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, call 1-866-348-9499. 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 call 1-800-550-5242 to request a copy.

Important Questions	Answers		Why This Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	**$500** person / **$1,000** family Does not apply to preventive care.	**$1,000** person / **$2,000** family Does not apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes. In-network **preventive care**, office visits and prescription drugs are 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?	There are no other specific **deductibles**.		You don't have to meet specific **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	**$8,550** person / **$17,100** family	No maximum limit for individuals or families.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. There is a separate **coinsurance limit** of **$1,500**/person and **$3,000**/family (in-network) and **$3,000**/person and **$6,000**/family (out-of-network) that accumulates toward the **out-of-pocket limit**.
What is not included in the out-of-pocket limit?	Premiums, self-payments, balance billed charges, and health care this plan does not cover.		Even though you may be required to 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 the number on the back of your BCBSM ID card for a list of participating providers.		If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See chart starting on page 2 for how this plan pays different kinds of **providers**.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.		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		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	$40 co-pay/visit	40% co-insurance after deductible	Online visits with your medical provider will be billed at the $40 copay rate.
	Specialist visit	$40 co-pay/visit	40% co-insurance after deductible	Online visits with your medical provider will be billed at the $40 copay rate.
	Preventive care/screening/ immunization	No charge	40% co-insurance after deductible	Benefits covered at 100% in-network. Limitations may apply on number of visits.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance after deductible	40% co-insurance after deductible	---none---
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible	40% co-insurance after deductible	---none---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com	Generic drugs	$10 co-pay or 10% co-insurance (whichever is greater) but no more than a $100 for retail and mail order 30-day supply; $20 co-pay or 10% co-insurance (whichever is greater) but no more than a $200 for retail 90-day supply.	$10 co-pay or 10% co-insurance (whichever is greater) but no more than a $100 plus an additional 25% of BCBSM approved amount for the drug for a 30-day supply.	Mail order drugs are not covered out-of-network. 31-83 day supplies only available through mail order. Certain drugs subject to step therapy and prior authorization. Please contact the Plan Administrator for more details.
	Preferred brand drugs	$10 co-pay or 20% co-insurance (whichever is greater) but no more than a $100 for retail and mail order 30-day supply; $20 co-pay or 20% co-insurance (whichever is greater) but no more than a $200 for retail 90-day supply.	$10 co-pay or 20% co-insurance (whichever is greater) but no more than a $100 plus an additional 25% of BCBSM approved amount for the drug for a 30-day supply.	Mail order drugs are not covered out-of-network. 31-83 day supplies only available through mail order. Certain drugs subject to step therapy and prior authorization. Please contact the Plan Administrator for more details.
	Non-preferred brand drugs	$10 co-pay or 30% co-insurance (whichever is greater) but no more than a $100 for retail and mail order 30-day supply; $20 co-pay or 30% co-insurance (whichever is greater) but no more than a $200 for retail 90-day supply.	$10 co-pay or 30% co-insurance (whichever is greater) but no more than a $100 plus an additional 25% of BCBSM approved amount for the drug for a 30-day supply.	Mail order drugs are not covered out-of-network. 31-83 day supplies only available through mail order. Certain drugs subject to step therapy and prior authorization. Please contact the Plan Administrator for more details. **Prescription Drug Manufacturer Coupon Assistance Program is mandatory for Participants with prescription drugs (including Specialty drugs) that cost $400 or more and a manufacturer's coupon is available.** Health Plan Advocate, the program administrator, will contact the Participant. If a

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)	
				Manufacturer Coupon is not used, the Participant's cost sharing is 50% of the cost of the prescription drug.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	40% co-insurance after deductible	---none---
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	---none---
If you need immediate medical attention	Emergency room care	$250 co-pay	$250 co-pay	Copay is waived for in-patient admissions or accidents.
	Emergency medical transportation	20% co-insurance after deductible	20% co-insurance after deductible	---none---
	Urgent care	$40 co-pay	40% co-insurance after deductible	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible	40% co-insurance after deductible	A non-emergency hospital stay must be in a participating hospital.
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	Out-of-network in participating facilities only. Procedures that are the equivalent of an office visit will be treated and processed like an office visit subject to the fixed dollar office visit copay.
	Inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	---none---
If you are pregnant	Office visits	No charge for prenatal and postnatal preventive services required by federal law. Deductible does not apply.	40% co-insurance after deductible	Includes covered services provided by a certified nurse midwife
	Childbirth/delivery professional services	20% co-insurance after deductible	40% co-insurance after deductible	Includes covered services provided by a certified nurse midwife
	Childbirth/delivery facility services	20% co-insurance after deductible	40% co-insurance after deductible	Includes covered services provided by a certified nurse midwife
If you need help recovering or have other special health needs	Home health care	20% co-insurance after deductible	20% co-insurance after deductible	Must be medically necessary and provided by a participating home health care agency
	Rehabilitation services	20% co-insurance after deductible	40% co-insurance after deductible	Physical, Occupational, Speech therapy is limited to a combined maximum of 60 visits per member, per calendar year. Outpatient rehabilitation visits must be

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)	
				at a participating rehabilitation facility.
	Habilitation services	20% co-insurance after deductible	40% co-insurance after deductible	---none---
	Skilled nursing care	20% co-insurance after deductible	20% co-insurance after deductible	Limited to a maximum of 120 days per member per calendar year; Must be in a participating skilled nursing facility.
	Durable medical equipment	20% co-insurance after deductible	20% co-insurance after deductible	Items required to be covered under PPACA are covered at 100% for in-network only.
	Hospice services	No Charge	No Charge	Up to 28 pre-hospice counseling visits before electing hospice services; four 90-day periods – provided only through participating hospice programs
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	---none---
	Children's glasses	Not Covered	Not Covered	---none---
	Children's dental check-up	No Charge	N/A	Some out of network providers have separate agreements with BCBSM to certain pre-approved amounts for dental services from BCBSM. Please contact the Plan Administrator for more details.

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
- Weight loss programs
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Lifestyle Drugs

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

- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See http://provider.bcbs.com
- Private-duty nursing
- If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, co-payments, or co-insurance, or benefits not otherwise covered.
- Dental care (adult)

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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. 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 the Fund Office at 866-348-9499.

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 (248) 641-4925.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (248) 641-4925.]
[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (248) 641-4925.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (248) 641-4925.]

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	$500
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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	**$7,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,100**

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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	**$5,650**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$180
Coinsurance	$410
What isn't covered	
Limits or exclusions	$300
The total Joe would pay is	**$1,390**

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

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	**$1,550**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$100
Coinsurance	$340
What isn't covered	
Limits or exclusions	$25
The total Mia would pay is	**$965**

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