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 **www.bcbsm.com** or call (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 www.healthcare.gov/sbc-glossary or call (800)662-6667 to request a copy. For information on dental or vision benefits, please contact the Fund Office at www.benesysinc.com/benefit/sheet80fringe.asp or by calling (248)641-4980 or (800)400-7710.

Important Questions	Answers: Member / Family	Why This Matters:
What is the overall deductible?	$500 / $1,000	Generally, you must pay all 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	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment and coinsurance may apply
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 / $4,000	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 the number on the back of your BCBSM ID card 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-pocket 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, in-network only. Paper or electronic.	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 co-pay / visit. Deductible does not apply	Not covered	---none---
	Specialist visit	$20 co-pay / visit	Not covered	Requires referral. $5 co-pay for allergy injections / 50% co-insurance for allergy office visit & testing /Deductible applies
	Preventive care/screening/ immunization	No charge. Deductible does not apply	Not covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance. Lab services covered in full. Deductible does not apply to lab services	Not covered	May require prior authorization / No charge for lab services / Deductible applies except for lab service
	Imaging (CT/PET scans, MRIs)	20% co-insurance	Not covered	Requires prior authorization / Deductible applies
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.envisionrx.com or call (800) 361-4542.	Tier 1- Formulary Preferred (Mostly Generic)	$10 / Rx Retail or Mail. Deductible does not apply	Not covered	Prior authorization and step-therapy apply to selected drugs. 90-day retail co-pays are 2x the standard retail co-pays. 50% co-insurance for sexual dysfunction drugs. As of 1/1/2013, Tier 1 contraceptives are covered in full. Limited to a 30-day supply.
	Tier 2- Formulary Brand	$20 / Rx Retail or Mail. Deductible does not apply	Not covered	
	Tier 3- Non-Formulary	$40 / Rx Retail or Mail. Deductible does not apply	Not covered	
	Specialty drugs	Tiered co-pays listed above apply. Deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	Not covered	May require prior authorization / 50% co-insurance for weight reduction procedures, pregnancy termination, TMJ, orthognathic surgery, reduction mammoplasty,

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)	
				male mastectomy / Deductible applies
	Physician/surgeon fees	20% co-insurance	Not covered	See "Outpatient surgery facility fee"
If you need immediate medical attention	Emergency room care	$75 co-pay / visit	$75 co-pay / visit	Co-pay waived if admitted / Deductible applies
	Emergency medical transportation	20% co-insurance	20% co-insurance	Non-emergent transport is not covered / Deductible applies
	Urgent care	$50 co-pay / visit	$50 co-pay / visit	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	Not covered	Requires prior authorization / 50% co-insurance for weight reduction procedures, TMJ, pregnancy termination, orthognathic surgery, reduction mammoplasty, male mastectomy / Deductible applies
	Physician/surgeon fees	No charge	Not covered	See "Hospital stay facility fee"
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 co-pay / visit. Deductible does not apply	Not covered	Requires prior authorization / Deductible applies
	Inpatient services	20% co-insurance	Not covered	Requires prior authorization / Deductible applies
If you are pregnant	Office visits	No charge. Deductible does not apply	Not covered	Postnatal and non-routine prenatal office visits-$30 co-pay / visit. Only the routine prenatal visit is exempt form the deductible. Other services, deductible applies
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	20% co-insurance	Not covered	None
If you need help recovering or have other special health needs	Home health care	$20 co-pay / visit	Not covered	Requires preauthorization. Custodial care not covered. Deductible applies
	Rehabilitation services	$20 co-pay / visit	Not covered	Requires authorization / One period of treatment for any combination of therapies within 60 consecutive days per calendar year / Deductible applies
	Habilitation services	Not covered / ABA - $20 co-pay / visit	Not covered	PT/OT/ST for autism spectrum disorder has unlimited visits. Requires prior authorization.
	Skilled nursing care	20% co-insurance	Not covered	Requires prior authorization / Limited to 45 days per

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)	
				calendar year/ Deductible applies. Custodial care not covered.
	Durable medical equipment	50% co-insurance	Not covered	Requires prior authorization and must be authorized and obtained from a BCN supplier. Convenience and comfort items not covered. Deductible does not apply to diabetic supplies.
	Hospice services	No charge	Not covered	Inpatient care requires authorization / Deductible applies. Housekeeping and custodial care not covered.
If your child needs dental or eye care	Children's eye exam	$10 co-pay / Contact lens exam and fitting: up to $60 copay	$10 co-pay. The Plan pays up to $45 for an exam, you are responsible for the balance.	Eye exams are limited to once per calendar year.
	Children's glasses	$25 copay – includes frames, single lenses, bifocal lenses, trifocal lenses or lenticular and polycarbonate lenses for dependent children. Progressives: $55 to $175 co-pay Necessary Contacts: $25	The Plan pays up to the following limits, you are responsible for the balance - Single lenses: $30 Bifocal lenses:$50 Trifocal lenses: $65 Lenticular: $100 Progressives: N/A Frames: $70 Necessary Contacts: $210	Frames are limited to once every other calendar year. $130 basic frame allowance, $150 preferred brand allowance; 20% savings on amount over allowance. Lenses and enhancements are limited to once per calendar year. Contact lenses are limited to once per calendar year More information about vision coverage is available at www.vsp.com
	Children's dental check-up	No charge	20% co-insurance	Oral exams are limited to once per six-months and full mouth x-rays are limited to once per thirty-six months. Dental benefits limited to $1,500 per member per

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)	
				calendar year.

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
- Habilitation Services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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
- Hearing aids
- Infertility treatment
- Routine eye care (adult)
- Dental care (adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information contact the Fund Office at (800) 400-7710, the state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 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: U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa.

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 BCN 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	$500
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	N/A

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:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

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 copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	N/A

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:

Cost Sharing	
Deductibles	$500
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,060**

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

The plan's overall deductible	$500
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	N/A

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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