



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: Member/Family:		Why This Matters:
	In-Network	Out-of-Network	
What is the overall <u>deductible</u>?	\$100 Individual / \$200 Family	\$500 Individual / \$1000 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. 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>?	\$3,000 Indiv. / \$6,000 Family	None. There is a co-insurance up to \$3,000 Indiv/ \$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.		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 www.bcbsm.com 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.

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 per visit	Not covered	Preauthorization of out of network service may be required
	<u>Specialist</u> visit	\$20 co-pay per visit	20% co-insurance after deductible	Preauthorization of out of network service may be required
	Preventive care/ <u>screening</u> /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	<u>Diagnostic test</u> (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 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	\$20 for 34-day supply \$40 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	\$40 for 34-day supply \$80 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.	
	Specialty drugs	\$50 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 after deductible	20% co-insurance after deductible	Preauthorization may be required
	Physician/surgeon fees	No charge after deductible	20% co-insurance after deductible	Preauthorization may be required
If you need immediate medical attention	<u>Emergency room care</u>	\$50 co-pay if emergency services provided or if admitted, or \$250		None
	Emergency medical transportation	20% co-insurance after deductible		Non-emergent transport not covered
	<u>Urgent care</u>	\$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 after deductible	Requires preauthorization
	Physician/surgeon fees	No charge after deductible	20% co-insurance after deductible	Requires preauthorization
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	20% co-insurance after deductible	Requires preauthorization
	Inpatient services	No charge after deductible	20% co-insurance after deductible	Requires preauthorization
If you are pregnant	Office visits (pre- and postnatal)	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
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge after deductible	20% co-insurance after deductible	Combined in and out of network care limited to 60 days per calendar year
	Rehabilitation services	\$20 co-pay per visit	20% co-insurance after deductible	Limited to 60 combined visits per calendar year
	<u>Habilitation services</u>	\$20 co-pay per visit	20% co-insurance after deductible	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 after deductible	20% co-insurance after deductible	Deductible applies/limited to 100 days per calendar year in and out of network days combined
	<u>Durable medical equipment</u>	20% co-insurance	Not covered	Must be authorized and obtained from a BCN supplier
	Hospice services	No charge after deductible	20% co-insurance after deductible	Requires preauthorization
If your child needs dental or eye care	Children's eye exam	Not covered		None
	Children's glasses	Not covered		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)	
	Children's dental check-up	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) • Long term care 	<ul style="list-style-type: none"> • Non emergency care outside of the U.S. • Private-duty nursing • Hearing Aids • Routine eye exam 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Infertility treatment 	<ul style="list-style-type: none"> • 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 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>	\$100
<u>Specialist</u> [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:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
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>	\$100
<u>Specialist</u> [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*) monthly
 Diagnostic tests (*blood work*) Prescription drugs (*separate benefit*) Durable medical equipment (*glucose meter*)



In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$240
Coinsurance	\$0
<i>What isn't covered</i>	
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 <u>plan's</u> overall <u>deductible</u>	\$100
<u>Specialist</u> [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



In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$120
Coinsurance	\$0
<i>What isn't covered</i>	
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.

