



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](http://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                                                                                                                                          |                                                          | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                     | In-Network                                                                                                                                       | Out-of-Network                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| What is the overall <u>deductible</u> ?                             | \$175 Individual /<br>\$350 Family                                                                                                               | \$500 Individual /<br>\$1,000 Family                     | Generally, you must pay all of the costs from <u>provider's</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                            |
| Are there services covered before you meet your <u>deductible</u> ? | Yes                                                                                                                                              |                                                          | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. A <u>copayment</u> or <u>coinsurance</u> may apply however. For example, this <u>plan</u> covers certain <u>services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| Are there other <u>deductibles</u> for specific services?           | No                                                                                                                                               |                                                          | You do not have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | \$3,000 Individual /<br>\$6,000 Family                                                                                                           | \$3,000 Individual /<br>\$6,000 family, plus deductible. | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                   |
| What is not included in the <u>out-of-pocket limit</u> ?            | 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 <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <u>network provider</u> ?            | Yes. For a list of preferred providers, see <a href="http://www.bcbsm.com">www.bcbsm.com</a> or call the number on the back of your BCN ID card. |                                                          | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ).                                                                                                                                 |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | No                                                                                                                                               |                                                          | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                    |

 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                                                 |                                                                                                                                                                                                                                                                                                                    | Limitations, Exceptions, & Other Important Information                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                  |                                                        | Network Provider<br>(You will pay the least)                      | Out-of-Network Provider<br>(You will pay the most)                                                                                                                                                                                                                                                                 |                                                                                                                  |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                           | Primary care visit to treat an injury or illness       | \$25 co-pay per visit                                             | Not covered                                                                                                                                                                                                                                                                                                        | Preauthorization of out of network service may be required                                                       |
|                                                                                                                                                                                                  | <a href="#">Specialist</a> visit                       | \$25 co-pay per visit                                             | 20% co-insurance (after deductible)                                                                                                                                                                                                                                                                                | Preauthorization of out of network service may be required                                                       |
|                                                                                                                                                                                                  | <a href="#">Preventive care/screening/immunization</a> | 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                                                                                                                                                                               | <a href="#">Diagnostic test</a> (x-ray, blood work)    | No charge (after deductible)                                      | 20% co-insurance (after deductible)                                                                                                                                                                                                                                                                                | Preauthorization may be required/lab covered in full                                                             |
|                                                                                                                                                                                                  | Imaging (CT/PET scans, MRIs)                           | No charge (after deductible)                                      | 20% co-insurance (after deductible)                                                                                                                                                                                                                                                                                | Preauthorization may be required                                                                                 |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a> | Generic drugs                                          | \$15 for 34-day supply<br>\$30 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<br>\$60 for 90-day supply                  | You will pay copays until you reach your annual out of pocket maximum. Prior authorization and step therapy may be required.                                                                                                                                                                                       |                                                                                                                  |
|                                                                                                                                                                                                  | Non-preferred brand drugs                              | \$75 for 34-day supply<br>\$150 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 800-565-7105.                                                                                                                        |                                                                                                                  |
|                                                                                                                                                                                                  | <a href="#">Specialty drugs</a>                        | \$100 for 34 day supply                                           | Specialty drugs must be filled through the CVS Specialty Pharmacy ( <a href="http://www.cvsspecialty.com">www.cvsspecialty.com</a> ). 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)                 | No charge (after deductible)                                      | 20% co-insurance (after deductible)                                                                                                                                                                                                                                                                                | Preauthorization may be required                                                                                 |
|                                                                                                                                                                                                  | Physician/surgeon fees                                 | No charge                                                         | 20% co-insurance                                                                                                                                                                                                                                                                                                   | Preauthorization may be required                                                                                 |
| If you need immediate medical attention                                                                                                                                                          | <a href="#">Emergency room care</a>                    | No charge if emergency services provided or if admitted, or \$250 |                                                                                                                                                                                                                                                                                                                    | None                                                                                                             |
|                                                                                                                                                                                                  | <a href="#">Emergency medical transportation</a>       | 20% co-insurance (after deductible)                               |                                                                                                                                                                                                                                                                                                                    | Non-emergent transport not covered                                                                               |
|                                                                                                                                                                                                  | <a href="#">Urgent care</a>                            | \$30 co-pay                                                       |                                                                                                                                                                                                                                                                                                                    | None                                                                                                             |

| Common Medical Event                                                             | Services You May Need                       | What You Will Pay                            |                                                                     | Limitations, Exceptions, & Other Important Information                                                                                                                                                                             |
|----------------------------------------------------------------------------------|---------------------------------------------|----------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                             | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most)                  |                                                                                                                                                                                                                                    |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)          | No charge after deductible                   | 20% co-insurance (after deductible)                                 | Requires preauthorization                                                                                                                                                                                                          |
|                                                                                  | Physician/surgeon fees                      | No charge after deductible                   | 20% co-insurance (after deductible)                                 | Requires preauthorization                                                                                                                                                                                                          |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                         | No charge                                    | 20% co-insurance (after deductible)                                 | Requires preauthorization                                                                                                                                                                                                          |
|                                                                                  | Inpatient services                          | No charge after deductible                   | 20% co-insurance (after deductible)                                 | Requires preauthorization                                                                                                                                                                                                          |
| <b>If you are pregnant</b>                                                       | Office visits                               | No charge                                    | 20% co-insurance (after deductible)                                 | None                                                                                                                                                                                                                               |
|                                                                                  | Childbirth / delivery professional services | No charge after deductible                   | 20% co-insurance (after deductible)                                 | Out of network - preauthorization may be required                                                                                                                                                                                  |
|                                                                                  | Childbirth / delivery facility services     | No charge after deductible                   | 20% co-insurance (after deductible)                                 | Out of network - preauthorization may be required                                                                                                                                                                                  |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>            | No charge after deductible                   | 20% co-insurance (after deductible)                                 | Combined in and out of network care limited to 60 days per calendar year                                                                                                                                                           |
|                                                                                  | <a href="#">Rehabilitation services</a>     | \$20 co-pay per visit                        | 20% co-insurance (after deductible)                                 | Limited to 60 combined visits per year. Subject to medical criteria. Must use an approved provider.                                                                                                                                |
|                                                                                  | <a href="#">Habilitation services</a>       | Not covered                                  | Not covered                                                         | Applied behavioral analysis treatment for Autism must be provided by an Approved Autism Evaluation Center (AAEC).<br>Note: The applicable copay or coinsurance for the type of service may apply. Prior authorization is required. |
|                                                                                  | Autism Spectrum Disorder                    | No charge                                    | 20% co-insurance (after deductible for applied behavioral analysis) |                                                                                                                                                                                                                                    |
|                                                                                  | <a href="#">Skilled nursing care</a>        | No charge (after deductible)                 | 20% co-insurance (after deductible)                                 | Limited to 100 days, per calendar year, in and out of network days combined. Subject to medical criteria. Approved provider required.                                                                                              |
|                                                                                  | <a href="#">Durable medical equipment</a>   | 0%-20% co-insurance                          | Not covered                                                         | Must be authorized and obtained from a BCN supplier                                                                                                                                                                                |
|                                                                                  | <a href="#">Hospice services</a>            | No charge after deductible                   | 20% co-insurance (after deductible)                                 | Requires preauthorization.                                                                                                                                                                                                         |
| <b>If your child needs dental or eye care</b>                                    | 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 866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://www.HealthCare.gov) or call 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](http://www.michigan.gov/ofir) or 877-999-6442. For group health coverage subject to ERISA, you may also contact Employee Benefits Security Administration at 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$175 |
| ■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]   | \$25  |
| ■ Hospital (facility) [ <a href="#">cost sharing</a> ]          | 0%    |
| ■ Other [ <a href="#">cost sharing</a> ]                        | 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                      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$175        |
| <a href="#">Copayments</a>        | \$0          |
| <a href="#">Coinsurance</a>       | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Peg would pay is</b> | <b>\$175</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$175 |
| ■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]   | \$25  |
| ■ Hospital (facility) [ <a href="#">cost sharing</a> ]          | 0%    |
| ■ Other [ <a href="#">cost sharing</a> ]                        | 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                      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$175        |
| <a href="#">Copayments</a>        | \$25         |
| <a href="#">Coinsurance</a>       | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Joe would pay is</b> | <b>\$200</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |             |
|-----------------------------------------------------------------|-------------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$175       |
| ■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]   | \$25        |
| ■ Hospital (facility) [ <a href="#">cost sharing</a> ]          | 0%          |
| ■ Other [ <a href="#">cost sharing</a> ]                        | up to \$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                      |                    |
|-----------------------------------|--------------------|
| <a href="#">Deductibles</a>       | \$175              |
| <a href="#">Copayments</a>        | \$25               |
| <a href="#">Coinsurance</a>       | up to \$250        |
| What isn't covered                |                    |
| Limits or exclusions              | \$0                |
| <b>The total Mia would pay is</b> | <b>up to \$450</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered

services. **Group Number: 00100582**

### 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, kwijijigo holne' 877-469-2583, TTY: 711.]

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