




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 1-888-288-2738 or go online to www.bcbsm.com. 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 1-888-288-2738 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall <u>deductible</u> ? | In- <u>network providers</u> , \$0 individual /\$0 family Out-of- <u>network providers</u> , \$0 individual /\$0 family | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. All covered health services are covered without a <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? | Not Applicable. | This <u>plan</u> does not have an <u>out-of-pocket Limit</u> on your expenses. |
| What is not included in the <u>out-of-pocket limit</u> ? | Not Applicable. | This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses. |
| Will you pay less if you use a <u>network provider</u> ? | Yes. See https://www.bcbsm.com/marketplace/ppo/ or call 1-888-288-2738 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |

 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 | No charge | No charge | 24/7 medical virtual visits when performed through the BCBSM selected vendor app. |
| | <u>Specialist</u> visit | No charge | No charge | |
| | <u>Preventive care/screening/immunization</u> | No charge | No charge | None |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | No charge | No charge | None |
| | Imaging (CT/PET scans, MRIs) | No charge | No charge | Prior authorization required. The penalty for not having prior authorization is denial of payment. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.bcbsm.com/2025-select-ppo-druglist | Generic drugs | No charge | Not covered | Opioid-containing medications are limited to no more than a 30-day supply per fill and first fills of select opioid containing medications will be limited to a 5-day supply. Prior authorization, step therapy and quantity limits may apply to select drugs. The penalty for not having prior authorization is denial of payment. Any coupon, rebate or other credits received directly or indirectly from an assistance program or the drug manufacturer may not be applied to a consumer's <u>deductible</u> , <u>cost-sharing</u> or <u>out of pocket maximum</u> . For <u>out-of-network providers</u> , member must pay the full cost of the drug and submit to BCBSM for reimbursement. |
| | Preferred brand drugs | No charge | Not covered | |
| | Non-preferred brand drugs | No charge | Not covered | |

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com/index/plans/michigan-health-insurance/2025.html

| 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) | |
| <p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at https://www.bcbsm.com/2025-select-ppo-druglist</p> | <u>Specialty drugs</u> | No charge | Not covered | <p><u>Specialty drugs</u> are limited to a 30-day supply per fill, however some may be limited to a 15-day supply fill, depending on the medication. BCBSM has contracted with an exclusive pharmacy <u>network</u> for <u>specialty drugs</u>. Call the customer service phone number on the back of your ID card for the pharmacy's phone number or location nearest to you.</p> <p>Any coupon, rebate, or other credits received directly or indirectly from an assistance program or the drug manufacturer may not be applied to a consumer's <u>deductible</u>, <u>cost-sharing</u> or <u>out of pocket maximum</u>.</p> |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | No charge | Excludes cosmetic surgery, corrective eye surgery, investigational and experimental procedures. These services may require prior authorization. The penalty for not having prior authorization is denial of payment. Weight reduction procedures limited to one per lifetime. |
| | Physician/surgeon fees | No charge | No charge | |
| If you need immediate medical attention | <u>Emergency room care</u> | No charge | No charge | None |
| | <u>Emergency medical transportation</u> | No charge | No charge | Includes air and ground transportation. Excludes transportation for convenience. |
| | <u>Urgent care</u> | No charge | No charge | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | No charge | BCBSM participating hospitals only. These services require prior authorization. The penalty for not having prior authorization is denial of payment. |
| | Physician/surgeon fees | No charge | No charge | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No charge | No charge | Includes virtual visit with participating BCBSM <u>provider</u> and Blue Cross virtual care visit from BCBSM selected vendor app only. BCBSM approved facilities only. |
| | Inpatient services | No charge | No charge | BCBSM approved facilities only. These services require prior authorization. The penalty for not having prior authorization is denial of payment. |

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com/index/plans/michigan-health-insurance/2025.html

| 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 visits | No charge | No charge | None |
| | Childbirth/delivery professional services | No charge | No charge | |
| | Childbirth/delivery facility services | No charge | No charge | BCBSM participating hospitals only. These services require prior authorization. The penalty for not having prior authorization is denial of payment. |
| If you need help recovering or have other special health needs | <u>Home health care</u> | No charge | No charge | BCBSM participating agencies only. Excludes housekeeping and custodial services. |
| | <u>Rehabilitation services</u> | No charge | No charge | Physical, occupational, chiropractic and osteopathic manipulative therapy limited to a combined maximum of 30 visits per member per calendar year. Speech therapy limited to a maximum of 30 visits per member per calendar year. Cardiac/pulmonary visits limited to a maximum of 30 visits per member per calendar year. |
| | <u>Habilitation services</u> | No charge | No charge | Physical and occupational therapy limited to a combined maximum of 30 visits per member per calendar year. Speech therapy limited to a maximum of 30 visits per member per calendar year. |
| | <u>Skilled nursing care</u> | No charge | No charge | Limited to a maximum of 45 days per member per calendar year. BCBSM participating facilities only. Excludes custodial care. These services require prior authorization. The penalty for not having prior authorization is denial of payment. |
| | <u>Durable medical equipment</u> | No charge | No charge | Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription is required. Rental and purchase limited to basic equipment. |
| | <u>Hospice services</u> | No charge | No charge | Coverage includes inpatient and outpatient hospice care. BCBSM approved hospice programs only. Excludes housekeeping services. |

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com/index/plans/michigan-health-insurance/2025.html

| 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 your child needs dental or eye care | Children's eye exam | No charge | No charge | Limited to once in a calendar year. A child is defined as a member up to the age of 19. <u>Out-of-network</u> is paid up to the <u>allowed amount</u> . |
| | Children's glasses | No charge | No charge | Frames (chosen from a select collection) and lenses are covered once in a calendar year. A child is defined as a member up to the age of 19. <u>Out-of-network</u> is paid up to the <u>allowed amount</u> . |
| | Children's dental check-up | Not covered | Not covered | Stand-alone dental <u>plans</u> available. |

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com/index/plans/michigan-health-insurance/2025.html

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.) | | |
|---|---|--|
| <ul style="list-style-type: none">• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)• Acupuncture• Cosmetic Surgery | <ul style="list-style-type: none">• Dental care (Adult)• Hearing aids• Long-term care | <ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.• Private-duty nursing• Routine eye care (Adult)• Routine foot care |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
| <ul style="list-style-type: none">• Bariatric surgery | <ul style="list-style-type: none">• Chiropractic | <ul style="list-style-type: none">• Infertility treatment• Weight loss programs |

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: Michigan Department of Insurance and Financial Services at www.michigan.gov/difs at 1-877-999-6442. 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: Michigan Department of Insurance and Financial Services at michigan.gov/difs at 1-877-999-6442.

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? Not Applicable

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 888-288-2738

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-288-2738

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码888-288-2738

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 888-288-2738

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

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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 \$0
- Specialist copayment \$0
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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

| | |
|--------------------|-----|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

| | |
|-----------------------------------|-------------|
| The total Peg would pay is | \$60 |
|-----------------------------------|-------------|

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$0
- Specialist copayment \$0
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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

| | |
|--------------------|-----|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$20 |
|----------------------|------|

| | |
|-----------------------------------|-------------|
| The total Joe would pay is | \$20 |
|-----------------------------------|-------------|

Mia's Simple Fracture

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

- The plan's overall deductible \$0
- Specialist copayment \$0
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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

| | |
|--------------------|-----|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|------------|
| The total Mia would pay is | \$0 |
|-----------------------------------|------------|

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

