




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 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 1-800-229-2210 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	In-Network <a href="#">providers</a> : \$3,000 individual / \$6,000 family Out-of-Network <a href="#">providers</a> : \$4,000 individual / \$8,000 family	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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. In-network does not apply. Out-of-network <a href="#">prescription drugs</a> , <a href="#">emergency room services</a> , <a href="#">emergency medical transportation</a> , and <a href="#">durable medical equipment</a> .	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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	In-Network <a href="#">providers</a> : \$6,350 individual / \$12,700 family Out-of-Network <a href="#">providers</a> : \$12,700 individual / \$25,400 family	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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, prior authorization penalties, <a href="#">copayments</a> , and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://bluewaterbenefitsadmin.com">bluewaterbenefitsadmin.com</a> for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's 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 <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the network <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)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. No charge Out-of-Network: annual physical, gynecological exam, fecal occult blood screening, and prostate-specific antigen test.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$20 <a href="#">copay</a> <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	\$20 <a href="#">copay</a> + 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">bluewaterbenefitsadmin.com</a>	Generic drugs	\$5 <a href="#">copay</a> (retail) \$10 <a href="#">copay</a> (mail order) <a href="#">Deductible</a> does not apply	\$5 <a href="#">copay</a> (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 <a href="#">prior authorization</a> , or benefits will be reduced by 20%.
	Preferred brand drugs	\$20 <a href="#">copay</a> (retail) \$40 <a href="#">copay</a> (mail order) <a href="#">Deductible</a> does not apply	\$20 <a href="#">copay</a> (retail) + 25% cost share of eligible expenses. Mail order not available.	
	Non-preferred brand drugs	\$40 <a href="#">copay</a> (retail) \$80 <a href="#">copay</a> (mail order) <a href="#">Deductible</a> does not apply	\$40 <a href="#">copay</a> (retail) + 25% cost share of eligible expenses. Mail order not available	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> is required, or benefits will be reduced by 20%.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> is required, or benefits will be reduced by 20%.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a> <a href="#">Deductible</a> does not apply	\$200 <a href="#">copay</a>	<a href="#">Copay</a> waived if you are admitted to hospital as inpatient. Emergency Room physician covered at 100% following In-Network <a href="#">Deductible</a> .
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$20 <a href="#">copay</a> <a href="#">Deductible</a> does not apply	No charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> is required, or benefits will be reduced by 20%.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> is required, or benefits will be reduced by 20%.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <a href="#">copay</a> <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	None
	Inpatient services	No charge	40% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> is required, or benefits will be reduced by 20%.
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<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). <a href="#">Prior authorization</a> 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%.
	Childbirth/delivery professional services	No charge <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	No charge <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	

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>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Rehabilitation services</a>	Facility setting: 20% <a href="#">coinsurance</a> Office setting: \$20 <a href="#">copay</a> <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	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>	Facility setting: 20% <a href="#">coinsurance</a> Office setting: \$20 <a href="#">copay</a> <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	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>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Limited to 100 days per plan year.
	<a href="#">Durable medical equipment</a>	No charge	No charge	None
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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:

### 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    | • Long-Term Care                                      | • Routine Eye Care (Adult) |
| • Dental Care (Adult) | • Non-Emergency Care when travelling outside the U.S. | • Weight Loss Programs     |

### 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                    |
|                     |  | • 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](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 1-800-225-9674. 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](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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\* For more information about limitations and exceptions, see the [plan](#) or policy document at [bluewaterbenefitsadmin.com](http://bluewaterbenefitsadmin.com).

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

Cost Sharing	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$20
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,520</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

Cost Sharing	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$920</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$300</b>

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