⚠ 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, call the number on the back of your BCBSM ID card or visit us at 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/pdf/SBCUniformGlossary.pdf or call the number on the back of your BCBSM ID card to request a copy.

Important Questions	Answers		Why This Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$0	$250 Individual/ $500 Family	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes.		To see a list of preventive services and immunizations go to www.HealthCare.gov/center/regulations/prevention.html.
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	$2,000 Individual/ $4,000 Family	$2,250 Individual/ $4,500 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
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.		If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do you need a referral to see a specialist?	No.		You can see the specialist you choose without permission from this plan.

⚠ 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 provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay	20% co-insurance after deductible	---none---
	Specialist visit	$20 co-pay	20% co-insurance after deductible	---none---
	Preventive care/screening/ immunization	No Charge	Not Covered	---none---
If you have a test	Diagnostic test (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 prescription drug coverage 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. Some drugs may require step therapy. 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	20% co-insurance after deductible	---none---
	Physician/surgeon fees	No Charge	20% co-insurance after deductible	---none---
If you need immediate medical attention	Emergency room care	$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---
	Urgent care	$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	Home health care	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.
	Habilitation services	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.
	Durable medical equipment	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 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 manipulative 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 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.

Language Access Services:

For assistance in a language below please call the number on the back of your BCBSM ID card.

SPANISH (Español): Para ayuda en español, llame al número de servicio al cliente que se encuentra en este aviso ó en el reverso de su tarjeta de identificación.

TAGALOG (Tagalog): Para sa tulong sa wikang Tagalog, mangyaring tumawag sa numero ng serbisyo sa mamimili na nakalagay sa likod ng iyong pagkakakilanlan kard o sa paunawang ito.

CHINESE (**中文**): **要**获取中文帮助，请致电您的身份识别卡背面或本通知提供的客户服务 **号**码。

NAVAJO (Dine): Taa'dineji'keego shii'kaa'ahdool'wool ninizin'goo, beesh behane'e naal'tsoos bikii sin'dahiigii binii'deehgo eeh'doodago di'naaltsoo bikaiigii bichi'hoodillnii.

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	$0
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)*

Total Example Cost	$7,540

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 plan's overall deductible	$0
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) monthly*
Diagnostic tests *(blood work)*
Prescription drugs (*separate benefit*)
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,400

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 plan's overall deductible	$0
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) 6 visits*

Total Example Cost	$2,500

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

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