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, go to www.mielectricalhealth.org or call 1-855-756-4448. 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 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network provider: **$750**/person per calendar year; **$1,500**/family per calendar year; out-of-network provider: **$1,500**/person per calendar year **$3,000**/family per calendar year	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. Preventive care, hospice, prescription drugs, office visits, and in-network prenatal and postnatal 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.
Are there other deductibles for specific services?	No.	You don't have to meet other deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: **$7,150**/person, **$14,300**/family per calendar year overall (or "TROOP") limit; out-of-network: **$7,150**/person, **$14,300**/family per calendar year overall (or "TROOP") limit; **$2,000**/person, **$4,000**/family per calendar year in-network coinsurance limit coordinated with TROOP limit; **$2,000**/person, **$4,000**/family per calendar year out-of-network coinsurance limit coordinated with TROOP limit	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 limit until the overall family out-of-pocket limit has been met. In-network expenses don't apply toward out-of-network maximums.
What is not included in the out-of-pocket limit?	TROOP Limit: Premiums, balance billing, charges by out-of-network providers in excess of BCBSM approved amounts, pharmacy penalties and health care this plan doesn't cover. Coinsurance Limit: expenses excluded from the TROOP limit, copayments, and deductibles.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.bcbsm.com or call 1-877-790-2583 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 in-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
		In-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	$30 copay/office visit; deductible does not apply	30% coinsurance	Telehealth visits with a professional provider are covered at 100%.
	Specialist visit	$30 copay/office visit; deductible does not apply	30% coinsurance	
	Preventive care/screening/ Immunization	No charge	30% coinsurance for certain services and some services are 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)	20% coinsurance	30% coinsurance	May require preauthorization.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions*, & Other Important Information
		In-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.bcbsm.com/druglists	Generic drugs (Tier 1)	$20 copay (30-day retail); $40 copay (mail order & 90-day retail); deductible does not apply	$20 copay plus 25% coinsurance (retail); deductible does not apply	Preauthorization, step-therapy and quantity limits may apply to select drugs; must use generic equivalent if available or pay the difference in cost between the brand and generic drug. Preventive drugs covered in full. 90-day supply not covered out of network. Select diabetic supplies and devices may be covered under the prescription drug program. Specialty drugs paid as generic, preferred brand or non-preferred brand, as applicable; coverage for specialty drugs limited to 30 day supply-mail order available from Walgreens Specialty Pharmacy, LLC; For drugs that cost more than $400 per fill, must apply for and use an available Prescription Drug Assistance Program, or subject to 50% copay.
	Preferred brand drugs (Tier 2)	$35 copay (30-day retail); $70 copay (mail order & 90-day retail); deductible does not apply	$35 copay plus 25% coinsurance (retail); deductible does not apply	
	Non-preferred brand drugs (Tier 3)	$50 copay (30-day retail); $100 copay (mail order & 90-day retail); deductible does not apply	$50 copay plus 25% coinsurance (retail); deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Facility services must be provided by a participating ambulatory surgery facility.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	$200 copay/visit	$200 copay/visit	Copay waived if admitted or for treatment due to an accidental injury and 20% coinsurance after deductible applies instead.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Mileage limits apply.
	Urgent care	$30 copay/visit; deductible does not apply	30% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Preauthorization of non-emergency stays is required. No coverage for failure to preauthorize. Non-emergency services must be rendered in a participating hospital;
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None.

* For more information about limitations and exceptions, see the plan or policy document at www.mielectricalhealth.org

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions*, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office visit and 20% coinsurance for other outpatient services; deductible does not apply to office visit	30% coinsurance	Certain outpatient visits are considered an office visit. For services at outpatient facilities, must use participating a facility or clinic. Telehealth visits with a professional provider are covered at 100%.
	Inpatient services	20% coinsurance	30% coinsurance	Preauthorization of non-emergency stays is required. No coverage for failure to preauthorize. Non-emergency services must be rendered in a participating hospital;
If you are pregnant	Office visits	No charge	30% coinsurance	Cost sharing does not apply to certain preventive services or pre/post-natal care from in-network providers. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Must use participating home health care agency; preauthorization required; no coverage if fail to preauthorize.
	Rehabilitation services	20% coinsurance	30% coinsurance	Physical, occupational, and speech therapy services limited to 60 visits per calendar year combined. Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization.
	Habilitation services	20% coinsurance for Applied Behavioral Analysis; 20% coinsurance for Physical, Speech and Occupational Therapy	20% coinsurance for Applied Behavioral Analysis; 30% coinsurance for Physical, Speech and Occupational Therapy	
	Skilled nursing care	20% coinsurance	20% coinsurance	Must use participating skilled nursing care facility; preauthorization required; no coverage if fail to preauthorize. Facility and professional services covered up to 120 days per calendar year.
	Durable medical equipment	20% coinsurance	20% coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.

* For more information about limitations and exceptions, see the plan or policy document at www.mielectricalhealth.org

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions*, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	No charge	No charge	Must use participating hospice care program; preauthorization required; no coverage if fail to preauthorize. Visit limits apply.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Discounts available through VSP.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	If elected by your union or employer: no charge	If elected by your union or employer: no charge up to the BCBSM approved amount	Covered only if elected by your union or employer; coverage is limited to 2 check-ups per year.

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
- Cosmetic surgery (unless to correct defects incurred through traumatic injuries as a result of an accident, congenital defects, or as required by law)
- Hearing aids
- Infertility treatment
- Long-term care
- 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 (medical necessity)
- Chiropractic care limited to 24 visits per person per calendar year.
- Dental care (adult, if elected by your union or employer)
- Non-emergency care when traveling outside the U.S.
- Private duty nursing (50% coinsurance)

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 the Department of Labor's Employee Benefits Security Administration is 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families. 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: the Plan at 1-855-756-4448 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families. Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program at (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? 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 1-855-756-4448.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-756-4448.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-756-4448.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-756-4448.

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

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	**$750**
Specialist copayment	**$30**
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	$750
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,620**

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

The plan's overall deductible	**$750**
Specialist copayment	**$30**
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*	$200
Copayments	$1220
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,440**

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

The plan's overall deductible	**$750**
Specialist copayment	**$30**
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*	$750
Copayments	$270
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,320**

Note: You may file for reimbursement for some of these expenses, as permitted by the plan's account reimbursement program.

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