




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 1-800-229-2210. 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](http://www.dol.gov/ebsa/healthreform) or call 1-800-229-2210 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$250</b> individual / <b>\$500</b> family for In-Network providers and <b>\$500</b> individual / <b>\$1,000</b> family for Out-of-Network providers Copays and coinsurance do not count toward the deductible.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. In-network does not apply. Out-of-network prescription drugs, emergency room services, emergency medical transportation, and durable medical equipment.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductible</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$6,350</b> individual / <b>\$12,700</b> family for In-Network providers and <b>\$12,700</b> individual / <b>\$25,400</b> family for Out-of-Network providers.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billing charges, prior authorization penalties, copayments and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.bluewaterbenefitsadmin.com">www.bluewaterbenefitsadmin.com</a> for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ).
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$10 copay + 0% coinsurance	Deductible + 20% coinsurance	—————none—————
	<a href="#">Specialist</a> visit	\$10 copay + 0% coinsurance	Deductible + 20% coinsurance	—————none—————
	<a href="#">Preventive care/screening/immunization</a>	No charge	Deductible + 20% coinsurance	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. No charge Out-of-Network: annual physical, gyn exam, fecal occult blood screening, and PSA.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$10 copay + 0% coinsurance	Deductible + 20% coinsurance	—————none—————
	Imaging (CT/PET scans, MRIs)	\$10 copay + Deductible + 10% coinsurance	Deductible + 20% coinsurance	—————none—————
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://bluewaterbenefitsadmin.com">bluewaterbenefitsadmin.com</a>	Generic drugs	\$5/prescription (retail) \$10/prescription (mail order) Deductible does not apply	\$5/prescription (retail) + 25% cost share of eligible expenses. Mail order not available.	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%.
	Preferred brand drugs	\$20/prescription (retail) \$40/prescription (mail order) Deductible does not apply	\$20/prescription (retail) + 25% cost share of eligible expenses. Mail order not available.	
	Non-preferred brand drugs	\$40/prescription (retail) \$80/prescription (mail order) Deductible does not apply	\$40/prescription (retail) + 25% cost share of eligible expenses. Mail order not available	Not applicable.
	<a href="#">Specialty drugs</a>	Not applicable	Not applicable	Not applicable.

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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Deductible + 10% coinsurance	Deductible + 20% coinsurance	Prior authorization is required, or benefits will be reduced by 20%.
	Physician/surgeon fees	Deductible + 10% coinsurance	Deductible + 20% coinsurance	Prior authorization is required, or benefits will be reduced by 20%.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 copay + 0% coinsurance	\$100 copay + Deductible + 0% coinsurance	Copay waived if you are admitted to hospital. Emergency Room physician covered at 100% following In-Network Deductible.
	<a href="#">Emergency medical transportation</a>	Deductible + 10% coinsurance	Deductible + 10% coinsurance	—————none—————
	<a href="#">Urgent care</a>	\$10 copay + 0% coinsurance	Deductible + 0% coinsurance	—————none—————
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Deductible + 10% coinsurance	Deductible + 20% coinsurance	Prior authorization is required, or benefits will be reduced by 20%.
	Physician/surgeon fees	Deductible + 10% coinsurance	Deductible + 20% coinsurance	Prior authorization is required, or benefits will be reduced by 20%.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$10 copay + 0% coinsurance	Deductible + 20% coinsurance	—————none—————
	Inpatient services	Deductible + 0% coinsurance	Deductible + 20% coinsurance	Prior authorization is required, or benefits will be reduced by 20%.
<b>If you are pregnant</b>	Office visits	Deductible + 10% coinsurance	Deductible + 20% coinsurance	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of service, a <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	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%.

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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Deductible + 10% coinsurance	Deductible + 20% coinsurance	—————none—————
	<a href="#">Rehabilitation services</a>	Deductible + 10% coinsurance (Facility setting) / \$10 copay + 0% coinsurance (Office setting)	Deductible + 20% coinsurance	Limited to 30 visits per plan year for speech therapy. Limited to 30 visits per plan year combined for physical and occupational therapy.
	<a href="#">Habilitation services</a>	Deductible + 10% coinsurance (Facility setting) / \$10 copay + 0% coinsurance (Office setting)	Deductible + 20% coinsurance	Limited to 30 visits per plan year for speech therapy. Limited to 30 visits per plan year combined for physical and occupational therapy.
	<a href="#">Skilled nursing care</a>	Deductible + 10% coinsurance	Deductible + 20% coinsurance	Limited to 100 days per plan year.
	<a href="#">Durable medical equipment</a>	Deductible + 0% coinsurance	Deductible + 0% coinsurance	—————none—————
	<a href="#">Hospice services</a>	Deductible + 10% coinsurance	Deductible + 20% coinsurance	—————none—————
<b>If your child needs dental or eye care</b>	Children’s eye exam	Not covered	Not covered	Not covered.
	Children’s glasses	Not covered	Not covered	Not covered.
	Children’s dental check-up	Not covered	Not covered	Not covered.

**Excluded Services & Other Covered Services:**

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a>.)</b>			
<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult and Child)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-Term Care</li> <li>• Non-Emergency Care when travelling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Eye Care (Adult and Child)</li> <li>• Weight Loss Programs</li> </ul>	

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Acupuncture
- Chiropractic Care (Limited to 30 visits per calendar year)
- Infertility Treatment (except in-vitro)
- Bariatric Surgery
- Hearing Aids payable once every 36 months
- Private-Duty Nursing
- Male Sterilization
- 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 1-800-229-2210, 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](http://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](http://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](http://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 1-800-229-2210. 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](http://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](http://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](http://www.michigan.gov/lara) or email [difs-hicap@michigan.gov](mailto: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 1-800-229-2210.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-229-2210.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-229-2210.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-229-2210.

*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](#) \$250
- [Specialist](#) copayment \$10
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$20
<a href="#">Coinsurance</a>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$830</b>

**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 10%
- Other coinsurance 10%

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$680</b>

**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 10%
- Other coinsurance 10%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$150
<a href="#">Coinsurance</a>	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$460</b>

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