**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services

**BCN Muskegon Union**

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, visit [www.bcbsm.com](http://www.bcbsm.com). 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 [http://www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-800-662-6667 to request a copy.

**Important Questions**

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>None</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care services and virtual office visits are covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$1,000 per Member/$2,000 per contract per calendar year</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for services and healthcare the plan does not cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.bcbsm.com">www.bcbsm.com</a> or call 800-662-6667 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes, in-network only.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</td>
</tr>
</tbody>
</table>

**Coverage Period:** 1/1/2022-12/31/2022

**Coverage for:** All Tiers | Plan Type: HMO

(OMB control number: 1545-0047/Expiration Date: 12/31/2019) (DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022) (HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)
**copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 copay</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 copay</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>Covered 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Office visit <strong>copay</strong> may apply per member, per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Office visit <strong>copay</strong> may apply per member, per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>$10 <strong>copay</strong> (30-day supply)</td>
<td>Not covered</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.bcbsm.com">www.bcbsm.com</a></td>
<td>Preferred brand drugs</td>
<td>$20 <strong>copay</strong> (30-day supply)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>40% <strong>coinsurance</strong> (minimum <strong>copay</strong> $40, maximum <strong>copay</strong> $90) Open Formulary Includes health habit prescription drugs.</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Tiered <strong>copays</strong> listed above apply</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>25% <strong>coinsurance</strong> per hospital admission</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>25% <strong>coinsurance</strong></td>
<td>Not covered</td>
</tr>
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<td>----------------------------------------------------------</td>
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<td>-------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$100 copay</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$25 copay per transport</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 copay</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>25% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>25% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$20 Copay</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>25% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Covered 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>Covered 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>25% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>$20 copay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$20 copay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$20 copay/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>Covered 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>50% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>Covered 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.):

- Acupuncture
- Dental care (adult)
- Private-duty nursing

[* For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com.]
Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's dental check up
- Children's eye exam
- Children's glasses
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside of the U.S.
- Routine eye care (adults)
- Routine foot care
- Services provided by Cancer Treatment Centers of America including health care services provided by physicians and other health care professionals at the facility.

Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Bariatric Surgery
- Telehealth/Telemedicine
- Chiropractic Care
- Weight loss program

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: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform 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: bcbsm.com or 1-866-917-7537.

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 p-800-ay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al To get help reading in your language call the customer service number on the back of your ID card.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa To get help reading in your language call the customer service number on the back of your ID card.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码To get help reading in your language call the customer service number on the back of your ID card.
Navajo (Dine): Dinek'ehgo shika at'ohwl ninisingo, kwijig hołne' To get help reading in your language call the customer service number on the back of your ID card.

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

[* For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com.]
Estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-185

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 $0
- Specialist [cost sharing] $20
- Hospital (facility) [cost sharing] 25%
- Other [cost sharing] 25%

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 $0
- Copayments $11
- Coinsurance $2139

What isn’t covered:
- Limits or exclusions $61

The total Peg would pay is $2211

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

- The plan’s overall deductible $0
- Specialist [cost sharing] $20
- Hospital (facility) [cost sharing] 25%
- Other [cost sharing] 25%

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 $0
- Copayments $1000
- Coinsurance $122

What isn’t covered:
- Limits or exclusions $22

The total Joe would pay is $1144

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

- The plan’s overall deductible $0
- Specialist [cost sharing] $20
- Hospital (facility) [cost sharing] 25%
- Other [cost sharing] 25%

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 $0
- Copayments $230
- Coinsurance $105

What isn’t covered:
- Limits or exclusions $35

The total Mia would pay is $370

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

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