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 1-800-229-2210. 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 1-800-229-2210 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network providers: $3,000 individual / $6,000 family Out-of-Network providers: $4,000 individual / $8,000 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. In-network does not apply. Out-of-network prescription drugs, emergency room services, emergency medical transportation, and durable medical equipment.	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?	In-Network providers: $6,350 individual / $12,700 family Out-of-Network providers: $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, prior authorization penalties, copayments, 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 bluewaterbenefitsadmin.com 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 network 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	$20 copay Deductible does not apply	40% coinsurance	None
	Specialist visit	$20 copay Deductible does not apply	40% coinsurance	None
	Preventive care/screening/ immunization	No charge Deductible does not apply	40% coinsurance	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. No charge Out-of-Network: annual physical, gynecological exam, fecal occult blood screening, and prostate-specific antigen test.
If you have a test	Diagnostic test (x-ray, blood work)	$20 copay Deductible does not apply	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$20 copay + 20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bluewaterbenefitsadmin.com	Generic drugs	$5 copay (retail) $10 copay (mail order) Deductible does not apply	$5 copay (retail) + 25% cost share of eligible expenses. Mail order not available.	Covers up to a 31-day supply (retail prescription); 90-day supply (mail order prescription). Some prescription drugs are subject to prior authorization, or benefits will be reduced by 20%.
	Preferred brand drugs	$20 copay (retail) $40 copay (mail order) Deductible does not apply	$20 copay (retail) + 25% cost share of eligible expenses. Mail order not available.	
	Non-preferred brand drugs	$40 copay (retail) $80 copay (mail order) Deductible does not apply	$40 copay (retail) + 25% cost share of eligible expenses. Mail order not available	

* For more information about limitations and exceptions, see the plan or policy document at bluewaterbenefitsadmin.com.

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	40% coinsurance	Prior authorization is required, or benefits will be reduced by 20%.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Prior authorization is required, or benefits will be reduced by 20%.
If you need immediate medical attention	Emergency room care	$200 copay Deductible does not apply	$200 copay	Copay waived if you are admitted to hospital as inpatient. Emergency Room physician covered at 100% following In-Network Deductible.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$20 copay Deductible does not apply	No charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Prior authorization is required, or benefits will be reduced by 20%.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Prior authorization is required, or benefits will be reduced by 20%.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay Deductible does not apply	40% coinsurance	None
	Inpatient services	No charge	40% coinsurance	Prior authorization is required, or benefits will be reduced by 20%.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Prior authorization is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay or benefits will be reduced by 20%.
	Childbirth/delivery professional services	No charge Deductible does not apply	40% coinsurance	
	Childbirth/delivery facility services	No charge Deductible does not apply	40% coinsurance	

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	Home health care	20% coinsurance	40% coinsurance	None
	Rehabilitation services	Facility setting: 20% coinsurance Office setting: $20 copay Deductible does not apply	40% coinsurance	Limited to 30 visits per plan year for speech therapy. Limited to 30 visits per plan year combined for physical and occupational therapy.
	Habilitation services	Facility setting: 20% coinsurance Office setting: $20 copay Deductible does not apply	40% coinsurance	Limited to 30 visits per plan year for speech therapy. Limited to 30 visits per plan year combined for physical and occupational therapy.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 100 days per plan year.
	Durable medical equipment	No charge	No charge	None
	Hospice services	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

* For more information about limitations and exceptions, see the plan or policy document at bluewaterbenefitsadmin.com.

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.)

- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-Emergency Care when travelling outside the U.S.
- Routine Eye Care (Adult)
- Weight Loss Programs

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

- Acupuncture
- Bariatric Surgery – 1 per lifetime
- Chiropractic Care – 30 visits per calendar year
- Hearing Aids payable once every 36 months
- Infertility Treatment (except in-vitro and egg retrieval)
- Private-Duty Nursing – by licensed practical nurse
- Routine Foot Care – ankles, toes, heels including surgery, x-rays and orthotics

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: the plan at 1-800-225-9674, the state insurance department, the U.S. Department of Labor, the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: the plan at 1-800-225-9674. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program at 1-877-999-6442 or www.michigan.gov/lara or email 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 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.

Language Access Services:

Spanish Español): Para obtener asistencia en Español, llame al 1-800-229-2210.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-229-2210.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-229-2210.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-229-2210.

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

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* For more information about limitations and exceptions, see the plan or policy document at bluewaterbenefitsadmin.com.

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	**$3,000**
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	$3000
Copayments	$0
Coinsurance	$1500.0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4500.00**

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

The plan's overall deductible	**$3,000**
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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3000.
Copayments	$80.00
Coinsurance	$360.000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3460.00**

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

The plan's overall deductible	**$3,000**
Specialist copayment	**$20**
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	$2600.000
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2800.00300**

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