




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 <http://www.bcbsm.com> or call 1-800-662-6667. 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 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 provider's up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
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 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 ?	\$2,000 individual / \$4,000 family	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 , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit 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 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 1-800-662-6667 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	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 .

 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 copay /visit. Deductible does not apply.	Not covered	Only the PCP office visit is exempt from the deductible . Other services received in the office, deductible applies.
	Specialist visit	\$20 copay /visit. Deductible does not apply.	Not covered	Requires referral . Deductible applies for allergy testing and chiropractic visits.
	Preventive care/screening /immunization	No charge. Deductible 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.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Requires preauthorization
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsm.com/customdruglist)	Generic drugs	\$10 copay / retail prescription \$20 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 .
	Preferred brand drugs	\$30 copay / retail prescription \$60 copay / mail order prescription Deductible does not apply.	Not covered	
	Non-preferred brand drugs	\$60 copay / retail prescription \$120 copay / mail order prescription Deductible does not apply.	Not covered	

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

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 help recovering or have other special health needs	Home health care	\$20 copay /visit	Not covered	None
	Rehabilitation services	\$20 copay /visit. Deductible does not apply.	Not covered	Requires preauthorization . Limited to 90 visits for any combination of Physical, Speech, and Occupational therapies per calendar year.
	Habilitation services	No charge. Deductible does not apply.	Not covered	PT/OT/ST for autism spectrum disorder has unlimited visits. Requires preauthorization .
	Skilled nursing care	No charge	Not covered	Up to 120 days per confinement. Requires prior authorization.
	Durable medical equipment	No charge. Deductible 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
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Vision exam covered for children through the age of 17
	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](#).)

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|-----------------------|--|----------------------------|
| • Acupuncture | • Long-term care | • Routine eye care (Adult) |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Routine foot care |
| • Dental Care (Adult) | | • Weight loss programs |

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

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|---------------------|-------------------------|------------------------|
| • Bariatric surgery | • Hearing aids | • Private-duty nursing |
| • Chiropractic care | • Infertility treatment | |

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 [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, 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, kwijigo holne' 1-877-469-2583.

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 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	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$70
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$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:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$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*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$400

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.