### Important Questions

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$1,400 Individual/ $2,800 Family</td>
<td>$2,800 Individual/ $5,600 Family</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care services are covered before you meet your deductible.</td>
<td></td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td></td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan? (May include a coinsurance maximum)</td>
<td>$2,300 Individual/ $4,600 Family</td>
<td>$7,300 Individual/ $14,600 Family</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn't cover.</td>
<td></td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. For a list of network providers see <a href="http://www.bcbsm.com">www.bcbsm.com</a> or call 1-877-752-1233</td>
<td></td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td></td>
</tr>
</tbody>
</table>

### Why This Matters:

- **What is the overall deductible?**
  - 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?**
  - 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/](https://www.healthcare.gov/coverage/preventive-care-benefits/).
- **Are there other deductibles for specific services?**
  - You don’t have to meet deductibles for specific services.
- **What is the out-of-pocket limit for this plan?**
  - 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, the overall family out-of-pocket limit must be met.
- **What is not included in the out-of-pocket limit?**
  - Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn’t cover.
- **Will you pay less if you use a network provider?**
  - 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?**
  - You can see the specialist you choose without a referral.
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
</table>
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness   | **In-Network Provider** *(You will pay the least)*: No charge  
**Out-of-Network Provider** *(You will pay the most)*: 20% coinsurance | None |
|                                                   | Specialist visit                                    | **In-Network Provider** *(You will pay the least)*: No charge  
**Out-of-Network Provider** *(You will pay the most)*: 20% coinsurance | None |
|                                                   | Preventive care/screening/imunization               | **In-Network Provider** *(You will pay the least)*: No charge; deductible does not apply  
**Out-of-Network Provider** *(You will pay the most)*: Not Covered | You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test                                | Diagnostic test (x-ray, blood work)                | **In-Network Provider** *(You will pay the least)*: No charge  
**Out-of-Network Provider** *(You will pay the most)*: 20% coinsurance | None |
|                                                   | Imaging (CT/PET scans, MRIs)                        | **In-Network Provider** *(You will pay the least)*: No charge  
**Out-of-Network Provider** *(You will pay the most)*: 20% coinsurance | May require preauthorization. |
| If you need drugs to treat your illness or condition | Generic or prescribed over-the-counter drugs       | $10 copay/prescription for retail 30-day supply, $20 copay/prescription for mail order 90-day supply  
**Out-of-Network Provider** *(You will pay the most)*: $10 copay/prescription plus an additional 20% of BCBSM approved amount for the drug | Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. Mail order drugs are not covered out-of-network. |
|                                                   | Preferred brand-name drugs                          | $40 copay/prescription for retail 30-day supply, $80 copay/prescription for mail order 90-day supply  
**Out-of-Network Provider** *(You will pay the most)*: $40 copay/prescription plus an additional 20% of BCBSM approved amount for the drug |  |
|                                                   | Non-Preferred brand-name drugs                     | $40 copay/prescription for retail 30-day supply, $80 copay/prescription for mail order 90-day supply  
**Out-of-Network Provider** *(You will pay the most)*: $40 copay/prescription plus an additional 20% of BCBSM approved amount for the drug |  |
| If you have outpatient surgery                    | Facility fee (e.g., ambulatory surgery center)     | **In-Network Provider** *(You will pay the least)*: No charge  
**Out-of-Network Provider** *(You will pay the most)*: 20% coinsurance | None |
|                                                   | Physician/surgeon fees                              | **In-Network Provider** *(You will pay the least)*: No charge  
**Out-of-Network Provider** *(You will pay the most)*: 20% coinsurance | None |
|                                                   | Emergency room care                                 | **In-Network Provider** *(You will pay the least)*: No charge  
**Out-of-Network Provider** *(You will pay the most)*: No charge | None |

More information about prescription drug coverage is available at [www.bcbsm.com/druglists](http://www.bcbsm.com/druglists)
<table>
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<th>What You Will Pay</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency medical transportation</td>
<td>In-Network Provider (You will pay the least): No charge</td>
<td>Out-of-Network Provider (You will pay the most): No charge</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>If you need behavioral health services (mental health and substance use disorder)</strong></td>
<td>Outpatient services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>Prenatal: No charge; deductible does not apply</td>
<td>Prenatal: 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
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<td>-------------------</td>
<td>---------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children’s eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
### 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
- Coverage provided outside the United States. See [http://provider.bcbs.com](http://provider.bcbs.com)
- 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, copayments, or coinsurance, or benefits not otherwise covered.
- Non-Emergency care when travelling 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: Department of Labor’s Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling 1-877-752-1233. 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 Cross® and Blue Shield® of Michigan by calling 1-877-752-1233.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or http://www.michigan.gov/difs or difs-HICAP@michigan.gov

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. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: See Addendum

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.

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#### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan’s overall deductible**: $1,400
- **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 | $12,700 |

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$1,400</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments</td>
<td>$30</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $60

**The total Peg would pay is**: $1,490

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#### Managing Joe’s Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan’s overall deductible**: $1,400
- **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 | $7,400 |

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$1,400</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments</td>
<td>$700</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $60

**The total Joe would pay is**: $2,160

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

- **The plan’s overall deductible**: $1,400
- **Specialist copayment**: $0
- **Hospital (facility) coinsurance**: 0%
- **Other coinsurance**: 0%

This EXAMPLE event includes services like:
- Emergency room care (*including medical supplies*)
- Diagnostic tests (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

| Total Example Cost | $1,900 |

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$1,400</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0

**The total Mia would pay is**: $1,400

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

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: 888-599-0578, email: Civilrights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.