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 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 In-network	Out-of-Network	Why This Matters:
What is the overall deductible?	$2,000 Individual/ $4,000 Family	$4,000 Individual/ $8,000 Family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible 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 deductible?	Yes		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,000 Individual/ $6,000 Family	$6,000 Individual/ $12,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	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 out-of-pocket limit.
Will you pay less if you use a network provider?	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 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 referral to see a specialist?	No		You can see the specialist you choose without a referral.

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 Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	Not Covered	---none---
	Specialist visit	20% co-insurance	Not Covered	---none---
	Preventive care/screening/ immunization	No charge	Not Covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	20% co-insurance	---none---
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	---none---
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs	20% co-insurance	Prescription Drug Coverage provided through CVS/Caremark. 90- day supply only available through CVS/Caremark mail order and MSU Pharmacies.	
	Preferred brand drugs	20% co-insurance	Prescription Drug Coverage provided through CVS/Caremark. Prior authorization may be required. 90-day supply only available via CVS/Caremark mail order or MSU Pharmacy.	
	Non-preferred brand drugs	20% co-insurance	Prescription Drug Coverage provided through CVS/Caremark. 90- day supply only available through CVS/Caremark mail order and MSU Pharmacies.	
	Specialty drugs	20% co-insurance	Prescription Drug Coverage provided through CVS/Caremark. Step therapy may be required. 90-day supply is not available.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	---none---
	Physician/surgeon fees	20% co-insurance	40% co-insurance	---none---
If you need immediate medical attention	Emergency room care	20% co-insurance	20% co-insurance	---none---
	Emergency medical transportation	20% co-insurance	20% co-insurance	---none---
	Urgent care	20% co-insurance	Not covered	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	---none---
	Physician/surgeon fees	20% co-insurance	40% co-insurance	---none---

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance	40% co-insurance	---none---
	Inpatient services	20% co-insurance	40% co-insurance	---none---
If you are pregnant	Office visits	Prenatal: No Charge Postnatal: 20% co-insurance	40% co-insurance	---none---
	Childbirth/delivery professional services	20% co-insurance	40% co-insurance	---none---
	Childbirth/delivery facility services	20% co-insurance	40% co-insurance	---none---
If you need help recovering or have other special health needs	Home health care	20% co-insurance	20% co-insurance	Limited to 60 days per member per calendar year.
	Rehabilitation services	20% co-insurance	40% co-insurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	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.
	Skilled nursing care	20% co-insurance	20% co-insurance	Limited to a maximum of 100 days per member per calendar year.
	Durable medical equipment	20% co-insurance	20% co-insurance	---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 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, 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 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 Financiald 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

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]*	$0
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	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$3,000

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]*	$0
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	
Deductibles	$2,000
Copayments	$0
Coinsurance	$680
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$2,680

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist *[cost sharing]*	$0
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	
Deductibles	$2,000
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,100

The plan would be responsible for the other costs of these EXAMPLE covered services.

ADDENDUM - LANGUAGE ACCESS SERVICES and N ON-DISCRIM IN ATION

We spea k your language

If you, or someone you're helping, needs assistance, you

have the right to get help andinformation in your languageat no cost. To talk to an interpret er, call t he Customer Servi ce n umbe r on the back of your card, or 877-469-2583, TTY: 711 if you ar e no t already amember.

Si ust ed, o alguien a quien usted est a ayudando, necesita

asistenci a, ti ene derecho a obtener ayuda e informaci6n en su i dioma sin costo alguno. Para hablar con un int erpret e, !lame al numero telef6nico de Servicio al cli ent e, que aparece en la parte trasera de su t arjeta, o 877-469-2583, TTY: 711 si uste d todavia no es un miembro.

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Falls Sie oder jemand, dem Sie helfen, Unt erstUtzung bentitigt, haben Sie das Recht, kosten lose Hilfe und Informa t ionen in Ihrer Sp rache zu erhalt en, Um mit einem Dolmet scher zu sprechen, ru fen Sie bitte dieNummer des Kunden dienstes auf der Ruckseite Ihrer Kart e an oder 877-469-2583, TTY: 71 1, wenn Si e 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 interpret e, ri volgiti al Servizi o Assistenza al numero indicato sul retro della tua scheda o chiama ii 877-469-2583, TTY: 711 se non sei ancora membro .

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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 li ko d ng iyong tarhe ta,

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Important disclosure

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 CrossBlue 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 interpreters and information in other formats. If you need theseservices, 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 orig,in age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Officeof Civil Right s 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:llocrportal.hhs.gov/ocr/oortal/lobby.isf.* 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/filelindex.html*.