The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 1-800-843-4876. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <u>www.healthcare.gov/sbc-glossary</u> or call 1-800-843-4876 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$400/Individual or \$800/Family Out-of-Network: \$800/Individual or \$1,600/Family	Generally, you must pay all of the costs from <u>providers</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 deductible?	Yes. Emergency Services and other services as noted are covered before you meet your deductible.	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</u> <u>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 (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 <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-Network: \$2,000/Individual or \$4,000/Family Out-of-Network: \$3,000/Individual or \$6,000/Family	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 out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even through you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbsm.com or 1-800- 843-4876 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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 provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the specialist you choose without a referral.

		What You Will Pay		Limitations Evantions 9 Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$20 <u>copay</u> <u>Deductible</u> does not apply	20% coinsurance	None
	Specialist visit	\$20 <u>copay</u> <u>Deductible</u> does not apply	20% coinsurance	None
If you visit a health care provider's office or clinic	Preventive care/screening/immunization	No charge <u>Deductible</u> does not apply	20% coinsurance	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Out-of-network services limited to colonoscopy, diabetes self-management, mammography, and childhood immunizations.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% coinsurance	20% coinsurance	The test must be deemed medically necessary. Experimental, investigational or services for your convenience or the convenience of your provider are not covered under the plan.
If you have a test	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	The test must be deemed medically necessary. Experimental, investigational or services for your convenience or the convenience of your provider are not covered under the plan.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com/som	Generic drugs	\$10 <u>copay</u> (retail) \$20 <u>copay</u> (mail order) <u>Deductible</u> does not apply	Not covered	You can find information regarding
	Preferred brand drugs	\$30 <u>copay</u> (retail) \$60 <u>copay</u> (mail order) <u>Deductible</u> does not apply	Not covered	specific limitations and exceptions by utilizing the formulary link on the Optum Rx State of Michigan website or by contacting Optum Rx Customer Service at 866-633-6433.
	Non-preferred brand drugs	\$60 <u>copay</u> (retail) \$120 <u>copay</u> (mail order) <u>Deductible</u> does not apply	Not covered	

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.bcbsm.com/som</u>.

		What You Will Pay		Limitations, Exceptions, & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	None
surgery	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
	Emergency room care	\$200 <u>copay</u> <u>Deductible</u> does not apply	\$200 <u>copay</u> <u>Deductible</u> does not apply	The <u>copay</u> is waived if admitted as inpatient.
If you need immediate medical attention	Emergency medical transportation	10% coinsurance	10% coinsurance	You are covered for ambulance transport to the nearest medical facility capable of treating your condition.
	<u>Urgent care</u>	\$20 <u>copay</u> <u>Deductible</u> does not apply	20% coinsurance	None
If you have a hospital	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Unlimited for general medical care days.
stay	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
	Outpatient services	10% coinsurance Deductible does not apply	50% coinsurance Deductible does not apply	Out-of-network is covered 50% of allowed amount or billed charges (whichever is less).
If you need mental health, behavioral health, or substance abuse services	Inpatient services	No charge <u>Deductible</u> does not apply	50% <u>coinsurance</u> <u>Deductible</u> does not apply	Unlimited day for behavioral health. Up to 28 days per treatment period for substance abuse with a maximum of two periods per calendar year. Out-of-network is covered 50% of allowed amount or billed charges (whichever is less).
If you are pregnant	Office visits	No charge <u>Deductible</u> does not apply	20% coinsurance	Cost sharing does not apply for preventive services. Depending on the
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	type of services, <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	may include tests and services described elsewhere in the SBC (e.g., ultrasound).

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.bcbsm.com/som</u>.

		What You Will Pay		Limitations, Exceptions, & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Home health care	10% <u>coinsurance</u>	Not covered	Unlimited visits. Your <u>plan</u> does not cover custodial care, non-skilled care rest therapy and care in a nursing or rest home facility. Must be rendered by a participating home health care agency.
If you need help recovering or have other special health needs	Rehabilitation services	10% coinsurance	20% coinsurance	Your plan covers 90 combined visits for physical, occupational, speech, and massage therapies per calendar year. Chiropractors may perform massage therapy when provided as part of a complete physical therapy plan. Massage therapy performed by a massage therapist must be supervised by a chiropractor and be part of a formal course of physical therapy. Massage therapy not part of a formal course of treatment is not a covered benefit.
	Habilitation services	10% coinsurance	20% coinsurance	None
	Skilled nursing care	10% coinsurance	Not covered	Up to 120 days per confinement. Must be in a Blue Cross approved skilled nursing facility.
	Durable medical equipment	No charge	20% coinsurance	You will pay 20% coinsurance plus the difference between the non-participating provider's charge and the Blue Cross approved amount.
	Hospice services	No charge	Not covered	Limited to the lifetime dollar maximum that is adjusted by the State. Must be a Blue Cross or Medicare-certified hospice program.
16	Children's eye exam	Not covered	Not covered	None
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	None
,	Children's dental check-up	Not covered	Not covered	None

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.bcbsm.com/som</u>.

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.)

- Cosmetic surgery
- Dental care (Adult)

- Infertility treatment
- Long-term care

- Non-emergency care when traveling outside the U.S.
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery

- Chiropractic care
- Hearing aids

- Private-duty nursing
- Routine eye care (Adult)
- Weight Loss

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/healthreform, 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 <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Blue Cross Blue Shield of Michigan, Conference Coordination Unit, P.O. Box 2456, Detroit, MI 48231-2459. For state of Michigan assistance contact the Civil Service Commission, Employee Benefits Division, P.O. Box 30002, Lansing, MI, 48909 or the Department of Insurance and Financial Services, Office of General Counsel-Appeals Section, 530 W. Allegan Street, 7th Floor, P. O. Box 30220, Lansing, MI 48909-7720, http://www.michigan.gov/difs; call 1-877-999-6442 or fax: 517-284-8838.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-469-2583.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawagsa 1-877-469-2583.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-469-2583.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-469-2583

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^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.bcbsm.com/som</u>.

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 está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. المتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 111 873-879، إذا لم تكن مشتر كا بالفعل.

如果您, 或是您正在協助的對象, 需要協助, 您有權利 免費以您的母語得到幫助和訊息。要洽詢一位翻譯員, 請撥在您的卡背面的客戶服務電話;如果您還不是會員 ,請撥電話 877-469-2583, TTY: 711。

کی کیسلاف، نے بند فئی فقی دضیورورافی ، هینور بافی خینواکی، کیسلافی کیسلافی خورورکی کیسلافی خینواکی مختصی مافی خیا دلینیموری دلک لمبخی، لموجورکیکی خور بند محافق کیسکی، مافی خلا الالمجابزی در کیسکی خلا نشک که دوراموروری نی 2014:411 822-469-877 کی کالی لمافی خوروی.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, ভাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও ভখ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কখা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্লাহক সহায়ভা নম্বরে কল করুন বা ৪77-469-2583, TTY: 711 যদি ইভোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号(メンバーでない方は877-469-2583, TTY: 711)までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

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 Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary 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 these services, 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 origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights 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://ocrportal.hhs.gov/ocr/portal/lobby.jsf. 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/file/index.html.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$400
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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		
<u>Deductibles</u>	\$400	
Copayments	\$33	
Coinsurance	\$980	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$1,473	

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$400
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	10%
■ Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$134	
Copayments	\$699	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$255	
The total Joe would pay is	\$1,088	

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$400
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	10%
■ Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$400	
Copayments	\$20	
Coinsurance	\$98	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$518	