



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 <u>deductible</u> ?	\$100 Individual / \$200 Family	\$500 Individual / \$1,000 Family	Generally, you must pay all 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
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 Individual/ \$6,000 Family	\$3,000 Individual/ \$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 <a href="http://www.bcbsm.com">www.bcbsm.com</a> 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. 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)	
<b>If you visit a health care provider's office or clinic</b>	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
<b>If you have a test</b>	<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
<b>If you need drugs to treat your illness or condition</b> 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.	
<b>If you have outpatient surgery</b>	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
<b>If you need immediate medical attention</b>	<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)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge	20% co-insurance	Requires preauthorization
	Physician/surgeon fees	No charge	20% co-insurance	Requires preauthorization
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No charge	20% co-insurance	Requires preauthorization
	Inpatient services	No charge	20% co-insurance	Requires preauthorization
<b>If you are pregnant</b>	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
<b>If you need help recovering or have other special health needs</b>	<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). 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
<b>If your child needs dental or eye care</b>	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.

### Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 877-469-2583, TTY: 711.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-469-2583, TTY: 711.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码877-469-2583, TTY: 711.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 877-469-2583, TTY: 711.]

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