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, visit http://www.bcbsm.com or call 1-800-662-6667. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-662-6667 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|---|--|
| What is the overall deductible? | \$0 individual / \$0 family | Generally, you must pay all of 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 deductible? | Yes. Labs, preventive care, DME/P&O, diabetic supplies, PCP office visits, urgent care, allergy injections, outpatient mental health and substance use services. | 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 (https://www.healthcare.gov/coverage/preventive-care-benefits/). |
| Are there other deductibles for specific services? | No | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ? | \$2,000 individual / \$4,000 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 limits</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u> ? | Premiums, balance billing charges 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 <u>network provider</u> ? | Yes. See (<u>www.BCBSM.com</u>) or call 1-800-662-6667 for a list of <u>network providers</u> . | 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> ? | Yes | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> . |



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| | | What You Will Pay | | | |
|---|--|--|---|--|--|
| 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> /visit. <u>Deductible</u> does not apply. | Not covered | Only the PCP office visit is exempt from the deductible. Other services received in the office, deductible applies. | |
| If you visit a health care provider's office or clinic | Specialist visit | \$20 <u>copay</u> /visit. <u>Deductible</u> does not apply. | Not covered | Requires <u>referral</u> . <u>Deductible</u> applies for allergy testing and chiropractic visits. | |
| | Preventive care/screening/ immunization | No charge. <u>Deductible</u> does not apply. | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. | |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | Not covered | May require prior authorization. Deductible does not apply to laboratory services. | |
| If you have a test | Imaging (CT/PET scans, MRIs) | No charge | Not covered | Requires preauthorization | |
| If you need drugs to | Generic drugs | \$10 copay/ retail prescription \$20 copay/ mail order prescription Deductible does not apply. | Not covered | | |
| treat your illness or condition More information about prescription drug coverage is available at www.bcbsm.com/custo | Preferred brand drugs | \$30 copay/ retail prescription \$60 copay/ mail order prescription Deductible does not apply. | Not covered | Preauthorization & step-therapy apply to select drugs. Tier 1 contraceptives are covered in full. 90 day mail order and retail copays are 2x the standard retail copays. | |
| mdruglist) | Non-preferred brand drugs | \$60 copay/ retail prescription \$120 copay/ mail order prescription Deductible does not apply. | Not covered | | |

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

| | | What You Will Pay | | | |
|---|--|--|--|---|--|
| 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 | |
| If you have outpatient | Facility fee (e.g., ambulatory surgery center) | No charge | Not covered | May require <u>preauthorization</u> . | |
| surgery | Physician/surgeon fees | No charge | Not covered | None | |
| | Emergency room care | \$200 <u>copay</u> /visit. <u>Deductible</u> does not apply. | \$200 <u>copay</u> /visit. <u>Deductible</u> does not apply. | Copay waived if admitted as inpatient. | |
| If you need immediate medical attention | Emergency medical transportation | No charge | No charge | Non-emergent transport is covered when authorized. | |
| | <u>Urgent care</u> | \$20 <u>copay</u> /visit. <u>Deductible</u> does not apply. | \$20 <u>copay</u> /visit. <u>Deductible</u> does not apply. | None | |
| If you have a hospital | Facility fee (e.g., hospital room) | No charge | Not covered | Preauthorization is required. Unlimited days. | |
| stay | Physician/surgeon fees | No charge | Not covered | None | |
| If you need mental health, behavioral | Outpatient services | No charge. <u>Deductible</u> does not apply. | Not covered | Preauthorization is required. | |
| health, or substance abuse services | Inpatient services | No charge | Not covered | Preauthorization is required. | |
| | Office visits | No charge. Deductible does not apply. | Not covered | Cost sharing does not apply for preventive services. Depending on the type of services, a | |
| If you are pregnant | Childbirth/delivery professional services | No charge | Not covered | copay or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound). Postnatal and non- | |
| | Childbirth/delivery facility services | No charge | Not covered | routine prenatal office visits-\$20 copay. Only the routine prenatal visit is exempt from the deductible | |

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

| | | What You Will Pay | | | |
|---|----------------------------|---|---|---|--|
| 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 | |
| | Home health care | \$20 <u>copay</u> /visit | Not covered | None | |
| | Rehabilitation services | \$20 <u>copay</u> /visit. <u>Deductible</u> does not apply. | Not covered | Requires <u>preauthorization</u> . Limited to 90 visits for any combination of Physical, Speech, and Occupational therapies per calendar year. | |
| If you need help | Habilitation services | No charge. <u>Deductible</u> does not apply. | Not covered | PT/OT/ST for autism spectrum disorder has unlimited visits. Requires <u>preauthorization</u> . | |
| recovering or have other special health needs | Skilled nursing care | No charge | Not covered | Up to 120 days per confinement. Requires prior authorization. | |
| | Durable medical equipment | No charge. <u>Deductible</u> does not apply. | Not covered | Must be authorized and obtained from a BCN supplier. Diabetic supplies covered in full. Unattached shoe insert covered. Hair prosthesis covered with limits. Deductible does not apply to diabetic supplies. | |
| | Hospice services | No charge | Not covered | Inpatient care requires preauthorization | |
| | Children's eye exam | No charge | Not covered | Vision exam covered for children through the age of 17 | |
| 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 plan or policy document at bcbsm.com/som.

Excluded Services & Other Covered Services:

- Acupuncture
- Cosmetic surgery
- Dental Care (Adult)

- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- 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

Chiropractic care

- Hearing aids
- Infertility treatment

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/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 Care Network, Appeals and Grievance Unit, MC C248, P.O. Box 284, Southfield, MI 48086 or fax. 1-866-522-7345. For state of Michigan assistance contact 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

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:

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.

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

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 نساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلختك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 171:711 873-469، إذا لم تكن مشتركا بالفحل.

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。

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

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.

-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 <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> | \$0 |
|---|------|
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other coinsurance | 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

| • | | |
|---------------------------------|-------|--|
| In this example, Peg would pay: | | |
| Cost Sharing | | |
| <u>Deductibles</u> | \$100 | |
| Copayments | \$70 | |
| Coinsurance | \$0 | |
| What isn't covered | | |
| Limits or <u>exclusions</u> | \$60 | |
| The total Peg would pay is | \$230 | |

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 copayment | \$20 |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other coinsurance | 0% |

This EXAMPLE event includes services like:

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

<u>Diagnostic tests</u> (blood work)

Prescription drugs

Total Example Cost

\$12.800

Durable medical equipment (glucose meter)

| In this example, Joe would pay: | | | |
|---------------------------------|--------------|--|--|
| Cost Sharing | Cost Sharing | | |
| <u>Deductibles</u> | \$0 | | |
| Copayments | \$800 | | |
| Coinsurance | \$0 | | |
| What isn't covered | | | |
| Limits or exclusions | \$60 | | |
| The total Joe would pay is | \$860 | | |

Mia's Simple Fracture

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

| ■ The plan's overall deductible | \$0 |
|-----------------------------------|------|
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other coinsurance | 0% |

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

\$7,400

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

Rehabilitation services (physical therapy)

| Total Example Cost | \$1,900 |
|--------------------|---------|
| | |

In this example, Mia would pay:

| in this example, into would pay. | | |
|----------------------------------|-------|--|
| Cost Sharing | | |
| <u>Deductibles</u> | \$100 | |
| Copayments | \$300 | |
| Coinsurance | \$0 | |
| What isn't covered | | |
| Limits or exclusions | \$0 | |
| The total Mia would pay is | \$400 | |