




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 1-800-843-4876. 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 1-800-843-4876 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network: \$400/Individual or \$800/Family Out-of-Network: \$800/Individual or \$1,600/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. Emergency Services and other services as noted 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 ?	In-Network: \$2,000/Individual or \$4,000/Family Out-of-Network: \$3,000/Individual or \$6,000/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 , 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, and health care this plan doesn't cover.	Even through 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 1-800- 843-4876 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	\$20 copay Deductible does not apply	20% coinsurance	None
	Specialist visit	\$20 copay Deductible does not apply	20% coinsurance	None
	Preventive care/screening/immunization	No charge Deductible does not apply	20% 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. Out-of-network services limited to colonoscopy, diabetes self-management, mammography, and childhood immunizations.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	The test must be deemed medically necessary . Experimental, investigational or services for your convenience or the convenience of your provider are not covered under the plan .
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	The test must be deemed medically necessary . Experimental, investigational or services for your convenience or the convenience of your provider are not covered under the plan .
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com/som	Generic drugs	\$10 copay (retail) \$20 copay (mail order) Deductible does not apply	Not covered	You can find information regarding specific limitations and exceptions by utilizing the formulary link on the Optum Rx State of Michigan website or by contacting Optum Rx Customer Service at 866-633-6433.
	Preferred brand drugs	\$30 copay (retail) \$60 copay (mail order) Deductible does not apply	Not covered	
	Non-preferred brand drugs	\$60 copay (retail) \$120 copay (mail order) Deductible does not apply	Not covered	

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.bcbsm.com/som.

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)	10% coinsurance	20% coinsurance	None
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	\$200 copay Deductible does not apply	\$200 copay Deductible does not apply	The copay is waived if admitted as inpatient.
	Emergency medical transportation	10% coinsurance	10% coinsurance	You are covered for ambulance transport to the nearest medical facility capable of treating your condition.
	Urgent care	\$20 copay Deductible does not apply	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Unlimited for general medical care days.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance Deductible does not apply	50% coinsurance Deductible does not apply	Out-of-network is covered 50% of allowed amount or billed charges (whichever is less).
	Inpatient services	No charge Deductible does not apply	50% coinsurance Deductible does not apply	Unlimited day for behavioral health. Up to 28 days per treatment period for substance abuse with a maximum of two periods per calendar year. Out-of-network is covered 50% of allowed amount or billed charges (whichever is less).
If you are pregnant	Office visits	No charge Deductible does not apply	20% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	

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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	10% coinsurance	Not covered	Unlimited visits. Your plan does not cover custodial care, non-skilled care rest therapy and care in a nursing or rest home facility. Must be rendered by a participating home health care agency.
	Rehabilitation services	10% coinsurance	20% coinsurance	Your plan covers 90 combined visits for physical, occupational, speech, and massage therapies per calendar year. Chiropractors may perform massage therapy when provided as part of a complete physical therapy plan. Massage therapy performed by a massage therapist must be supervised by a chiropractor and be part of a formal course of physical therapy. Massage therapy not part of a formal course of treatment is not a covered benefit.
	Habilitation services	10% coinsurance	20% coinsurance	None
	Skilled nursing care	10% coinsurance	Not covered	Up to 120 days per confinement. Must be in a Blue Cross approved skilled nursing facility.
	Durable medical equipment	No charge	20% coinsurance	You will pay 20% coinsurance plus the difference between the non-participating provider's charge and the Blue Cross approved amount.
	Hospice services	No charge	Not covered	Limited to the lifetime dollar maximum that is adjusted by the State. Must be a Blue Cross or Medicare-certified hospice program.
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

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.bcbsm.com/som.

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)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Private-duty nursing
- Routine eye care (Adult)
- Weight Loss

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: 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. 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 Blue Shield of Michigan, Conference Coordination Unit, P.O. Box 2456, Detroit, MI 48231-2459. For state of Michigan assistance contact the Civil Service Commission, Employee Benefits Division, P.O. Box 30002, Lansing, MI, 48909 or the Department of Insurance and Financial Services, Office of General Counsel-Appeals Section, 530 W. Allegan Street, 7th Floor, P. O. Box 30220, Lansing, MI 48909-7720, <http://www.michigan.gov/difs>; call 1-877-999-6442 or fax: 517-284-8838.

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 1-877-469-2583.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawagsa 1-877-469-2583.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-469-2583.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-469-2583

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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	\$400
■ Specialist copayment	\$0
■ 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$33
Coinsurance	\$980
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,473

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$400
■ 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$134
Copayments	\$699
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$255
The total Joe would pay is	\$1,088

Mia's Simple Fracture

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

■ The plan's overall deductible	\$400
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$20
Coinsurance	\$98
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$518

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.