



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 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		Why This Matters:
	In-network	Out-of-Network	
What is the overall <a href="#">deductible</a> ?	\$2,000 Individual/ \$4,000 Family	\$4,000 Individual/ \$8,000 Family	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the plan begins to pay. Deductible is combined for medical and prescription drug coverage.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes		This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No		You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$3,000 Individual/ \$6,000 Family	\$6,000 Individual/ \$12,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billed charges, any pharmacy penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. For a list of in-network providers, see <a href="http://www.bcbsm.com">www.bcbsm.com</a> 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 <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No		You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 (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% co-insurance (after deductible)	40% co-insurance (after deductible)	---none---
	<a href="#">Specialist</a> visit	20% co-insurance (after deductible)	40% co-insurance (after deductible)	---none---
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not Covered	---none---
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% co-insurance (after deductible)	20% co-insurance (after deductible)	---none---
	Imaging (CT/PET scans, MRIs)	20% co-insurance (after deductible)	40% co-insurance (after deductible)	---none---
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs	20% co-insurance	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	20% co-insurance	Copays apply after the overall deductible has been met. Prior authorization and step therapy may be required.	
	Non-preferred brand drugs	20% co-insurance	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.	
	<a href="#">Specialty drugs</a>	20% co-insurance	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 once your Deductible portion has been met.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance (after deductible)	40% co-insurance (after deductible)	---none---
	Physician/surgeon fees	20% co-insurance (after deductible)	40% co-insurance (after deductible)	---none---
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% co-insurance (after deductible)	20% co-insurance (after deductible)	---none---
	<a href="#">Emergency medical transportation</a>	20% co-insurance (after deductible)	20% co-insurance (after deductible)	---none---
	<a href="#">Urgent care</a>	20% co-insurance (after deductible)	60% co-insurance (after deductible)	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance (after deductible)	40% co-insurance (after deductible)	---none---
	Physician/surgeon fees	20% co-insurance	40% co-insurance	---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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% co-insurance (after deductible)	40% co-insurance (after deductible)	---none---
	Inpatient services	20% co-insurance (after deductible)	40% co-insurance (after deductible)	---none---
<b>If you are pregnant</b>	Office visits	No charge	40% co-insurance (after deductible)	---none---
	Childbirth/delivery professional services	20% co-insurance (after deductible)	40% co-insurance (after deductible)	---none---
	Childbirth/delivery facility services	20% co-insurance	40% co-insurance (after deductible)	---none---
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% co-insurance (after deductible)	20% co-insurance (after deductible)	Limited to 60 days per member per calendar year.
	<a href="#">Rehabilitation services</a>	20% co-insurance (after deductible)	40% co-insurance (after deductible)	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	<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). Note: The applicable copay or coinsurance for the type of service may apply. Prior authorization is required.
	<a href="#">Autism Spectrum Disorder</a>	20% co-insurance (after deductible)	60% co-insurance (after deductible)	
	<a href="#">Skilled nursing care</a>	20% co-insurance (after deductible)	20% co-insurance (after deductible)	Limited to a maximum of 100 days per member per calendar year.
	<a href="#">Durable medical equipment</a>	0%-20% co-insurance	20% co-insurance	Both In and Out of Network are after deductible
	<a href="#">Hospice services</a>	No charge	No charge	---none---
<b>If your child needs dental or eye care</b>	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
- Hearing aids
- Routine eye care (Adult)
- Cosmetic surgery
- Infertility treatment
- Routine foot care
- Dental care (Adult)
- Long-term 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
- Coverage provided outside the United States. See <http://provider.bcbs.com>
- Non-emergency care when traveling outside the U.S.
- Chiropractic Care (Limited to a combined maximum of 24 visits per member per calendar year for chiropractic and osteopathic therapy.)
- 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.
- 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](http://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](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 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 Insurance Regulation at [www.michigan.gov/ofir](http://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](#) \$2,000
- [Specialist \[cost sharing\]](#) 20%
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 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*)

In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,000
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,000</b>

**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist \[cost sharing\]](#) 20%
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 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*)

In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$680
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,680</b>

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist \[cost sharing\]](#) 20%
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 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*)

In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$100
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,100</b>

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

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