BCBSM – Standard (Similar to Wellmark Blue Advantage HMO) **Coverage for: All Tier Levels Plan Type: 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: $1,250 single/$2,500 family Tier 2: $3,500 single/$7,000 family Tier 3: $7,150 single/$14,300 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?	**No**	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	Tier 1: $6,000 single/$12,000 family Tier 2: $7,150 single/$14,300 family Tier 3: $7,150 single/$14,300 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 Providers	Tier 2 Providers	Tier 3 Providers	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	$30 **copay**	$80 **copay**	0% coinsurance after deductible met	Out of network services are not covered unless noted.
	Specialist visit	$40 **copay**	$80 **copay**	0% coinsurance after deductible met	Out of network services are not covered unless noted.
	Preventive care/screening/ immunization	No charge	No charge	No charge	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)	No charge	40% coinsurance deductible waived.	0% coinsurance after deductible met.	Out of network services are not covered unless noted
	Imaging (CT/PET scans, MRIs)	Outpatient facility & inpatient facility: 15% coinsurance after deductible met.	Outpatient & inpatient facility: 40% coinsurance after deductible met	Outpatient & inpatient facility: 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	Retail/Mail Order/TH in house pharmacy 34-day supply – 30% coinsurance after deductible ($0 min - $100 max) 90 Day supply – 30% coinsurance after deductible ($0 min - $300 max)	Retail/Mail Order/TH in house pharmacy 34-day supply – 30% coinsurance after deductible ($0 min - $100 max) 90 Day supply – 30% coinsurance after deductible ($0 min - $300 max)	Retail/Mail Order/TH in house pharmacy 34-day supply – 30% coinsurance after deductible ($0 min - $100 max) 90 Day supply – 30% coinsurance after deductible ($0 min - $300 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 Providers	Tier 2 Providers	Tier 3 Providers	Limitations, Exceptions, & Other Important Information
	Preferred brand drugs	Retail/Mail Order/TH in house pharmacy 34-day supply – 40% coinsurance after deductible ($10 min - $200 max) 90 Day supply – 40% coinsurance after deductible ($30 min - $600 max)	Retail/Mail Order/TH in house pharmacy 34-day supply – 40% coinsurance after deductible ($10 min - $200 max) 90 Day supply – 40% coinsurance after deductible ($30 min - $600 max)	Retail/Mail Order/TH in house pharmacy 34-day supply – 40% coinsurance after deductible ($10 min - $200 max) 90 Day supply – 40% coinsurance after drug deductible ($30 min - $600 max)	
	Non-preferred brand drugs	Retail/Mail Order/TH in house pharmacy 34-day supply – 60% coinsurance after drug deductible ($20 min - no max) 90 Day supply – 60% coinsurance after deductible ($60 min - no max)	Retail/Mail Order/TH in house pharmacy 34-day supply – 60% coinsurance after deductible ($20 min - no max) 90 Day supply – 60% coinsurance after deductible ($60 min - no max)	Retail/Mail Order/TH in house pharmacy 34-day supply – 60% coinsurance after deductible ($20 min - no max) 90 Day supply – 60% coinsurance after deductible ($60 min - no max)	
	Specialty drugs	**Generic/Preferred/Biosimilars** only filled at First Med Pharmacy 34-day supply – 40% coinsurance after deductible ($50min - $500 max) 90 day – 40% coinsurance after drug deductible ($150 min - $1500 max) **Non-Preferred** only filled at First Med Pharmacy 34-day supply – 60% coinsurance after deductible ($100 min - $1,000 max)	**Generic/Preferred/Biosimilars** only filled at First Med Pharmacy 34-day supply – 40% coinsurance after deductible ($50min - $500 max) 90 day – 40% coinsurance after deductible ($150 min - $1500 max) **Non-Preferred** only filled at First Med Pharmacy 34-day supply – 60% coinsurance after deductible ($100 min - $1,000 max)	**Generic/Preferred/Biosimilars** only filled at First Med Pharmacy 34-day supply – 40% coinsurance after deductible ($50min - $500 max) 90 day – 40% coinsurance after deductible ($150 min - $1500 max) **Non-Preferred** only filled at First Med Pharmacy 34-day supply – 60% coinsurance after deductible ($100 min - $1,000 max)	

Common Medical Event	Services You May Need	What You Will Pay Tier 1 Providers	Tier 2 Providers	Tier 3 Providers	Limitations, Exceptions, & Other Important Information
		90day - 60% coinsurance after deductible ($300 min - $3000 max)	90day - 60% coinsurance after deductible ($300 min - $3000 max)	90day - 60% coinsurance after deductible ($300 min - $3000 max)	
	Obesity Medication	Retail/Mail Order/TH in house pharmacy 34-day supply – 60% coinsurance after deductible ($20 min – no max) 90-day supply 60% coinsurance after deductible ($60 min – 0 max) GLP 1's excluded from 90-day supply	Retail/Mail Order/TH in house pharmacy 34-day supply – 60% coinsurance after deductible ($20 min – no max) 90-day supply 60% coinsurance after deductible ($60 min – 0 max) GLP 1's excluded from 90-day supply	Retail/Mail Order/TH in house pharmacy 34-day supply – 60% coinsurance after deductible ($20 min – no max) 90-day supply 60% coinsurance after deductible ($60 min – 0 max) GLP 1's excluded from 90-day supply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible met	40% coinsurance after deductible met	0% coinsurance after deductible met	Out of Network – 20% coinsurance after Tier 1 deductible
	Physician/surgeon fees	20% coinsurance after deductible met	40% coinsurance after deductible met	0% coinsurance after deductible met	Out of Network – 20% coinsurance after Tier 1 deductible
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
	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
	Urgent Care	$30 **copay**	$80 **copay**	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	40% 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	40% 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	Office Visit - $30 copay Outpatient facility – 20% coinsurance after deductible met	Office Visit - $30 copay Outpatient facility – 20% coinsurance after Tier 1 deductible met	Office Visit - $30 copay Outpatient facility – 20% coinsurance after deductible met	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 Tier 1 Providers	Tier 2 Providers	Tier 3 Providers	Limitations, Exceptions, & Other Important Information
	Inpatient services	20% coinsurance after deductible met	20% coinsurance after Tier 1 deductible met	20% 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	No charge	No charge	0% coinsurance after **deductible**	Out of network services are not covered unless noted
	Childbirth/delivery facility services	No charge	No charge	0% coinsurance after deductible met	Out of network services are not covered unless noted
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible met	40% 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
	Rehabilitation services	Office and Outpatient facility- $40 copay	Office - $120 copay Outpatient facility - $85 copay	Office and Outpatient facility - 0% coinsurance after deductible met	60 maximum visits per member, per therapy, per calendar year. Out of network services are not covered unless noted
	Habilitation services	Office and Outpatient facility- $40 copay	Office - $120 copay Outpatient facility - $85 copay	Office and Outpatient facility - 0% coinsurance after deductible met	60 maximum visits per member per calendar year all therapies combined. Pre-certification required. Out of network services are not covered unless noted
	Skilled nursing care	20% coinsurance after deductible met	40% 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	40% coinsurance after deductible met	0% coinsurance after deductible met	Out of network services are not covered unless noted
	Hospice services	No charge	No Change	No charge	(Respite care – 5 days or less in a 30 day period) 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
- Extended home skilled nursing
- Glasses
- Cosmetic surgery
- Custodial care – in home or facility
- Hearing aids
- Some pharmacy drugs
- Long-term care
- Non-emergency care when traveling outside U.S
- Routine foot care
- 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
- Bariatric surgery
- Telehealth/Telemedicine
- Private-duty nursing
- Infertility treatment
- Private duty nursing
- Chiropractic care (12 max visits per calendar yr)
- Routine eye 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: 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.

[* For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.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 plan's overall deductible	**$1250**
PCP Coinsurance	**$30**
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	$1250
Copayments	$0
Coinsurance	$1400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$27100**

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

The plan's overall deductible	**$1250**
PCP Coinsurance	**$40**
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	$100
Copayments	$500
Coinsurance	$1500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2120**

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

The plan's overall deductible	**$1250**
PCP Coinsurance	**$40**
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	$1250
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1550**

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.