



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 [www.\[insert\].com](#) or call 1-800-229-2210 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                          | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$1,750 individual / \$3,500 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> , the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.                                                                                                                                                                                                                                                                                                                               |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | 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> .                                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                                                              | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | In-Network <a href="#">providers</a> :<br>\$6,350 individual / \$12,700 family<br>Out-of-Network <a href="#">providers</a> :<br>\$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 the overall family <a href="#">out-of-pocket limit</a> must be met.                                                                                                                                                                                                                                                                                                                                                                                                                                |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="#">bluewaterbenefitsadmin.com</a> for a list of network <a href="#">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. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | 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<br>(You will pay the least)                                   | Out-of-Network Provider<br>(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="#">coinsurance</a>                                                | 40% <a href="#">coinsurance</a>                                                                         | \$10 <a href="#">copay</a> applies after satisfaction of <a href="#">deductible</a> .                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                      | <a href="#">Specialist</a> visit                       | 20% <a href="#">coinsurance</a>                                                | 40% <a href="#">coinsurance</a>                                                                         | \$10 <a href="#">copay</a> applies after satisfaction of <a href="#">deductible</a> .                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                      | <a href="#">Preventive care/screening/immunization</a> | No charge<br><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 provider 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="#">coinsurance</a>                                                | 40% <a href="#">coinsurance</a>                                                                         | None                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                      | Imaging (CT/PET scans, MRIs)                           | 20% <a href="#">coinsurance</a>                                                | 40% <a href="#">coinsurance</a>                                                                         | None                                                                                                                                                                                                                                                                                                                                         |
| If you need drugs to treat your illness or condition<br>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)<br>\$10 <a href="#">copay</a> (mail order)  | \$5 <a href="#">copay</a> (retail) + 25% cost share of eligible expenses.<br>Mail order not available.  | <a href="#">Copays</a> apply after the overall <a href="#">deductible</a> has been met. Covers up to a 31-day supply (retail prescription); 90-day supply (mail order prescription). Some <a href="#">prescription drugs</a> are subject to <a href="#">prior authorization</a> , or benefits will be reduced by 20%.                        |
|                                                                                                                                                                                      | Preferred brand drugs                                  | \$20 <a href="#">copay</a> (retail)<br>\$40 <a href="#">copay</a> (mail order) | \$20 <a href="#">copay</a> (retail) + 25% cost share of eligible expenses.<br>Mail order not available. |                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                      | Non-preferred brand drugs                              | \$40 <a href="#">copay</a> (retail)<br>\$80 <a href="#">copay</a> (mail order) | \$40 <a href="#">copay</a> (retail) + 25% cost share of eligible expenses.<br>Mail order not available  |                                                                                                                                                                                                                                                                                                                                              |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [bluewaterbenefitsadmin.com](#).

| Common Medical Event                                                             | Services You May Need                            | What You Will Pay                                                        |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                               |
|----------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                                  | Network Provider<br>(You will pay the least)                             | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>If you have outpatient surgery</b>                                            | Facility fee (e.g., ambulatory surgery center)   | 10% <a href="#">coinsurance</a>                                          | 20% <a href="#">coinsurance</a>                    | <a href="#">Prior authorization</a> is required, or benefits will be reduced by 20%.                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                  | Physician/surgeon fees                           | 10% <a href="#">coinsurance</a>                                          | 20% <a href="#">coinsurance</a>                    | <a href="#">Prior authorization</a> is required, or benefits will be reduced by 20%.                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you need immediate medical attention</b>                                   | <a href="#">Emergency room care</a>              | \$200 <a href="#">copay</a><br><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> | 10% <a href="#">coinsurance</a>                                          | 10% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                  | <a href="#">Urgent care</a>                      | \$20 <a href="#">copay</a><br><a href="#">Deductible</a> does not apply  | No charge                                          | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)               | 10% <a href="#">coinsurance</a>                                          | 20% <a href="#">coinsurance</a>                    | <a href="#">Prior authorization</a> is required, or benefits will be reduced by 20%.                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                  | Physician/surgeon fees                           | 10% <a href="#">coinsurance</a>                                          | 20% <a href="#">coinsurance</a>                    | <a href="#">Prior authorization</a> is required, or benefits will be reduced by 20%.                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                              | \$20 <a href="#">copay</a><br><a href="#">Deductible</a> does not apply  | 20% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                  | Inpatient services                               | No charge                                                                | 20% <a href="#">coinsurance</a>                    | <a href="#">Prior authorization</a> is required, or benefits will be reduced by 20%.                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you are pregnant</b>                                                       | 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 (e.g., 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        | 20% <a href="#">coinsurance</a>                                          | 40% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                  | Childbirth/delivery facility services            | 20% <a href="#">coinsurance</a>                                          | 40% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

| Common Medical Event                                                  | Services You May Need                     | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information |
|-----------------------------------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
|                                                                       |                                           | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(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>   | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | None                                                   |
|                                                                       | <a href="#">Habilitation services</a>     | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | None                                                   |
|                                                                       | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>              | 20% <a href="#">coinsurance</a>                    | Limited to 100 days per plan year.                     |
|                                                                       | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>              | 20% <a href="#">coinsurance</a>                    | 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                                     | • Hearing Aids payable once every 36 months                 | • Private-Duty Nursing – by licensed practical nurse                              |
| • Bariatric Surgery – 1 per lifetime              | • Infertility Treatment (except in-vitro and egg retrieval) | • Routine Foot Care – ankles, toes, heels including surgery, x-rays and orthotics |
| • Chiropractic Care – 30 visits per calendar year |                                                             |                                                                                   |

**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> | \$1,700 |
| ■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]   | \$0     |
| ■ Hospital (facility) [ <a href="#">cost sharing</a> ]          | 20%     |
| ■ Other [ <a href="#">cost sharing</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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,700        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$1,000        |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$2,700</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> | \$1,700 |
| ■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]   | \$0     |
| ■ Hospital (facility) [ <a href="#">cost sharing</a> ]          | 20%     |
| ■ Other [ <a href="#">cost sharing</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> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,700        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$820          |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,540</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> | \$1,700 |
| ■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]   | \$0     |
| ■ Hospital (facility) [ <a href="#">cost sharing</a> ]          | 20%     |
| ■ Other [ <a href="#">cost sharing</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> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,700        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$460          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,160</b> |

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