



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 <a href="#">deductible</a> ?	\$100 Individual / \$200 Family	\$500 Individual / \$1,000 Family	Generally, you must pay all the costs from <a href="#">provider's</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
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	\$3,000 Individual/ \$6,000 family plus deductible	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> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	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 <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 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 <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ).
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 <a href="#">provider's</a> 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
	<a href="#">Specialist</a> visit	\$20 co-pay per visit	20% co-insurance	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	20% co-insurance	Preauthorization may be required/lab covered in full
	Imaging (CT/PET scans, MRIs)	No charge	20% co-insurance	Preauthorization may be required
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.[insert].com</a>	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.	
	<a href="#">Specialty drugs</a>	\$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	20% co-insurance	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>	\$250 co-pay (waived based on signs, symptoms or if admitted)	None	
	<a href="#">Emergency medical transportation</a>	20% co-insurance	Non-emergent transport not covered	
	<a href="#">Urgent care</a>	\$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	20% co-insurance	Requires preauthorization
	Physician/surgeon fees	No charge	20% co-insurance	Requires preauthorization
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	20% co-insurance	Requires preauthorization
	Inpatient services	No charge	20% co-insurance	Requires preauthorization
If you are pregnant	Office visits	No charge	20% co-insurance	None
	Childbirth/delivery professional services	No charge	20% co-insurance	Out of network - preauthorization may be required
	Childbirth/delivery facility services	No charge	20% co-insurance	Out of network - preauthorization may be required
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	20% co-insurance	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	Limited to 60 combined visits 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) - limited through age 19. Note: The applicable copay or coinsurance for the type of service may apply. Prior authorization is required.
	<a href="#">Skilled nursing care</a>	No charge	20% co-insurance	Deductible applies/limited to 100 days per calendar year in and out of network days combined
	<a href="#">Durable medical equipment</a>	20% co-insurance	Not covered	Must be authorized and obtained from a BCN supplier
	<a href="#">Hospice services</a>	No charge	20% co-insurance	Requires preauthorization
If your child needs dental or eye care	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 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 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](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 and 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](#) \$100
- [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*)

In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$100
<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>\$100</b>

**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$100
- [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*)

In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$240
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$340</b>

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$100
- [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*)

In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$120
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$120</b>

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

## ADDENDUM - LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

### We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

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

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Falls Sie oder jemand, dem Sie helfen, Unt erstUtzung benti tigt, haben Sie das Rech t, kosten lose Hilfe und Informationen in Ihrer Sprache zu erhalten, Um mit einem Dolmet scher zuspr echen, rufen Sie bitte dieNummer des Kundendienstes auf der Ruckseite Ihrer Karte an oder 877-469-2583, TTY: 71 1, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai ii diritto di ottenereaiuto einformazioni nella tua lingua gratuit amente. Per parlare con un interprete, ri volgiti al Servizi o Assistenza al numero indicato sul retro dell a t ua sched a o chiama ii 877-469-2583, TTY: 711 se non sei ancora membro .

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Uko liko Varniii nekome kome Vi pomazete treba pomoc, imate pravo da besplatno dobijete pomoc i informacije na svom jeziku. Dabiste razgovarali sa prevodiocem, pozovite broj korisnicke sluzbe sa zadnje strane kartice iii 877-469-2583, TTY: 711 ako vecniste clan.

Kung ikaw, o ang iyong tinutulungan, aynangangailangan ng tulong, may karapat an ka na makakuha ng tulong at impormasyon sa iyo ng wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa nu mero ng Customer Service sa likod ng iyong tarhe ta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro .

### Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Netwo rk comply wit h Federal civil right s laws and do not discriminate on t he basis of race, color, national origin, age, disability, or sex. Blue Cr ossBlue Shield of Michigan and Blue Care Network provide freeauxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language inter preters and informa ti on in othe r format s. If you need t heseservices, call the Cust omer Service number on t he back of your card, or 877-469-2583, TTY: 711 if yo u are no t already a mem b er. If you b elieve t hat Blue Cro ss Blue Shield of M ichi gan or Blue Care Net wor k has failed to pr ovid e services or discriminate d in another way on t he basis of race, color, national orig, in age, disability, or sex, you can f ile a grievance in person, by mail, fax, or email with: Office of Civil Righ ts Coordinato r, 600 E. Lafayette e Blvd., MC1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: [CivilRights@bcbsm.com](mailto:CivilRights@bcbsm.com). If you need help filing a grievance, t he Office of Civil Right s Coordinator is availabl e to help you.

You can also file a civil rights complaint wit h the U.S. Department of Health & Human Serv ices Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal availabl eat <http://www.ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by ma il, ph o ne, or emai l at : U .S. Depart ment of Health & Human Services, 200 Independence Ave, S.W., Washing ton, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, emai l: [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov). Complaint form s are avail able at <http://www.hhs.gov/ocr/office/fileindependencex.html>.