Coverage Period: 1/1/2022-12/31/2022

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** All Contract Types **Plan Type:** PPO

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.claimchoice.com or call (800) 221-4254 . For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms

Important Questions	Answers: Member / Family	Why This Matters:
What is the overall deductible?	$1,500/$3,000 In-Network $3,000/$6,000 Out of Network	Generally, you must pay all of the costs from provider's 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 paidby all family members meets the overall family deductible.
Are there services covered beforeyou meet your deductible?	Yes. Lab, preventive care, DME/P&O, diabetic supplies, PCP office visits, specialist office visits, urgent care, allergyinjections, prescription drugs, outpatient mental health and substance use services	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 preventiveservices 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 forthis plan?	$6,350/$12,700 In-Network No Limit for Out of Network	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 theout–of–pocket limit?	Premiums, balance billed charges and health care this plan does not cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit
Will you pay less if you use anetwork provider?	Yes. See (www.cofinity.com) or call thephone number on the back of your ID card for a list of network providers. (800) 831.1166 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.

Important Questions	Answers: Member / Family	Why This Matters:
Do you need a referral to see aspecialist?	No	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.
Precertification Requirement & Penalty for Non-Compliance	Plan requires for certain treatment, procedures and services. Services are noted below with Precertification Required and full list in the Summary Plan Description.	For any scheduled or non-emergency treatment is required at least 2 weeks prior to date of treatment. Emergency must be done within 72 hours. Non-Compliance will result in maximum payment of 125% of Medicare for billed charges. Employee may be balance billed for difference.
Second Opinion Requirement & Penalty for Non-Compliance	Plan requires for certain treatment, procedures and services. Refer to Summary Plan Document for complete list of surgeries or treatments requiring Second Opinion.	If a Physician recommends Surgery for a Participant, the Participant is required to request a second opinion as to whether or not the Surgery is Medically Necessary. When a second opinion is requested, the Plan will pay 100% of the Maximum Allowable Charge up to $250 Incurred for that opinion along with laboratory, x-ray and other Medically Necessary services ordered by the second Physician without application of the Deductible. Penalty for non-compliance is $500 reduction in benefits paid.

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 ImportantInformation
		Network Provider (You will pay the least)	Out-of-Network Provider(You will pay the most)	
If you visit a health careprovider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit. Deductibledoes not apply	Deductible then 50%	Only the PCP office visit is exempt from the deductible. Other services received in the office, deductible applies. $0 copay for onlinevisits.
	Specialist visit	$40 copay/visit. Deductibledoes not apply	Deductible then 50%	30 combined visits for spinalmanipulations performed by a chiropractor or osteopathic physician /Deductible applies for allergy testing
	Preventive care/screening/immunization	No charge, Deductible does not apply. Deductibledoes not apply	Not covered	Deductible does not apply to preventive services. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then checkwhat your plan will pay for.

If you have a test	Diagnostic test (x-ray, blood work)	X-ray: Deductible then 20% Lab: Deductible then plan pays 100%	Deductible then 50%	*For services received at In-Network facility, if Ancillary providers bill as Out-Of-Network, In-Network Benefits will apply, with payment capped at 150% of Medicare. May require Precertification. Deductible doesnot apply to preventive services
	Imaging (CT/PET scans, MRIs) If performed at: (MRI/CT/Stress Test/Echo) M1 – East Beltline Imaging	Deductible then plan pays 100% after $150 copay If contact and go to Sympl Location, Deductible is Waived.	Deductible then 50%	Requires Precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other ImportantInformation
		Network Provider (You will pay the least)	Out-of-Network Provider(You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage**is available at (www.southernscripts.net)	Tier 1 - Mostly Generics	$6 copay/30 days. Deductible does not apply	Not covered	Preauthorization & step-therapy apply to select drugs. Weight Loss covered at 50%. Needles/Syringes covered at 100% $0 copay. 90 day mail order and retail copays are 2x the standard retail copays.
	Tier 2 - Preferred Brand	$50 copay/30 days. Deductible does not apply	Not covered	
	Tier 3 - Non-Preferred Brand	$80 copay/30 days. Deductible does not apply	Not covered	
	Specialty drugs	Not Covered	Not covered	Patient Assistance Programs may be available.
If you have outpatientsurgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 20% coinsurance	Deductible then 50% coinsurance	*For services received at In-Network facility, if Ancillary providers bill as Out-Of-Network, In-Network Benefits will apply, with payment capped at 150% of Medicare. Requires Precertification.
	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 50% coinsurance	See "Outpatient surgery facility fee"

If you need immediatemedical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Copay waived if admitted
	Emergency medical transportation	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Non-emergent transport is covered when preauthorized
	Urgent care	$50 copay/visit. Deductibledoes not apply	50% after Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	Deductible then 50% coinsurance	*For services received at In-Network facility, if Ancillary providers bill as Out-Of-Network, In-Network Benefits will apply, with payment capped at 150% of Medicare. Requires Precertification.
	Physician/surgeon fee	Deductible then 50% coinsurance	Deductible then 50% coinsurance	See "Hospital stay facility fee". *For services received at In-Network facility, if Ancillary providers bill as Out-Of-Network, In-Network Benefits will apply, with payment capped at 150% of Medicare.
If you need mental health,behavioral health, or substance use disorder services	Outpatient services	$20 copay/visit. Deductibledoes not apply	Deductible then 50% coinsurance	None
	Inpatient services	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Requires Precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other ImportantInformation
		Network Provider (You will pay the least)	Out-of-Network Provider(You will pay the most)	
If you are pregnant	Office visits	$30 copay/visit. Deductibledoes not apply	Deductible then 50% coinsurance	Postnatal and non-routine prenatal office visits, no charge. Deductible does not apply toroutine maternity care. Only the routine prenatal visit is exempt from the deductible. Other services, deductible applies
	Childbirth/delivery professional services	Pre-natal care: No Charge Post	Deductible then 50% coinsurance	None
	Childbirth/delivery facility services	No Charge	Deductible then 50% coinsurance	Requires Precertification for extended stay only
If you need help recovering or have otherspecial health needs	Home health care	$40 copay/visit	Deductible then 50%	Requires precertification. Custodial care not covered. Limited to 100 visits per calendar year.
	Rehabilitation services	$40 copay/visit	Deductible then 50% coinsurance	Requires precertification/Limited to 60 visitsper benefit year. Subject to meaningful improvement within 60 days.
	Habilitation services	Not Covered	Not covered	Not Covered
	Skilled nursing care	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Requires precertification/Limited to 45 daysper benefit year. Custodial care not covered.
	Durable medical equipment	50% coinsurance. Deductible does not apply	Deductible then 50% coinsurance	Requires precertification. Convenience and comfort items not covered. Diabetic supplies covered in full. Deductible does notapply to diabetic supplies.
	Hospice services	No charge	Deductible then 50% coinsurance	Inpatient care requires precertification. Housekeeping and custodial care not covered.
	Children's eye exam	Not covered	Not covered	Contact your benefit administrator for coverage information.

If your child needs dentalor eye care	Children's glasses	Not covered	Not covered	Contact your benefit administrator for coverage information.
	Children's dental check-up	Not covered	Not covered	Contact your benefit administrator for coverage information.

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 (if prescribed for rehabilitation purposes)
- Cosmetic surgery
- Dental Care (Adult)
- Elective Abortion
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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 (Limited to one per lifetime. Requires preauthorization)
- Chiropractic care
- Infertility treatment (Coverage includes diagnosis/ counseling/treatment of infertility when medically necessary and preauthorized by BCN. SeeCertificate of Coverage for exclusions)

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: ClaimChoice Administrators at 1-800-221-4254 You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit their website at www.dol.gov/ebsa/healthreform. Additionally, a Consumer Assistance Program may be able to help you file your appeal. Visit http://www.healthcare.gov/law/features/rights/consumer-assistance-program/index.html to see if your state has a Consumer Assistance Program that may be able to help you file your appeal.

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 the Minimum Value Standard? 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 Care Network of Michigan is assuming that your coverage provides for all Essential Health Benefits (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 for specific EHB categories, for example, prescription drugs, through another carrier.)

Translation available

To get help reading in your language call the customer service number on the back of your ID card.

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

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 careand a hospital delivery)

The plan's overall deductible	**$5000**
Specialist copayment	**$45**
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**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	**$5000**
Specialist copayment	**$45**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like: Primary care physician office visits (*includingdisease education)*
Diagnostic tests (*blood work*)Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

Mia's Simple Fracture

(in-network emergency room visit

The plan's overall deductible	**$5000**
Specialist copayment	**$45**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$1,900**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$100
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,160**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$30
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,290**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$100
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,250**