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, www.bcbsm.com. 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.dol.gov/ebsa/healthreform** or call **1-888-890-5754** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$250** person / **$500** family for preferred providers. Doesn't apply to office visits and preventive care.	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 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. Preventive care and primary care services 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?	**No.**	You don't have to meet specific deductibles for specific services.
What is the out-of-pocket limit for this plan?	For preferred providers **$3,150** person/ **$6,300** 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-billed 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 1-888-890-5754 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	Not covered	If you receive services, in addition to office visit, additional copays or deductibles may apply
	Specialist visit	$40 copay/visit	Not covered	If you receive services, in addition to office visit, additional copays or deductibles may apply
	Preventive care/screening/ immunization	No charge	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	Covered at 100% in-network if related to a preventive exam. Deductible applies
	Imaging (CT/PET scans, MRIs)	$150 copay/visit	Not covered	Deductible applies
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	Not covered	Not covered	See Prescription SBC
	Preferred brand drugs	Not covered	Not covered	See Prescription SBC
	Non-preferred brand drugs	Not covered	Not covered	See Prescription SBC
	Specialty drugs	Not covered	Not covered	See Prescription SBC
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	Deductible applies
	Physician/surgeon fees	10% coinsurance	Not covered	Deductible applies
If you need immediate medical attention	Emergency room care	$100 copay/visit	Not covered	Copay waived if admitted
	Emergency medical transportation	10% coinsurance	Not covered	Deductible applies
	Urgent care	$20 copay/visit	Not covered	If you receive services in addition to urgent care, deductible or coinsurance may apply
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	Deductible applies
	Physician/surgeon fees	10% coinsurance	Not covered	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 need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	Not covered	————————none————————
	Inpatient services	10% coinsurance	Not covered	Deductible applies
If you are pregnant	Office visits	No charge	Not covered	————————none————————
	Childbirth/delivery professional services	0% coinsurance	Not covered	Deductible applies
	Childbirth/delivery facility services	10% coinsurance	Not covered	Deductible applies
If you need help recovering or have other special health needs	Home health care	$40 copay/visit	Not covered	Deductible applies. Unlimited visits
	Rehabilitation services	$40 copay/visit	Not covered	Limited to 60 combined visits per calendar year. Deductible applies.
	Habilitation services	$20 copay/visit for ABA $40 copay/visit for PT/OT/ST	Not covered	Deductible applies.
	Skilled nursing care	10% coinsurance	Not covered	Deductible applies. Limited to 45 days per member per calendar year
	Durable medical equipment	No charge	Not covered	————————none————————
	Hospice services	0% coinsurance	Not covered	Preauthorization required. Deductible applies
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/child)
- Hearing aids
- Long term care
- Private-duty nursing
- 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
- Emergency coverage provided outside the United States. See www.bcbsm.com
- Habilitation services
- 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, 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: BCBSM, P.O. Box 230555, Grand Rapids, MI 49523-0555 or 1-888-890-5754; Kent County, Attention: Plan Sponsor/Human Resources Department, 300 Monroe NW, Grand Rapids, MI 49503-2222. 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 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:

To get help reading in your language call the customer service number on the back of your ID card.

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	$250
Specialist copayment	$40
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	**$12,655**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$100
Coinsurance	$1,001
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,411**

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

The plan's overall deductible	$250
Specialist copayment	$40
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	**$7,465**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copayments	$1,775
Coinsurance	$279
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,964**

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

The plan's overall deductible	$250
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	**$2,016**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$600
Coinsurance	$82
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$932**

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