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, contact BCBSM and Express Scripts for pharmacy questions. 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 **www.BCBSM.com** or call **1-877-760-8575** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$5,000/Individual or $10,000/family for participating providers. $10,000/Individual or $20,000/family for non-participating providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $5,000 individual / $10,000 family; for out-of-network providers $10,000 individual / $20,000 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 1-877-760-8575 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?	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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Covered 100%	Covered 100%	Deductible applies
	Specialist visit Telemedicine visit	Covered 100% Covered 100%	Covered 100%	If you receive services, in addition to office visit, additional copays or deductibles may apply. Deductible applies
	Chiropractic visit	Covered 100%	Covered 100%	Up to 24 visits per year. Deductible applies
	Preventive care/screening/ immunization	No charge	Covered 100%	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)	Covered 100%	Covered 100%	Deductible applies. Covered at 100% in-network if related to a preventative exam
	Imaging (CT/PET scans, MRIs)	Covered 100%	Covered 100%	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs (Tier 1)	Covered 100% after ded.	Copay plus 25% for each prescription. Retail only	Deductible applies. Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). Step Therapy may apply
	Brand drugs (Tier 2)	Covered 100% after ded.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Covered 100%	Covered 100%	Deductible applies
	Physician/surgeon fees	Covered 100%	Covered 100%	Deductible applies
If you need immediate medical attention	Emergency room care	Covered 100%	Covered 100%	In-network deductible applies
	Emergency medical transportation	Covered 100%	Covered 100%	In-network deductible applies
	Urgent care	Covered 100%	Covered 100%	If you receive services in addition to urgent care, deductible or coinsurance may apply.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	Covered 100%	Covered 100%	Preauthorization may be required. Deductible applies
	Physician/surgeon fees	Covered 100%	Covered 100%	Deductible applies
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Covered 100%	Covered 100%	Deductible applies
	Inpatient services	Covered 100%	Covered 100%	Deductible applies
If you are pregnant	Office visits	No charge	Covered 100%	Deductible applies
	Childbirth/delivery professional services	Covered 100%	Covered 100%	
	Childbirth/delivery facility services	Covered 100%	Covered 100%	
If you need help recovering or have other special health needs	Home health care	Covered 100%	Covered 100%	Deductible applies; Must be provided by participating home care agency.
	Rehabilitation services	Covered 100%	Covered 100%	60 visits/year. Includes physical therapy, speech therapy, and occupational therapy. Deductible applies
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	Covered 100%	Covered 100%	90 visits/calendar year. Deductible applies
	Durable medical equipment	Covered 100%	Covered 100%	Deductible applies
	Hospice services	Covered 100%	Covered 100%	In- Network Deductible applies. 360 day max
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 • Cosmetic Surgery • Dental Care (Adult)	• Hearing Aids • Infertility Treatment • Long-Term Care	• 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	• Non-emergency care when traveling outside the U.S.	• 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. 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: BCBSM, P.O. Box 230555, Grand Rapids, MI 49523-0555 or 1-877-760-8575. Express Scripts, 1-855-612-3121. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 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.

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**	**$5,000**
■ **Specialist copayment**	**0%**
■ **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	**$12,732**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	**$5,000**
■ **Specialist copayment**	**0%**
■ **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	**$7,390**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$5,055**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$5,000**
■ **Specialist copayment**	**0%**
■ **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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,925
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

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