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 800-662-6667. 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 800-662-6667 to request a copy.

Important Questions	Answers In-Network	Out-of-Network	Why This Matters:
What is the overall deductible?	$100 Individual / $200 Family	$500 Individual / $1,000 Family	Generally, you must pay all of the costs from provider's 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		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?	$3,000 Individual/ $6,000 Family	$3,000 Individual/ $6,000 family, plus deductible.	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, prescription drugs, balanced billed charges and health care this plan doesn't cover.		**Prescription plan has a separate out-of-pocket limit: $1,000 individual / $2,000 family** 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 preferred providers, see www.bcbsm.com or call thenumber on the back of your BCN ID card.		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).
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. Prior authorization may apply.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	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 co-pay per visit	Not covered	Preauthorization of out of network service may be required
	Specialist visit	$20 co-pay per visit	20% co-insurance	Preauthorization of out of network service may be required
	Preventive care/screening/ immunization	No charge	Not covered	Out of Network-select screenings have 20% coinsurance after deductible. Flu shots covered in full out of network
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% co-insurance	Preauthorization may be required/lab covered in full
	Imaging (CT/PET scans, MRIs)	No charge	20% co-insurance	Preauthorization may be required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$10 for 34-day supply $20 for 90-day supply	Prescription Drug Coverage provided through CVS/Caremark. 90- day supply only available through CVS/Caremark mail order and select Maintenance Choice participating pharmacies.	
	Preferred brand drugs	$30 for 34-day supply $60 for 90-day supply	You will pay copays until you reach your annual out of maximum. Prior authorization and step therapy may be required.	
	Non-preferred brand drugs	$60 for 34-day supply $120 for 90-day supply	Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, visit the HR Benefits Prescription Drug Plan page, or call CVS/ Caremark at 1-800-565-7105.	
	Specialty drugs	$75 for 34 day supply	Specialty drugs must be filled through the CVS Specialty Pharmacy (www.cvsspecialty.com). If enrolled in the PrudentRx Specialty Drug copay program, your co-pay will be reduced to $0.00 for members enrolled in the program and 30% copay for members not enrolled.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% co-insurance	Preauthorization may be required
	Physician/surgeon fees	No charge	20% co-insurance	Preauthorization may be required
If you need immediate medical attention	Emergency room care	$50 co-pay if emergency services provided or if admitted, or $250		None
	Emergency medical transportation	20% co-insurance		Non-emergent transport not covered
	Urgent care	$25 co-pay		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)	No charge after deductible	20% co-insurance	Requires preauthorization
	Physician/surgeon fees	No charge after deductible	20% co-insurance	Requires preauthorization
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after deductible	20% co-insurance	Requires preauthorization
	Inpatient services	No charge after deductible	20% co-insurance	Requires preauthorization
If you are pregnant	Office visits	No charge	20% co-insurance	None
	Childbirth/delivery professional services	No charge after deductible	20% co-insurance	Out of network - preauthorization may be required
	Childbirth/delivery facility services	No charge after deductible	20% co-insurance	Out of network - preauthorization may be required
If you need help recovering or have other special health needs	Home health care	No charge after deductible	20% co-insurance	Combined in and out of network care limited to 60 days per calendar year
	Rehabilitation services	$20 co-pay per visit	20% co-insurance	Limited to 60 combined visits per year. Subject to medical criteria. Must use an approved provider
	Habilitation services Autism Spectrum Disorder	Not covered $20 co-pay per visit	Not Covered 20% co-insurance	Applied behavioral analysis treatment for Autism must be provided by an Approved Autism Evaluation Center (AAEC). Note: The applicable copay or coinsurance for the type of service may apply. Prior authorization is required.
	Skilled nursing care	No charge after deductible	20% co-insurance	Deductible applies/limited to 100 days per year in and out of network days combined. Subject to medical criteria. Approved provider required.
	Durable medical equipment	20% co-insurance	Not covered	Must be authorized and obtained from a BCN supplier
	Hospice services	No charge after deductible	20% co-insurance	Requires preauthorization.
If your child needs dental or eye care	Children's eye exam	Not covered		None
	Children's glasses	Not covered		None
	Children's dental check-up	Not covered		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.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Long term care
- Non-emergency care outside of the U.S.
- Private-duty nursing
- Hearing Aids
- Routine eye exam
- 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.)

- Bariatric surgery
- Infertility treatment
- Chiropractic care (Requires preauthorization. Limited to a combined maximum of 24 visits per member per calendar year for chiropractic and osteopathic manipulative therapy.)

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Blue Cross®and Blue Shield®of Michigan by calling the number on the back of your BCBSM ID card. Or, you can contact Michigan Office of Financial and Insurance Regulation at **www.michigan.gov/ofir** or 1-877-999-6442. For group health coverage subject to ERISA, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

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.

Translation available

To get help reading in your language call the customer service number on the back of your ID card

*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	$100
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

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)*

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$100**

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

The plan's overall deductible	$100
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

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)*

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$240
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$340**

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

The plan's overall deductible	$100
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	$250

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$120
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$120**

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

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 877-469-2583, TTY: 711.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-469-2583, TTY: 711.]

[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码877-469-2583, TTY: 711.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 877-469-2583, TTY: 711.]

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