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, www.bcbsm.com. 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 http://www.dol.gov/ebsa/healthreform or call 1-800-662-6667 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**None**	See the Common Medical Events chart below for your costs for services this **plan** covers.
Are there services covered before you meet your deductible?	Yes. **Preventive care services and virtual office visit**s are covered before you meet your **deductible**.	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?	$1,000 per Member/$2,000 per contract per calendar year	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, penalties for failure to obtain **pre-authorization** for services and healthcare the **plan** does not 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. See www.bcbsm.com or call 800-662-6667 for a list of network providers.	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**). Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	Yes, in-network only.	This **plan** will pay some or all of the costs to see a **specialist** for covered services but only if you have a **referral** before you see the **specialist.**

ll **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 provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay	Not covered	
	Specialist visit	$20 copay	Not covered	
	Preventive care/screening/ immunization	Covered 100%	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	Office visit **copay** may apply per member, per visit	Not covered	
	Imaging (CT/PET scans, MRIs)	Office visit **copay** may apply per member, per visit	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com	Generic drugs	$10 **copay** (30-day supply)	Not covered	Contraceptive drugs and drugs for the treatment of sexual dysfunction not covered; 30-day supply; Mail order covered at 2.5x the applicable tiered **copay** up to a 90-day supply.
	Preferred brand drugs	$20 **copay** (30-day supply)	Not covered	Contraceptive drugs and drugs for the treatment of sexual dysfunction not covered; 30-day supply; Mail order covered at 2.5x the applicable tiered **copay** up to a 90-day supply.
	Non-preferred brand drugs	40% **coinsurance** (minimum **copay** $40, maximum **copay** $90) Open **Formulary** Includes health habit **prescription drugs**.	Not covered	Contraceptive drugs and drugs for the treatment of sexual dysfunction not covered; 30-day supply; Mail order covered at 2.5x the applicable tiered **copay** up to a 90-day supply.
	Specialty drugs	Tiered **copays** listed above apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% **coinsurance** per hospital admission	Not covered	
	Physician/surgeon fees	25% **coinsurance**	Not covered	

[* For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com.]

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 need immediate medical attention	Emergency room care	$100 **copay**	Not covered	**Copay** waived if admitted to the hospital.
	Emergency medical transportation	$25 **copay** per transport	Not covered	
	Urgent care	$50 **copay**	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	Not covered	
	Physician/surgeon fees	25% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 Copay	Not covered	
	Inpatient services	25% coinsurance	Not covered	
If you are pregnant	Office visits	Covered 100%	Not covered	
	Childbirth/delivery professional services	Covered 100%	Not covered	
	Childbirth/delivery facility services	25% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	$20 copay/visit	Not covered	
	Rehabilitation services	$20 copay/visit	Not covered	Requires prior authorization; limited to 60 visits for each PT/OT/ST per medical episode per calendar year.
	Habilitation services	$20 copay/visit	Not covered	Limited to 60 visits combined for PT/OT/ST per medical episode per calendar year.
	Skilled nursing care	Covered 100%	Not covered	Limited to 45 days per calendar year.
	Durable medical equipment	50% coinsurance	Not covered	
	Hospice services	Covered 100%	Not covered	Covered 100% when receive authorization.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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
- Dental care (adult)
- Private-duty nursing

[* For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com.]

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Children's dental check up • Children's eye exam • Children's glasses • Cosmetic surgery	• Hearing aids • Infertility treatment • Long term care • Non-emergency care when traveling outside of the U.S.	• Routine eye care (adults) • Routine foot care • Services provided by Cancer Treatment Centers of America including health care services provided by physicians and other health care professionals at the facility.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery • Telehealth/Telemedicine	• Chiropractic Care	• Weight loss program

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: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform 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: bcbsm.com or 1-866-917-7537.

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 p-800-ay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al To get help reading in your language call the customer service number on the back of your ID card.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa To get help reading in your language call the customer service number on the back of your ID card.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码To get help reading in your language call the customer service number on the back of your ID card.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' To get help reading in your language call the customer service number on the back of your ID card.

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To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[* For more information about limitations and exceptions, see the plan or policy document at www.bcbsm.com.]

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	**$0**
Specialist *[cost sharing]*	**$20**
Hospital (facility) *[cost sharing]*	**25%**
Other *[cost sharing]*	**25%**

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$11
Coinsurance	$2139
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$2211**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist *[cost sharing]*	**$20**
Hospital (facility) *[cost sharing]*	**25%**
Other *[cost sharing]*	**25%**

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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1000
Coinsurance	$122
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$1144**

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

The plan's overall deductible	**$0**
Specialist *[cost sharing]*	**$20**
Hospital (facility) *[cost sharing]*	**25%**
Other *[cost sharing]*	**25%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$230
Coinsurance	$105
What isn't covered	
Limits or exclusions	$35
The total Mia would pay is	**$370**

The plan would be responsible for the other costs of these EXAMPLE covered services.70

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