The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-482-0948. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network $500 / individual or $1,000 / family; for out-of-network $1,000 / individual or $2,000 / family per calendar year.	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. In-network preventive care and primary 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.	There are no other deductibles.
What is the out-of-pocket limit for this plan?	For in and out-of-network providers $8,550 / individual or $17,100 / 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. For in-network providers there is a separate coinsurance limit of $2,500 / individual or $5,000 / family maximum that accumulates toward the out-of-pocket limit. For out-of-network providers there is a $3,000 per individual or $6,000 / family maximum that accumulates toward the out-of-pocket limit.
What is not included in the out-of-pocket limit?	Deductible, copayments, out-of-network balance-billing 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 1-877-790-2583 for a list of network providers.	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?	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		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/office visit	40% coinsurance after deductible	Out-of-Network providers may balance bill.
	Specialist visit	$30 copay/visit	40% coinsurance after deductible	Out-of-Network providers may balance bill.
	Preventive care/screening/ Immunization	No charge	Not covered	Out-of-Network not covered.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	Out-of-Network providers may balance bill.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	Out-of-Network providers may balance bill.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsm.com	Tier 1 - Generic drugs	$15 copay 1-30 day; $30 copay 84-90 day supply	$15 copay plus an additional 25% of BCBSM approved amount for the drug.	Preauthorization and step-therapy may be required for some prescriptions. Out-of-network charges also include an additional 25% of the BCBSM approved amount for the drug. Drugs costing $400 or more that have a drug manufacturer coupon will have a co-pay of up to 50%. There will be no co-pay if a coupon is used.
	Tier 2 - Preferred brand drugs	$30 copay 1-30 day; $60 copay 84-90 day supply	$30 copay plus an additional 25% of BCBSM approved amount for the drug.	
	Tier 3 - Non-preferred brand drugs	$60 copay 1-30 day; $120 copay 84-90 day supply	$60 copay plus an additional 25% of BCBSM approved amount for the drug.	
	Tier 4 - Specialty drugs, generic and preferred brand	20% up to a maximum copayment of $200		Preauthorization required for select specialty pharmaceutical drugs in BCBSM approved locations. Specialty drugs can be generic, preferred or non-preferred drugs.
	Tier 5 - Specialty drugs, non-preferred brand name	25% up to a maximum copayment of $300		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	Out-of-Network providers may balance bill.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	Out-of-Network providers may balance bill.

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 immediate medical attention	Emergency room care	$200 copayment	$200 copayment	Copayment waived if admitted or an accidental injury. Out-of-Network providers may balance bill.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Out-of-Network providers may balance bill.
	Urgent care	$30 copay/visit	40% coinsurance after deductible	Out-of-Network providers may balance bill.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Non-emergency services must be rendered in a participating hospital.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	Out-of-Network providers may balance bill.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Treatment must be preauthorized and performed in an approved facility. Non-participating facilities are not covered. In-network cost-sharing will apply if there is no PPO network.
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	
If you are pregnant	Office visits	0% coinsurance	40% coinsurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Out-of-Network providers may balance bill.
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	20% coinsurance after deductible	Must be medically necessary and provided by a participating home health care agency.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Out-of-Network providers may balance bill.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	20% coinsurance after deductible	20% coinsurance after deductible	Must be in a participating skilled nursing facility.
	Durable medical equipment	20% coinsurance after deductible	20% coinsurance after deductible	Must be in a participating skilled nursing facility.
	Hospice services	0% coinsurance	0% coinsurance	Provided through a participating hospice program only.

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 your child needs dental or eye care	Children's eye exam	$5 copay	Reimbursed up to $50 less $5 copay	One eye exam in any period of 12 consecutive months. Out-of-Network providers may balance bill.
	Children's glasses	$10 copay combined	Reimbursed up to $70 less $10 copay	
	Children's dental check-up	0% coinsurance for preventive services	20% coinsurance for preventive services	$1,500 maximum benefit / individual per calendar year, preventive services once every 6 months.

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
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Motorized vehicle injuries
- Routine foot care
- Weight loss programs
- Non-emergency care when traveling outside the U.S.

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

- Bariatric surgery (medical necessity)
- Chiropractic care
- Smoking cessation drugs
- Routine dental care
- Routine eye care
- Hearing aids
- 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: Department of Labor, Employee Benefits Security Administration, 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: Michigan State Painters Insurance Plan at 1-800-482-0948. You may also contact the Department of Laborer Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-482-0948.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-482-0948.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-482-0948.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-482-0948.

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

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	$500
Specialist copayment	$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	$500
Copayments	$10
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,470**

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

The plan's overall deductible	$500
Specialist copayment	$30
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	$1100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

The plan's overall deductible	$500
Specialist copayment	$30
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*	$500
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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