HCC HumanCapitalConcepts

JALEN ROSE LEADERSHIP ACADEMY JRLA

**Benefits Summary**

*Plan Year July 1, 2022 – June 30, 2023*

**All Full-Time Employees are eligible for benefits to begin on the <u>first of the month following date of hire</u>.**
**Benefit premiums are collected one month in advance and are based on 24 pays annually.**

Employees may change benefit elections mid-plan year only if you experience a qualifying event (marriage, birth of dependent, loss of other coverage, etc.) In this event, contact HCC within 30 days of the event to adjust your coverage.

***Please contact your HCC Benefits Specialist, Dana North, at dnorth@hcchr.com with any questions.***

## MEDICAL

| | Option 1 | Option 2 | Option 3 |
|---|---|---|---|
| Plan Name | HMO Gold: BCN | Choice PPO Gold: $1,000 | HSA HMO Gold: BCN |
| Coinsurance | 20% | 20% | 20% |
| Deductible: Individual/Family | $500/$1,000 | $1,000/$2,000 | $1,500/$3,000 |
| Out of Pocket: Individual/Family | $8,150/$16,300 | $6,600/$13,200 | $3,000/$6,000 |
| Physician/Specialist Office Visit | $30/$50 | $20/$40 | 20% |
| Emergency Room | $250 | $150 | 20% |
| Urgent Care | $35 | $60 | 20% |
| Virtual Visits | $0 | $20 | 20% |
| Prescriptions: Retail | $15/$80/$100/20% | $20/$60/$80/20% | $10/$60/$80/20% up to $200 |
| Prescriptions: Mail Order | $35/$230/$290/20% up to $200 | $50/$170/$no more than $290/20% | $20/$170/$230/20% up to $300 |
| Employee PER PAY Deduction | | | |
| Employee Only | Age-Rated | Age-Rated | Age-Rated |
| Employee + Spouse | Age-Rated | Age-Rated | Age-Rated |
| Employee + Child(ren) | Age-Rated | Age-Rated | Age-Rated |
| Family | Age-Rated | Age-Rated | Age-Rated |

## Flexible Spending Account (FSA) & Health Savings Account (HSA)

FSAs and HSAs allow employees to deposit money into savings accounts to use toward medical expenses and save money on their income taxes. Depending on which medical plan you elect, we can help you decide if an FSA or HSA is a better option for you. Dependent Care FSAs are also available to allow pre-tax payments toward daycare expenses. Please note 2022 contribution limits:

**<u>HSA: Employee Only: $3,650; Family: $7,300; Catch-up: $1,000</u>**
**<u>FSA: Medical: $2,850; Dependent Care: $5,000</u>**

## LIFE

| Life and ADD Coverage | 1x Salary up to $100,000 |
|---|---|
| Employee PER PAY Deduction | |
| Employee Only | $0.00 |

**DENTAL**

| | OPTION 1 | |
|---|---|---|
| | IN NETWORK | OUT OF NETWORK |
| Deductible: Individual/Family | $50/$150 | $50/$150 |
| Annual Max | $1,000 | $1,000 |
| Orthodontia Lifetime Max | No Coverage | No Coverage |
| Diagnostic/Preventive | 100% | 100% |
| Basic | 80% | 80% |
| Major | 50% | 50% |
| Orthodontia (Up to Age 19) | No Coverage | No Coverage |
| Employee PER PAY Deduction | | |
| Employee Only | $2.67 | |
| Employee + Spouse | $5.31 | |
| Employee + Child(ren) | $5.74 | |
| Family | $8.96 | |

Please visit www.metlink.com to search for providers in your area. Please note the Plan Type is PPO.

**VISION**

| | OPTION 1 | |
|---|---|---|
| | IN NETWORK | OUT OF NETWORK |
| Network | | |
| Exam Copay | $10 | $45 Allowance |
| Exam Limit | Once per 12 Months | Once per 12 Months |
| Lenses Copay | $25 | $30/$50/$65/$100 |
| Lenses Limit | Once per 12 Months | Once per 12 Months |
| Frames Allowance | Up to $130 + 20% Excess | $70 |
| Frames Limit | Once per 24 Months | Once per 24 Months |
| Contacts Lenses Allowance | $130 | $105 |
| Contacts Limit | Once per 12 Months | Once per 12 Months |
| Employee PER PAY Deduction | | |
| Employee Only | $.77 | |
| Employee + Spouse | $1.54 | |
| Employee + Child(ren) | $1.30 | |
| Family | $2.15 | |

Please visit www.metlink.com to search for providers in your area.

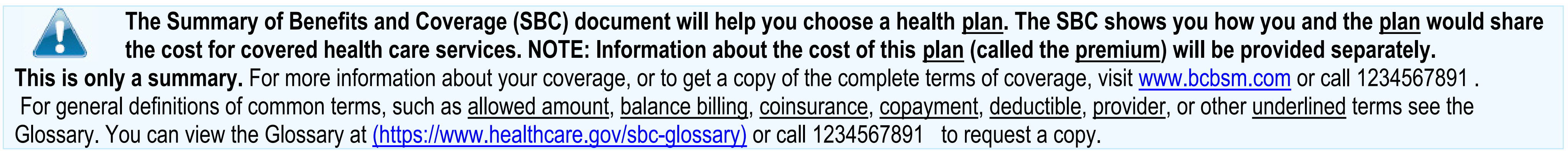
**STD/LTD**

| Long Term and Short Term Disability | |
|---|---|
| Employee PER PAY Deduction | |
| Employee Only | $0.00 |

# Jalen Rose Leadership Academy

**BCN HSA HMO Gold $1500/20%**

**Coverage for:** All Contract Types | **Plan Type: Medical**



**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 or call 1234567891 .
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 1234567891 to request a copy.

| Important Questions | Answers: Member / Family | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $1,500/$3,000 | 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 policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes.Preventive care and routine maternity care | 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?** | $3000/$6000 | 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. |
| **What is not included in the out–of–pocket limit?** | Premiums, balance billed charges and health care this 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 the phone number on the back of your ID card for a list of network providers. 1234567891 | 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. |
| **Do you need a referral to see a specialist?** | Yes. | 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. |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 20% coinsurance | Not covered | 20% coinsurance for online visits with a BCN participating online provider. Deductible does not apply to preventive services. |
| | Specialist visit | 20% coinsurance | Not covered | Requires referral/30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician |
| | Preventive care/screening/immunization | No charge, Deductible does not apply | Not covered | Deductible does not apply to preventive services. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | Not covered | May require preauthorization for non-preventive services |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | Not covered | Requires preauthorization. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at (https://www.bcbsm.com/2022-select-six-tier-druglist) | Tier 1A - Preferred Generics | $10 copay/30 days | Not covered | Preauthorization & step therapy may apply. Drugs for sexual dysfunction, weight loss and cough & cold are excluded. No charge for Tier 1A contraceptives. Any overall deductible/Out-of-pocket maxes apply. 84-90 day retail & 31-90 day mail order copays are 3x the 30-day copay minus $10. |
| | Tier 1B - Generics | $30 copay/30 days | Not covered | |
| | Tier 2 - Preferred Brand | $60 copay/30 days | Not covered | |
| | Tier 3 - Non-Preferred Brand | $80 copay/30 days | Not covered | |
| | Tier 4 - Preferred Specialty | 20% coinsurance | Not covered | $200 copay max. Limited to a 30 day supply. Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network. |
| | Tier 5 - Non-Preferred Specialty | 20% coinsurance | Not covered | $300 copay max. Limited to a 30 day supply. Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Not covered | May require preauthorization/50% coinsurance for weight reduction, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy. |
| | Physician/surgeon fees | 20% coinsurance | Not covered | See "Outpatient surgery facility fee" |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | 20% coinsurance | None |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Non-emergent transport is covered when preauthorized |
| | Urgent care | 20% coinsurance | 20% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | Not covered | Preauthorization is required. 50% coinsurance for weight reduction procedures, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy |
| | Physician/surgeon fee | 20% coinsurance | Not covered | See "Hospital stay facility fee" |
| **If you need behavioral health services (mental health and substance use disorder)** | Outpatient services | 20% coinsurance | Not covered | None |
| | Inpatient services | 20% coinsurance | Not covered | Preauthorization is required |
| **If you are pregnant** | Office visits | No charge for routine prenatal | Not covered | Postnatal and non-routine prenatal office visits- 20% coinsurance / Deductible applies except for routine maternity care |
| | Childbirth/delivery professional services | 20% coinsurance | Not covered | None |
| | Childbirth/delivery facility services | 20% coinsurance | Not covered | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | Not covered | Requires preauthorization. Custodial care not covered. |
| | Rehabilitation services | 20% coinsurance | Not covered | Requires preauthorization/Limited to 30 visits per calendar year for PT/OT combined / 30 visits per calendar year for speech therapy/30 visits per calendar year for pulmonary/cardiac. |
| | Habilitation services | ABA - 20% coinsurance | Not covered | Requires preauthorization/limited to 30 visits per calendar year for PT/OT combined. 30 visits per calendar year for speech therapy. |
| | Skilled nursing care | 20% coinsurance | Not covered | Requires preauthorization/Limited to 45 days per calendar year. Custodial care not covered. |
| | Durable medical equipment | 50% coinsurance | Not covered | Requires preauthorization and must be obtained from a BCN supplier. Convenience and comfort items not covered. Diabetic supplies covered with 20% coinsurance.. Certain diabetic supplies are covered through the pharmacy benefit. Applicable pharmacy cost-sharing will apply. |
| | Hospice services | 20% coinsurance | Not covered | Inpatient care requires preauthorization. Housekeeping and custodial care not covered. |
| If your child needs dental or eye care | Children's eye exam | No Charge | Difference between the BCN approved amount and the amount charged by the provider. | Limited to once in a calendar year through the last day of the year in which the individual turns age 19 |
| | Children's glasses | No Charge | Difference between the BCN approved amount and the amount charged by the provider. | Frames (chosen from a select collection) and lenses are covered once in a calendar year through the last day of the year in which the individual turns age 19. |
| | Children's dental check-up | Contact your benefit administrator for coverage information. | Contact your benefit administrator for coverage information. | None |

# Jalen Rose Leadership Academy

**BCN HMO Gold $500/20%**

**Coverage for:** All Contract Types | **Plan Type: Medical**

**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 or call 1234567891 . 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 1234567891 to request a copy.

| Important Questions | Answers: Member / Family | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $500/$1,000 | 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.Lab, preventive care, DME/P&O, diabetic supplies, PCP office visits, specialist office visits, urgent care, allergy injections, prescription drugs, outpatient mental health and substance use services | 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?** | $8,150/$16,300<br>Coinsurance Maximum - $5,000/$10,000 | 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 and health care this plan doesn't 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 the phone number on the back of your ID card for a list of network providers. 1234567891 | 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. |
| **Do you need a referral to see a specialist?** | Yes. | 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. |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 copay/visit. Deductible does not apply | Not covered | Only the PCP office visit is exempt from the deductible. Other services received in the office, deductible applies. $0 copay for medical online visits. |
| | Specialist visit | $50 copay/visit. Deductible does not apply | Not covered | Requires referral. $5 copay for allergy injections/50% coinsurance for allergy office visit and testing /30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician Deductible applies for allergy testing |
| | Preventive care/screening/immunization | No charge. Deductible does not apply | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance. | Not covered | May require preauthorization / No charge for lab services Deductible does not apply to lab services. |
| | Imaging (CT/PET scans, MRIs) | $150 copay | Not covered | Requires preauthorization |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at (https://www.bcbsm.com/2022-select-six-tier-druglist) | Tier 1A - Preferred Generics | $15 copay/30 days. Deductible does not apply | Not covered | Preauthorization & step therapy may apply. Drugs for sexual dysfunction, weight loss and cough & cold are excluded. No charge for Tier 1A contraceptives. 84-90 day retail & 31-90 day mail order copays are 3x the 30-day copay minus $10. Your plan includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum. |
| | Tier 1B - Generics | $40 copay/30 days. Deductible does not apply | Not covered | |
| | Tier 2 - Preferred Brand | $80 copay/30 days. Deductible does not apply | Not covered | |
| | Tier 3 - Non-Preferred Brand | $100 copay/30 days. Deductible does not apply | Not covered | |
| | Tier 4 - Preferred Specialty | 20% coinsurance. Deductible does not apply | Not covered | $200 copay max. Limited to a 30 day supply. Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network. |
| | Tier 5 - Non-Preferred Specialty | 20% coinsurance. Deductible does not apply | Not covered | $300 copay max. Limited to a 30 day supply. Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Not covered | May require preauthorization/50% coinsurance for weight reduction procedures,TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy |
| | Physician/surgeon fees | 20% coinsurance | Not covered | See "Outpatient surgery facility fee" |
| **If you need immediate medical attention** | Emergency room care | $250 copay/visit. | $250 copay/visit. | Copay waived if admitted as inpatient. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Non-emergent transport is covered when preauthorized |
| | Urgent care | $35 copay/visit. Deductible does not apply | $35 copay/visit. Deductible does not apply | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | Not covered | Preauthorization is required. 50% coinsurance for weight reduction procedures, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy |
| | Physician/surgeon fee | No charge | Not covered | See "Hospital stay facility fee" |
| **If you need behavioral health services (mental health and substance use disorder)** | Outpatient services | $30 copay/visit. Deductible does not apply | Not covered | May require preauthorization. |
| | Inpatient services | 20% coinsurance | Not covered | Preauthorization is required. |
| **If you are pregnant** | Office visits | No charge. Deductible does not apply | Not covered | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services, cost share may apply. Postnatal and non-routine prenatal office visits-$30 copay.. Only the routine prenatal visit is exempt from the deductible. Other services, deductible applies |
| | Childbirth/delivery professional services | No charge | Not covered | None |
| | Childbirth/delivery facility services | 20% coinsurance | Not covered | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | $50 copay/visit | Not covered | None |
| | Rehabilitation services | $50 copay/visit | Not covered | Requires preauthorization/limited to 30 visits per calendar year for PT/OT combined/30 visits per calendar year for speech therapy./30 visits per calendar year for pulmonary/cardiac. |
| | Habilitation services | ABA - $30 copay per visit. $50 copay per visit for PT/OT/ST. Deductible does not apply to ABA services | Not covered | Requires preauthorization/limited to 30 visits per calendar year for PT/OT combined. 30 visits per calendar year for speech therapy. |
| | Skilled nursing care | 20% coinsurance | Not covered | Requires preauthorization/Limited to 45 days per calendar year |
| | Durable medical equipment | 50% coinsurance. Deductible does not apply | Not covered | Must be authorized and obtained from a BCN supplier. Certain diabetic supplies are covered through the pharmacy benefit. Applicable pharmacy cost-sharing will apply. Deductible does not apply to diabetic supplies |
| | Hospice services | No charge | Not covered | Inpatient care requires preauthorization |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | Difference between the BCN approved amount and the amount charged by the provider. | Limited to once in a calendar year through the last day of the year in which the individual turns age 19 |
| | Children's glasses | No Charge | Difference between the BCN approved amount and the amount charged by the provider. | Frames (chosen from a select collection) and lenses are covered once in a calendar year through the last day of the year in which the individual turns age 19. |
| | Children's dental check-up | Contact your benefit administrator for coverage information. | Not Covered | Contact your benefit administrator for coverage information. |

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

# Jalen Rose Leadership Academy

## Blue Cross Physician Choice PPO Gold $1000

**Coverage for:** Individual/Family | **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 www.bcbsm.com or call the number on the back of your BCBSM ID card. 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 the number on the back of your BCBSM ID card to request a copy.

| Important Questions | Answers | | | Why this Matters: |
|---|---|---|---|---|
| | In-Network | | Out-of-Network | |
| | Level 1 | Level 2 | | |
| **What is the overall deductible?** | $1,000 Individual/ $2,000 Family | $2,500 Individual/ $5,000 Family | $5,000 Individual/ $10,000 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 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?** (May include a coinsurance maximum) | $6,600 Individual/ $13,200 Family | | $13,200 Individual/ $26,400 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-billing charges, any pharmacy penalty and health care this plan doesn't 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. For a list of in-network providers and their levels, see (http://www.bcbsm.com) or call the number on the back of your BCBSM ID card. | | | You pay the least if you use a provider in Level 1. You pay more if you use a provider in Level 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. |

| Important Questions | Answers | | | Why this Matters: |
|---|---|---|---|---|
| | In-Network | | Out-of-Network | |
| | Level 1 | Level 2 | | |
| **Do you need a referral to see a specialist?** | Referrals are optional; referrals are needed from your Level 1 primary care doctor to maintain Level 1 cost share when seeking services outside your OSC. | | | 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. |

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 |
|---|---|---|---|---|---|
| | | In-Network Provider | | Out-of-Network Provider (You will pay the most) | |
| | | Level 1 (You will pay the least) | Level 2 (You will pay more) | | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 copay/office visit; deductible does not apply | $40 copay/office visit; deductible does not apply | 50% coinsurance | None |
| | Specialist visit | $40 copay/visit; deductible does not apply | $60 copay/visit; deductible does not apply | 50% coinsurance | None |
| | Preventive care/ screening/ immunization | No Charge; deductible does not apply | No Charge; deductible does not apply | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 20% coinsurance | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 20% coinsurance | 50% coinsurance | May require preauthorization |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.bcbsm.com/druglists | Generic drugs | $20 copay/prescription for retail 30-day supply; $50 copay/prescription for retail or mail order 90-day supply; deductible does not apply | $20 copay/prescription for retail 30-day supply; $50 copay/prescription for retail or mail order 90-day supply; deductible does not apply | In-Network copay plus an additional 25% coinsurance of the approved amount for the drug; deductible does not apply | Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not covered out of network. Select diabetic supplies and devices may be covered under the prescription drug program. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | In-Network Provider | | Out-of-Network Provider (You will pay the most) | |
| | | Level 1 (You will pay the least) | Level 2 (You will pay more) | | |
| | Preferred brand-name drugs | $60 copay/prescription for retail 30-day supply; $170 copay/prescription for retail or mail order 90-day supply; deductible does not apply | $60 copay/prescription for retail 30-day supply; $170 copay/prescription for retail or mail order 90-day supply; deductible does not apply | In-Network copay plus an additional 25% coinsurance of the approved amount for the drug; deductible does not apply | |
| | Nonpreferred brand-name drugs | $80 copay/prescription or 50% coinsurance of the approved amount (whichever is greater), but no more than $100 for retail 30-day supply; $230 copay/prescription or 50% coinsurance of the approved amount (whichever is greater), but no more than $290 copay/prescription for retail or mail order 90-day supply; deductible does not apply | $80 copay/prescription or 50% coinsurance of the approved amount (whichever is greater), but no more than $100 for retail 30-day supply; $230 copay/prescription or 50% coinsurance of the approved amount (whichever is greater), but no more than $290 copay/prescription for retail or mail order 90-day supply; deductible does not apply | In-Network copay plus an additional 25% coinsurance of the approved amount for the drug; deductible does not apply | |
| | Generic and preferred brand-name specialty drugs | 20% coinsurance of the approved amount, but no more than $200 copay/prescription for retail or mail order 30-day supply; deductible does not apply | 20% coinsurance of the approved amount, but no more than $200 copay/prescription for retail or mail order 30-day supply; deductible does not apply | In-Network copay plus an additional 25% coinsurance of the approved amount for the drug. Generics excluded from deductible. | Preauthorization is required. Specialty drugs limited to a 15 or 30-day supply. Pharmacy Specialty drugs obtained from other than an Exclusive Specialty Pharmacy Network provider will not be covered. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | In-Network Provider | | Out-of-Network Provider (You will pay the most) | |
| | | Level 1 (You will pay the least) | Level 2 (You will pay more) | | |
| | Nonpreferred brand-name specialty drugs | 25% coinsurance of the approved amount, but no more than $300 copay/prescription for retail or mail order 30-day supply; deductible does not apply | 25% coinsurance of the approved amount, but no more than $300 copay/prescription for retail or mail order 30-day supply; deductible does not apply | In-Network copay plus an additional 25% coinsurance of the approved amount for the drug; deductible does not apply | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 20% coinsurance | 50% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance | 20% coinsurance | 50% coinsurance | None |
| If you need immediate medical attention | Emergency room care | $150 copay/visit; deductible does not apply | $150 copay/visit; deductible does not apply | $150 copay/visit; deductible does not apply | Copay waived if admitted |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | 20% coinsurance | Mileage limits apply |
| | Urgent care | $60 copay/visit; deductible does not apply | $60 copay/visit; deductible does not apply | 50% coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 20% coinsurance | 50% coinsurance | Preauthorization is required |
| | Physician/surgeon fee | 20% coinsurance | 20% coinsurance | 50% coinsurance | 50% coinsurance after deductible for bariatric surgery |
| If you need behavioral health services (mental health and substance use disorder) | Outpatient services | 20% coinsurance | 20% coinsurance | 20% coinsurance for mental health; 50% coinsurance for substance use disorder | Your cost share may be different for services performed in an office setting |
| | Inpatient services | 20% coinsurance | 20% coinsurance | 50% coinsurance | Preauthorization is required. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | In-Network Provider | | Out-of-Network Provider (You will pay the most) | |
| | | Level 1 (You will pay the least) | Level 2 (You will pay more) | | |
| If you are pregnant | Office visits | Prenatal: No Charge; deductible does not apply Postnatal: 20% coinsurance | Prenatal: No Charge; deductible does not apply Postnatal: 20% coinsurance | Prenatal; 50% coinsurance Postnatal: 50% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services cost share may apply. Cost sharing does not apply for preventive services. |
| | Childbirth/delivery professional services | 20% coinsurance | 20% coinsurance | 50% coinsurance | None |
| | Childbirth/delivery facility services | 20% coinsurance | 20% coinsurance | 50% coinsurance | None |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 20% coinsurance | 20% coinsurance | Physician certification required. |
| | Rehabilitation services | 20% coinsurance | 20% coinsurance | 50% coinsurance | Physical and Occupational Therapy is limited to a combined maximum of 30 visits per member, per calendar year; Speech Therapy is limited to a maximum of 30 visits per member, per calendar year. |
| | Habilitation services | 20% coinsurance for Applied Behavioral Analysis; 20% coinsurance for Physical, Speech and Occupational Therapy | 20% coinsurance for Applied Behavioral Analysis; 20% coinsurance for Physical, Speech and Occupational Therapy | 20% coinsurance for Applied Behavioral Analysis; 50% coinsurance for Physical, Speech and Occupational Therapy | Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization. 30 visits/year, Includes physical therapy and occupational therapy. 30 visits/year, Includes speech therapy. |
| | Skilled nursing care | 20% coinsurance | 20% coinsurance | 20% coinsurance | Preauthorization is required. Limited to 120 days per member per calendar year |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | 50% coinsurance | Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required. |
| | Hospice services | No Charge; deductible does not apply | No Charge; deductible does not apply | No Charge; deductible does not apply | Physician certification required. Visit limits apply. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | In-Network Provider | | Out-of-Network Provider (You will pay the most) | |
| | | Level 1 (You will pay the least) | Level 2 (You will pay more) | | |
| **If your child needs dental or eye care** For more information on pediatric vision or dental, contact your plan administrator | Children's eye exam | No Charge; deductible does not apply | No Charge; deductible does not apply | You are responsible for the difference between the BCBSM approved amount and the amount charged by the provider. | Limited to once in a calendar year for members up to the age of 19. |
| | Children's glasses | No Charge; deductible does not apply | No Charge; deductible does not apply | You are responsible for the difference between the BCBSM approved amount and the amount charged by the provider. | Frames (chosen from a select collection) and lenses are covered once in a calendar year for members up to the age of 19. |
| | Children's dental check-up | Not covered | Not covered | Not covered | None |