




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		Why This Matters:
	In-Network	Out-of-Network	
What is the overall <u>deductible</u>?	\$0	\$250 Individual/ \$500 Family	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. 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. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.		You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$2,000 Individual/ \$4,000 Family	\$2,250 Individual/ \$4,500 Family	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, 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 <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	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 <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.

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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 co-pay	20% co-insurance after deductible	---none---
	<u>Specialist</u> visit	\$20 co-pay	20% co-insurance after deductible	---none---
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	---none---
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	20% co-insurance after deductible	---none---
	Imaging (CT/PET scans, MRIs)	No Charge	20% co-insurance after deductible	---none---
If you need drugs to treat your illness or condition For more information about <u>prescription drug coverage</u> contact your plan administrator	Generic drugs	\$10 for 34-day supply \$20 for 90-day supply	Prescription Drug Coverage provided through CVS/Caremark. 90-day supply is only available via CVS/Caremark mail order and MSU Pharmacies. Generic contraceptives covered in full.	
	Preferred brand drugs	\$30 for 34-day supply \$60 for 90-day supply	Prescription Drug Coverage provided through CVS/Caremark. Some drugs require prior authorization. 90-day supply is only available via CVS/Caremark mail order and MSU Pharmacies.	
	Non-preferred brand drugs	\$60 for 34-day supply \$120 for 90-day supply	Prescription Drug Coverage provided through CVS/Caremark. Some drugs may require step therapy. 90-day supply is only available via CVS/Caremark mail order and MSU Pharmacies.	
	<u>Specialty drugs</u>	\$75 for 34 day supply	Prescription Drug Coverage provided through CVS/Caremark. Some drugs may require step therapy. 90-day supply is not available.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% co-insurance after deductible	---none---
	Physician/surgeon fees	No Charge	20% co-insurance after deductible	---none---
If you need immediate medical attention	<u>Emergency room care</u>	\$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--

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)	
	Emergency medical transportation	No Charge	No Charge	---none---
	<u>Urgent care</u>	\$25 co-pay	20% co-insurance after deductible	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% co-insurance after deductible	---none---
	Physician/surgeon fees	No Charge	20% co-insurance after deductible	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	20% co-insurance after deductible	Your cost share may be different for services performed in an office setting
	Inpatient services	No Charge	20% co-insurance after deductible	---none---
If you are pregnant	Office visits	No Charge	20% co-insurance after deductible	---none---
	Childbirth/delivery professional services	No Charge	20% co-insurance after deductible	---none---
	Childbirth/delivery facility services	No Charge	20% co-insurance after deductible	---none---
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	No Charge	---none---
	Rehabilitation services	No Charge	20% co-insurance after deductible	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	<u>Habilitation services</u>	No Charge after deductible for Applied Behavioral Analysis; No Charge after deductible for Applied Behavioral Analysis;	No Charge after deductible for Applied Behavioral Analysis; 20% co-insurance after deductible for Physical, Speech and Occupational Therapy	Applied Behavioral Analysis (ABA) treatment for Autism – when rendered by an approved board- certified analyst – is covered through age 19 subject to prior authorization. ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.
	Skilled nursing care	No Charge	No Charge	Limited to a maximum of 120 days per member per calendar year.
	<u>Durable medical equipment</u>	No Charge	No Charge	---none---
	Hospice services	No Charge	No Charge	---none---
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 <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none">• Acupuncture• Cosmetic surgery• Dental care (Adult)	<ul style="list-style-type: none">• Hearing aids• Infertility treatment• Long-term care	<ul style="list-style-type: none">• 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 <u>plan</u> document.)		
<ul style="list-style-type: none">• Bariatric surgery• Chiropractic Care (Limited to a combined maximum of 24 visits per member per calendar year for chiropractic and osteopathic manipulative therapy.)	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can 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 page.

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 <u>plan's</u> overall <u>deductible</u>	\$0
→ <u>Specialist</u> [<u>cost sharing</u>]	\$20
→ Hospital (facility) [<u>cost sharing</u>]	0%
→ Other [<u>cost sharing</u>]	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
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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 <u>plan's</u> overall <u>deductible</u>	\$0
→ <u>Specialist</u> [<u>cost sharing</u>]	\$20
→ Hospital (facility) [<u>cost sharing</u>]	0%
→ Other [<u>cost sharing</u>]	0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*) monthly
 Diagnostic tests (*blood work*) Prescription drugs (*separate benefit*) Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,400
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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 <u>plan's</u> overall <u>deductible</u>	\$0
→ <u>Specialist</u> [<u>cost sharing</u>]	\$20
→ Hospital (facility) [<u>cost sharing</u>]	0%
→ Other [<u>cost sharing</u>]	\$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
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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

We speak your language

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فليدرك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 711 TTY: 877-469-2583. إذا لم تكن مشتركاً بالفعل.

[illegible]

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, ТТУ: 711, если у вас нет членства.

Kung ikaw, o ang iyong tinutulongan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.