**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 see the Glossary. You can view the Glossary at (https://www.healthcare.gov/sbc-glossary).

| Important Questions | Answers: Member / Family | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network:<br>$6,600 Individual/$13,200 Family<br><br>Out of Network:<br>Not covered. | Generally, you must pay all of the costs from provider's up to the deductible amount before this plan begins to pay.<br><br>ChoiceCare allows members to choose services based on price. When a member chooses a provider that is cost effective through ChoiceCare, their deductible and coinsurance can be waived for that procedure. For non-emergent/elective procedures please contact ChoiceCare for options. |
| **Are there services covered before you meet your deductible?** | Yes. Preventative Care. | 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/) |
| **What is the out–of–pocket limit for this plan?** | In-Network:<br>$6,850 Individual/$13,700 Family<br>Out of Network:<br>Not covered. | 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 a network provider?** | Yes. See (www.cofinity.net) or call the phone 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 complete bill if you use an out-of-network provider. 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 a specialist?** | No | You may choose to see any specialist without a referral. |
| **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 1 weeks prior to date of treatment. Emergency must be done within 72 hours. Non-Compliance will result in a penalty of $250. Employee may be balance billed for difference. |
| **Second Opinion Recommendation:** | Plan recommends for certain treatment, procedures and services. Refer to Summary Plan Document for complete list of surgeries or treatments. | If a Physician recommends Surgery for a Participant, the Participant is recommended 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. |

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 | Deductible then 20% coinsurance | Not covered | |
| | Specialist visit | Deductible then 20% coinsurance | Not covered | |
| | Preventive care/screening/immunization | Plan pays 100% Deductible does not apply. | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Deductible then 20% Coinsurance | Not covered | May require Precertification. Deductible does not apply to preventive services |
| | Imaging (CT/PET scans, MRIs) | Deductible then 20% Coinsurance | Not covered | Requires Precertification. Please note penalty will apply for non-compliance with precertification requirement. |

| 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 drugs to treat your illness or condition** More information about **prescription drug coverage** is available at (www.southernscripts.net) | Generic | Deductible then $10 copay/31 days. | Not covered | Generic drugs are mandatory. If a brand drug is dispensed when a generic drug is available, you will pay 100% of cost. 60 or 90 day mail order and retail copays are 2.5 x the standard retail copays. |
| | Brand - Preferred | Deductible then $35 copay/10 days. | Not covered | |
| | Brand – Non Preferred | Deductible then 50% to maximum OOP | Not covered | |
| | Specialty drugs | Not covered | Not covered | Patient Assistance available – Contact ChoiceRx |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Deductible then 20% Coinsurance | Not covered | *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 | Not covered | See "Outpatient surgery facility fee" |
| **If you need immediate medical attention** | Emergency room care | Deductible then 20% coinsurance. | Not covered | |
| | Emergency medical transportation | Deductible then 20% Coinsurance | Not covered | |
| | Urgent Care | Deductible then 20% coinsurance | Not covered | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Deductible then 20% Coinsurance | Not covered | *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 and 20% coinsurance | Not covered | 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** | Outpatient services | Deductible then 20% Coinsurance | Not covered | None |

| | | | | |
|---|---|---|---|---|
| **substance use disorder services** | Inpatient services | Deductible then 20% Coinsurance | Not covered | Requires Precertification. |

| 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 Visit | Plan pays 100% | Not covered | Covered as Women's wellness |
| | Childbirth/delivery professional services | Deductible then 20% Coinsurance | Not covered | Deductible will not apply for a newborn child whose length of stat in Hospital is same as the mother's length of stay. |
| | Childbirth/delivery facility services | Deductible then 20% Coinsurance | Not covered | Requires Precertification for extended stay. Deductible will not apply for a newborn child whose length of stat in Hospital is same as the mother's length of stay. |
| **If you need help recovering or have other special health needs** | Home health care | Deductible then 20% Coinsurance | Not covered | Requires precertification. Custodial care not covered. Limited to 100 visits per calendar year. |
| | Rehabilitation services | Deductible then 20% coinsurance | Not covered | May require precertification. PT/OT/Manipulative limited to combined 30 visits per year. Speech limited to 30 visits per year. Cognitive limited to 20 visits per year. Pulmonary/Cardiac limited to combined 30 visits per year. |
| | Habilitative services | Deductible then 20% coinsurance | Not Covered | May require precertification. PT/OT/Manipulative limited to combined 30 visits per year. Speech limited to 30 visits per year. Cognitive limited to 20 visits per year. Pulmonary/Cardiac limited to combined 30 visits per year. Note: no visit limits for PT/Speech/OT relating to Autism Spectrum Disorder for enrolled dependent children through age of 18. |
| | Skilled nursing care | Deductible then 20% Coinsurance | Not covered | Requires precertification/Limited to 45 days per benefit year. Custodial care not covered. |

| | | | | |
|---|---|---|---|---|
| | Durable Medical Equipment, Orthotics and Supplies | Deductible then 20% Coinsurance | Not covered | Requires precertification. Convenience and comfort items not covered. Diabetic supplies covered in full. Deductible does not apply to diabetic supplies. |
| | Hospice services | Deductible then 20% Coinsurance | Not covered | Inpatient care requires precertification. Housekeeping and custodial care not covered. |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | No Charge | Contact your benefit administrator for coverage information. |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | None |

## 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.)**

- Chiropractic care
- Infertility treatment (Coverage includes diagnosis/counseling/treatment of infertility when medically necessary and preauthorized. 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 care and 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** |

**In this example, Peg would pay:**

### 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 (*including disease education)*
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

| | |
|---|---|
| **Total Example Cost** | **$7,400** |

**In this example, Joe would pay:**

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

| | |
|---|---|
| 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, Mia 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** |

| *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** |

| *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** |