BCBSM – Classic (Similar to Alliance HDHP PPO) : **Coverage for: All Tier Levels Plan Type: HDHP PPO**

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 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 https://www.healthcare.gov/sbc-glossary/ or call 1-866-917-7537 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1: $3,500 single/$7,000 family Tier 2: $4,500 single/$9,000 family Tier 3: $6,550 single/$13,100 family	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes. **Preventive care** services (Tier 1 and Tier 2 only) are covered before you meet your **deductible**.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost sharing** and before you meet your **deductible.** See a list of covered **preventive services** at **https://www.healthcare.gov/coverage/preventive-care-benefits/.**
Are there other deductibles for specific services?	Yes, $3,500 single/$7,000 family per calendar year for prescriptions. Both medical and prescription deductibles accumulate together.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	Tier 1: $6,550 single/$13,100 family Tier 2: $6,550 single/$13,100 family Tier 3: $6,550 single/$13,100 family	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, they have to meet their own out-of-pocket limits until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	**Premiums**, balance-billed charges, penalties for failure to obtain **pre-authorization** for services and healthcare the **plan** does not cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit.**
Will you pay less if you use a network provider?	Yes. See www.BCBSM.com or call 1-866-917-7537 for a list of network providers.	You pay the least if you use a **provider** in Tier 1. You pay more if you use a **provider** in Tier 2. 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.
Do you need a referral to see a specialist?	No	You can see the **specialist** you choose without a **referral**.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay Tier 1 Trinity Health Facilities and Specific Trinity Health Professional Providers	Tier 2 PPO Network Facilities and Professional Providers	Tier 3 Providers PPO Network Facilities and Professional Providers Not in Tier 1 or Tier 2	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible met.	30% coinsurance after deductible met	0% coinsurance after deductible met	Out of network services are not covered unless noted.
	Specialist visit	20% coinsurance after deductible met	30% coinsurance after deductible met	0% coinsurance after deductible met	Out of network services are not covered unless noted.
	Preventive care/screening/ immunization	0%, **deductible** waived	0%,**deductible** waived	0%,**deductible** waived	Age and frequency limits may apply. Out of network services are not covered unless noted.
If you have a test	Diagnostic test (x-ray, blood work)	0% Coinsurance after deductible is met	30% Coinsurance after deductible met	0% Coinsurance after deductible is met	Out of network services are not covered unless noted
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible met.	30% coinsurance after deductible met	0% coinsurance after deductible met	To be eligible for coverage, these services may require approval before they are provided. Out of network services are not covered unless noted
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Optumrx.com	Generic drugs	34-day supply – 30% coinsurance after deductible ($0 min - $100 max) 35-90 Day supply – 30% coinsurance after deductible ($0 min - $300 max)	34-day supply – 30% coinsurance after deductible ($0 min - $100 max) 35-90 Day supply – 30% coinsurance after deductible ($0 min - $300 max)	34-day supply – 30% coinsurance after deductible ($0 min - $100 max) 35-90 Day supply – 30% coinsurance after deductible ($0 min - $300 max)	
	Preferred brand drugs	34-day supply – 40% coinsurance after deductible ($10 min - $200 max)	34-day supply – 40% coinsurance after deductible ($10 min - $200 max)	34-day supply – 40% coinsurance after deductible ($10 min - $200 max)	

[* For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com.]

Common Medical Event	Services You May Need	What You Will Pay: Tier 1 Trinity Health Facilities and Specific Trinity Health Professional Providers	What You Will Pay: Tier 2 PPO Network Facilities and Professional Providers	What You Will Pay: Tier 3 Providers PPO Network Facilities and Professional Providers Not in Tier 1 or Tier 2	Limitations, Exceptions, & Other Important Information
		35-90 day supply –40% coinsurance after deductible ($30 min - $600 max)	35-90 day supply –40% coinsurance after deductible ($30 min - $600 max)	35-90 day supply –40% coinsurance after deductible ($30 min - $600 max)	
	Non-preferred brand drugs	34 day supply – 60% coinsurance after deductible ($20 min - no max) 35-90 day supply – 60% coinsurance after deductible ($60 min - no max)	34 day supply – 60% coinsurance after deductible ($20 min - no max) 35-90 day supply – 60% coinsurance after deductible ($60 min - no max)	34 day supply – 60% coinsurance after deductible ($20 min - no max) 35-90 day supply – 60% coinsurance after deductible ($60 min - no max)	
	Specialty drugs	Specialty generic/formulary drugs – 34 day supply 40% coinsurance after deductible ($50 min-$500 max) Specialty generic/formulary drugs – 35-90 day supply 40% coinsurance after deductible ($150 min- $1,500 max) Non formulary specialty drugs 34 day supply 60% coinsurance after deductible ($100 min - $1000 max) Non formulary specialty drugs 35-90 day supply 60% coinsurance after	Specialty generic/formulary drugs – 34 day supply 40% coinsurance after deductible ($50 min-$500 max) Specialty generic/formulary drugs – 35-90 day supply 40% coinsurance after deductible ($150 min- $1,500 max) Non formulary specialty drugs 34 day supply 60% coinsurance after deductible ($100 min - $1000 max) Non formulary specialty drugs 35-90 day supply 60% coinsurance after	Specialty generic/formulary drugs – 34 day supply 40% coinsurance after deductible ($50 min-$500 max) Specialty generic/formulary drugs – 35-90 day supply 40% coinsurance after deductible ($150 min- $1,500 max) Non formulary specialty drugs 34 day supply 60% coinsurance after deductible ($100 min - $1000 max) Non formulary specialty drugs 35-90 day supply 60% coinsurance after	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Trinity Health Facilities and Specific Trinity Health Professional Providers	Tier 2 PPO Network Facilities and Professional Providers	Tier 3 Providers PPO Network Facilities and Professional Providers Not in Tier 1 or Tier 2	
		deductible ($300 min-$3000 max)	deductible ($300 Min - $3000 max)	deductible ($300 min - $3000 max)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible met	30% coinsurance after deductible met	0% coinsurance after deductible met	Out of network services are not covered unless noted
	Physician/surgeon fees	20% coinsurance after deductible met	30% coinsurance after deductible met	0% coinsurance after deductible met	Out of network services are not covered unless noted
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible met	20% coinsurance after Tier 1 deductible met	20% coinsurance after Tier 1 deductible met	Out of network - 20% coinsurance after Tier 1 deductible met
	Emergency medical transportation	20% coinsurance after deductible met	20% coinsurance after Tier 1 deductible met	20% coinsurance after Tier 1 deductible met	Out of network - 20% coinsurance after Tier 1 deductible met
	Urgent Care	20% coinsurance after deductible met	30% coinsurance after deductible met	0% coinsurance after deductible met	Out of network services are not covered unless noted
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible met	30% coinsurance after deductible met	0% coinsurance after deductible met	Out of network services are not covered unless noted
	Physician/surgeon fees	20% coinsurance after deductible met	30% coinsurance after deductible met	0% coinsurance after deductible met	Out of network services are not covered unless noted
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible met	20% coinsurance after Tier 1 deductible met	0% coinsurance after deductible met	Out of network services are not covered unless noted
	Inpatient services	20% coinsurance after deductible met	20% coinsurance after Tier 1 deductible met	00% coinsurance after deductible met	Out of network services are not covered unless noted
If you are pregnant	Office visits	No charge	No charge	No charge	Out of network services are not covered unless noted
	Childbirth/delivery professional services	0% coinsurance after **deductible**	0% coinsurance after **deductible**	0% coinsurance after **deductible**	Out of network services are not covered unless noted
	Childbirth/delivery facility services	20% coinsurance after deductible met	30% coinsurance after deductible met	0% coinsurance after deductible met	Out of network services are not covered unless noted
If you need help recovering or have	Home health care	20% coinsurance after deductible met	30% coinsurance after deductible met	0% coinsurance after deductible met	120 maximum visits per member per calendar year. Out of network services are not covered unless noted

[* For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com.]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Trinity Health Facilities and Specific Trinity Health Professional Providers	Tier 2 PPO Network Facilities and Professional Providers	Tier 3 Providers PPO Network Facilities and Professional Providers Not in Tier 1 or Tier 2	
other special health needs	Rehabilitation services	20% coinsurance after deductible met	30% coinsurance after deductible met	0% coinsurance after deductible met	60 maximum visits per member, per therapy, per calendar year (no visit limit for behavioral health/substance use disorder diagnosis). Out of network services are not covered unless noted
	Habilitation services	20% coinsurance after deductible met	30% coinsurance after deductible met	0% coinsurance after deductible met	60 maximum visits per member per calendar year all therapies combined (no visit limit for behavioral health/substance use disorder diagnosis). Pre-certification required. Out of network services are not covered unless noted
	Skilled nursing care	20% coinsurance after deductible met	30% coinsurance after deductible met	0% coinsurance after deductible met	120 maximum days per member per calendar year. Out of network services are not covered unless noted
	Durable medical equipment	20% coinsurance after deductible met	30% coinsurance after deductible met	0% coinsurance after deductible met	Out of network services are not covered unless noted
	Hospice services	20% coinsurance after deductible met	30% coinsurance after deductible met	0% coinsurance after deductible met	Out of network services are not covered unless noted
If your child needs dental or eye care	Children's eye exam	No charge	No charge	No charge	——————none——————
	Children's glasses	Not covered	Not covered	Not covered	——————none——————
	Children's dental check-up	No charge	No charge	No charge	——————none——————

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.)

- Dental care – adults
- Dental check ups - adults
- Cosmetic surgery
- Custodial care – in home or facility
- Long-term care
- Non-emergency care when traveling outside U.S

[* 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.)		
• Extended home skilled nursing	• Hearing aids	• Routine foot care
• Glasses	• Some pharmacy drugs	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Applied behavior analysis therapy	• Private-duty nursing	• Chiropractic care (20 max visits per calendar yr)
• Bariatric surgery	• Infertility treatment	• Routine eye care
• Telehealth/Telemedicine	• Private duty nursing	

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 or you may contact the plan at 1-866-917-7537. 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: 1-866-917-7537 or visit www.Preferredhealthchoices.com.

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 1-866-917-7537

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-917-7537

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-917-7537

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-917-7537

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:

[* For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com.]

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	**$3500**
PCP Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3500
Copayments	$0
Coinsurance	$1800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$53600**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	**$3500**
PCP Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3500
Copayments	$80
Coinsurance	$700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4300**

Mia's Simple Fracture

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

The plan's overall deductible	**$3500**
PCP Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2800
Copayments	$
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2800**

Note: If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA) then you may have access to additional funds to help cover certain out-of-pocket expenses like the deductible, copays, or coinsurance, or benefits not otherwise covered.