsurance do not apply | o Charge; deductible and coinsurance do not apply | Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods-provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management). |
| For more information about vision coverage, visit [www.e-nva.com](http://www.e-nva.com). More information about dental coverage, visit [www.deltadentalmi.com](http://www.deltadentalmi.com). Also refer to [www.oakgov.com/benefits](http://www.oakgov.com/benefits). | Children’s eye exam | Not covered | Not covered | No coverage for routine eye care under the medical plan, except as required by PPACA |
| Children’s glasses | Not covered | Not covered | No coverage for glasses under the medical plan |
| Children’s dental check-up | Not covered | Not covered | No coverage for routine dental care under the medical plan, except as required by PPACA |

**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 (except to the extent required to be covered by PPACA) * Glasses | * Infertility treatment (except the treatment of the underlying cause of infertility may be covered) * Hearing aids * Infertility treatment * Long term care | * Routine eye care (except to the extent required to be covered by PPACA) * Routine foot care * Weight loss programs (except to the extent required to be covered by PPACA) |

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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 * 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**

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 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** | **$100** | |  **Specialist copayment** | **$20** | |  **Hospital (facility) coinsurance** | **10%** | |  **Other coinsurance** | **10%** |   **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 | $100 | | Copayments | $20 | | Coinsurance | $500 | | *What isn’t covered* | | | Limits or exclusions | $20 | | **The total Peg would pay is** | **$640** | |  | |  | | --- | | **Managing Joe’s Type 2 Diabetes** (a year of routine in-network care of a well-controlled condition) |  |  |  | | --- | --- | |  **The plan’s overall deductible** | **$100** | |  **Specialist copayment** | **$20** | |  **Hospital (facility) coinsurance** | **10%** | |  **Other coinsurance** | **10%** |     **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 | $100 | | Copayments | $240 | | Coinsurance | $500 | | *What isn’t covered* | | | Limits or exclusions | $0 | | **The total Joe would pay is** | **$840** | |  | |  | | --- | | **Mia’s Simple Fracture** **(**in-network emergency room visit and  follow up care) |  |  |  | | --- | --- | |  **The plan’s overall deductible** | **$100** | |  **Specialist copayment** | **$20** | |  **Hospital (facility) coinsurance** | **10%** | |  **Other coinsurance** | **10%** |     **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** | **$2,800** |   **In this example, Mia would pay:**   |  |  | | --- | --- | | *Cost Sharing* | | | Deductibles | $100 | | Copayments | $40 | | Coinsurance | $200 | | *What isn’t covered* | | | Limits or exclusions | $10 | | **The total Mia would pay is** | **$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, copayments, or coinsurance, or benefits not otherwise covered. | | | | | |

