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, [insert contact information]. For 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.dol.gov/ebsa/healthreform or call 1-800-225-9674 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	**$250** individual / **$500** family for In Network providers and **$500** individual / **$1,000** family for Out-of-Network providers Copays and coinsurance do not count toward the deductible.	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. Generic and brand name drugs, emergency medical transportation, in-network rehabilitation services, skilled nursing care, hospice, home health care, mental health care, maternity care, and outpatient surgery.	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 deductible for specific services.
What is the out-of-pocket limit for this plan?	**$6,350** individual / **$12,700** family for In-Network providers and **$12,700** individual / **$25,400** family for Out-of-Network providers.	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 the out-of-pocket limit?	Premiums, balance-billing charges, prior authorization penalties, copayments and health care this plan doesn't 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.ushealthandlife.com 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).
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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay + Deductible + 0% coinsurance	Deductible + 20% coinsurance	——————none——————
	Specialist visit	$10 copay + Deductible + 0% coinsurance	Deductible + 20% coinsurance	——————none——————
	Preventive care/screening/ immunization	No charge Deductible does not apply	No charge Deductible does not apply	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: annual physical, gyn exam, fecal occult blood screening, and PSA.
If you have a test	Diagnostic test (x-ray, blood work)	$10 copay + Deductible + 0% coinsurance	Deductible + 20% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	$10 copay + Deductible + 0% coinsurance	Deductible + 20% coinsurance	——————none——————
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.[insert].com**	Generic drugs	$5/prescription (retail) $10/prescription (mail order)	$5/prescription (retail) $10/prescription (mail order)	Covers up to a 31-day supply (retail prescription); 90-day supply (mail order prescription). Some prescription drugs are subject to prior authorization, or benefits will be reduced by 20%. In-Network Deductible does not apply to Prescription Drugs.
	Preferred brand drugs	$20/prescription (retail) $40/prescription (mail order)	$20/prescription (retail) $40/prescription (mail order)	
	Non-preferred brand drugs	$40/prescription (retail) $80/prescription (mail order)	$40/prescription (retail) $80/prescription (mail order)	Not applicable.
	Specialty drugs	Not applicable	Not applicable	Not applicable.

		What You Will Pay:		
Common Medical Event	**Services You May Need**	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 0% coinsurance	Deductible + 20% coinsurance	Emergency room copay waived if admitted.
	Physician/surgeon fees	$10 copay + Deductible + 0% coinsurance	Deductible + 20% coinsurance	——————none——————
If you need immediate medical attention	Emergency room care	$100 copay + Deductible + 0% coinsurance	$100 copay + Deductible + 0% coinsurance	——————none——————
	Emergency medical transportation	No charge	No charge	Prior authorization is required, or benefits will be reduced by 20%.
	Urgent care	$10 copay + Deductible + 0% coinsurance	Deductible + 0% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 0% coinsurance	Deductible + 20% coinsurance	——————none——————
	Physician/surgeon fees	$10 copay + Deductible + 0% coinsurance	Deductible + 20% coinsurance	Prior authorization is required, or benefits will be reduced by 20%.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay + Deductible + 0% coinsurance	Deductible + 20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Inpatient services	Deductible + 0% coinsurance	Deductible + 20% coinsurance	Emergency room copay waived if admitted.
If you are pregnant	Office visits	No charge	No charge	——————none——————

		What You Will Pay:		
Common Medical Event	**Services You May Need**	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you are pregnant	Childbirth/delivery professional services	No charge	Deductible + 20% coinsurance	————————none————————
	Childbirth/delivery facility services	No charge	Deductible + 20% coinsurance	Prior authorization is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay or benefits will be reduced by 20%.
If you need help recovering or have other special needs	Home health care	Deductible + 10% coinsurance	Deductible + 20% coinsurance	————————none————————
	Rehabilitation services	Deductible + 0% coinsurance (Inpatient) / $10 copay + Deductible + 0% coinsurance (Outpatient)	Deductible + 20% coinsurance	Limited to 30 visits per plan year for each - physical therapy, occupational therapy and speech therapy. Services not conducted in Physician's office charge Deductible + 10% coinsurance.
	Habilitation services	Deductible + 0% coinsurance (Inpatient) / $10 copay + Deductible + 0% coinsurance (Outpatient)	Deductible + 20% coinsurance	Limited to 30 visits per plan year for each - physical therapy, occupational therapy and speech therapy. Services not conducted in Physician's office charge Deductible + 10% coinsurance.
	Skilled nursing care	Deductible + 0% coinsurance	Deductible + 20% coinsurance	Residential Home services covered at Deductible + 10% coinsurance
	Durable medical equipment	Deductible + 10% coinsurance	Deductible + 10% coinsurance	————————none————————
	Hospice services	Deductible + 10% coinsurance	Deductible + 20% Coinsurance	————————none————————
If your child needs dental or eye care	Children's eye exam	Deductible + 0% coinsurance	Deductible + 20% coinsurance	Limited to 1 routine exam.
	Children's glasses	Deductible + 0% coinsurance	Deductible + 20% coinsurance	Limited to 1 pair of eyeglass lenses or contact lenses, 1 frame.
	Children's dental checkups	Not covered	Not covered	Not covered.

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 and Child) • Glasses (Child) • Hearing Aids	• Long-Term Care • Non-Emergency Care when travelling outside the U.S.	• Routine Eye Care (Adult and Child) • Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric Surgery • Male Sterilization	• Chiropractic Care (Limited to 30 visits per calendar year) • Hearing Aids payable once every 36 months • Infertility Treatment (except in-vitro)	• Private-Duty Nursing • Routine Foot Care

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: the plan at 1-800-225-9674, the state insurance department, the U.S. Department of Labor, the 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 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: the plan at 1-800-225-9674. You may also contact your state insurance department, the 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. Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program at 1-877-999-6442 or www.michigan.gov/lara or email difs-hicap@michigan.gov.

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 1-800-225-9674.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-225-9674.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-225-9674.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-225-9674.

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 $250
- Specialist copayment $10
- 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	
Deductibles	$250
Copayments	$200
Coinsurance	$0

What isn't covered	
Limits or exclusions	$60

The total Peg would pay is	**$510**

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

- The plan's overall deductible $250
- Specialist copayment $10
- 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	
Deductibles	$250
Copayments	$800
Coinsurance	$60

What isn't covered	
Limits or exclusions	$20

The total Joe would pay is	**$1,310**

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

- The plan's overall deductible $250
- Specialist copayment $10
- 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	
Deductibles	$250
Copayments	$200
Coinsurance	$20

What isn't covered	
Limits or exclusions	$0

The total Mia would pay is	**$470**

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