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, www.bcbsm.com or call 888-288-1726.

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 888-288-1726 to request a copy.

Important Questions	Answers In-Network	Answers Out-of-Network	Why This Matters:
What is the overall deductible?	$0	$250 Individual/ $500 Family	See the Common Medical Events chart below for your costs for services this plan covers. 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?	$2,000 Individual/ $4,000 Family	$2,000 Individual/ $4,000 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, balance-billed charges, any pharmacy penalty 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 in-network providers, see www.bcbsm.com or call the number on the back of your BCBSM 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	20% co-insurance	---none---
	Specialist visit	$20 co-pay	20% co-insurance	---none---
	Preventive care/screening/ immunization	No Charge	Not covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% co-insurance	---none---
	Imaging (CT/PET scans, MRIs)	No Charge	20% co-insurance	---none---
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	---none---
	Physician/surgeon fees	No charge	20% co-insurance	---none---
If you need immediate medical attention	Emergency room care	$50 co-pay (if emergency services provided or if admitted) OR $250	$50 co-pay (if emergency services provided or if admitted) OR $250	---none---
	Emergency medical transportation	No charge	No charge	---none---
	Urgent care	$25 co-pay	20% co-insurance	---none---

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% co-insurance	---none---
	Physician/surgeon fees	No charge	20% co-insurance	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	20% co-insurance	Your cost share may be different for services performed in an office setting
	Inpatient services	No charge	20% co-insurance	---none---
If you are pregnant	Office visits	No charge	20% co-insurance	---none---
	Childbirth/delivery professional services	No charge	20% co-insurance	---none---
	Childbirth/delivery facility services	No charge	20% co-insurance	---none---
If you need help recovering or have other special health needs	Home health care	No charge	No charge	---none---
	Rehabilitation services	No charge	20% co-insurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per year. Subject to medical criteria .
	Habilitation services Autism Spectrum Disorder	Not Covered No charge	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	No charge	Approved facility. Up to 120 days per year
	Durable medical equipment	No charge	No charge	---none---
	Hospice services	No charge	No charge	Must be an approved program/facility
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	---none---
	Children's glasses	Not covered	Not covered	---none---
	Children's dental check-up	Not covered	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)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (adult)
- 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
- Chiropractic Care (Limited to a combined maximum of 24 visits per member per calendar year for chiropractic and osteopathic manipulative therapy.)
- Coverage provided outside the United States. See http://provider.bcbs.com
- If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses– like the deductible, co-payments, or co-insurance, or benefits not otherwise covered.
- Non-emergency care when traveling outside the U.S.
- 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: 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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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	$0
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)*

Total Example Cost	**$7,540**

In this example, Peg would pay:

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

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

The plan's overall deductible	$0
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)*

Total Example Cost	**$5,400**

In this example, Joe would pay:

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

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

The plan's overall deductible	$0
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) 6 visits*

Total Example Cost	**$2,500**

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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