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, go to www.myfordbenefits.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.healthcare.gov/sbc-glossary or call **1-800-248-4444** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	There is no deductible under this plan.	Not applicable.
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?	**In-Network:** None **Out-of-Network:** $250 individual / $500 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?	Copayments, balance-billing charges, penalties for failing to obtain preauthorization, 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 **1-800-482-5146** 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?	**In-Network:** No **Out-of-Network:** Yes	**In-Network:** You can see the specialist you choose without a referral. **Out-of-Network:** This plan will pay some or all of the costs to see a primary care provider or 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
		In-Network (You will pay the least)	Out-of-Network (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	Referral required for out-of-network coverage; not covered without referral.
	Specialist visit	$20 copay/visit	Not covered	Referral required for out-of-network coverage; not covered without referral.
	Preventive care/ screening/immunization	No charge	10% coinsurance	This plan provides National Health Care Reform Act Mandated Preventive Services and Immunizations. Age and frequency limits apply. All children and adult immunizations per Centers for Disease Control (CDC) guidelines (see www.cdc.gov/vaccines/acip/).
If you have a test	Diagnostic test (x-ray, blood work)	No charge	10% coinsurance	Michigan residents must use Quest Diagnostic network.
	Imaging (CT/PET scans, MRIs)	No charge	10% coinsurance	Michigan residents must receive preauthorization for non-emergent services with American Imaging Management (AIM). Outside Michigan, covered with certain criteria.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com or **1-800-482-5146**.	Generic drugs	**Retail:** $6 copay/prescription ED: $17 copay/prescription **Walgreens Smart90/ Home Delivery:** $12 copay/prescription	**Retail:** 25% coinsurance after applicable in-network copay **Home Delivery:** Not covered	Certain preventive medications are covered at 100%. Mandatory generic substitute applies. Maintenance/long-term drugs available only through home delivery or Walgreens Smart90 program, after three fills at pharmacy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com or **1-800-482-5146**.	Preferred and non-preferred brand drugs	**Retail:** $12 copay/prescription ED: $17 copay/prescription **Walgreens Smart90/ Home Delivery:** $17 copay/prescription ED: $21 copay/prescription	**Retail:** 25% coinsurance after applicable in-network copay **Home Delivery:** Not covered	Certain preventive medications are covered at 100%. Mandatory generic substitute applies. Maintenance/long-term drugs available only through home delivery or Walgreens Smart90 program, after three fills at pharmacy.
	Specialty drugs	Brand or generic copay applies. Contact plan.	Brand or generic copay applies. Contact plan.	Contact plan for details regarding coverage.
If you have outpatient surgery	Facility services (e.g., ambulatory surgery center)	No charge	10% coinsurance	Preauthorization may be required. Ambulatory Surgery Center must be approved by local plan. "Facility fee" not covered.
	Physician/surgeon fees	No charge	10% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Copay waived if admitted to hospital, placed into observation care or sent by Company Medical. Non-emergency use not covered.
	Emergency medical transportation	No charge	10% coinsurance	Non-Emergent Transport: Not covered.
	Urgent care	$50 copay/visit	$50 copay/visit	None
If you have a hospital stay	Facility services (e.g., hospital room)	No charge	10% coinsurance	Preauthorization required. Up to 365 days; renewable after 60 days. "Facility fee" not covered.
	Physician/surgeon fees	No charge	10% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Mental Health:** ***Visits 1-20:*** No charge ***Visits 21-35:*** 25% coinsurance, up to $20 ***Visits 36 & Over:*** $20 copay/visit **Substance Abuse:** ***Visits 1-35:*** No charge ***Visits 36 & Over:*** $20 copay/visit	Not covered	Unlimited visits/plan year; visit count resets each calendar year.
	Inpatient services	No charge	10% coinsurance	Preauthorization required. Up to 365 days; renewable after 60 days.
If you are pregnant	Office visits	**Prenatal:** No charge **Postnatal:** No charge	10% coinsurance	None
	Childbirth/delivery professional services	No charge	10% coinsurance	None
	Childbirth/delivery facility services	No charge	10% coinsurance	None
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	3 visits for each unused day of hospital care with participating agencies; contact plan for limitations.
	Rehabilitation services	**Inpatient Physical Therapy:** No charge **Outpatient Physical Therapy through TheraMatrix:** No charge **Outpatient Occupational and Speech Therapy:** No charge	**Inpatient Physical Therapy:** 10% coinsurance **Outpatient Physical Therapy through TheraMatrix:** No charge **Outpatient Occupational and Speech Therapy:** 10% coinsurance	Outpatient therapy services: physical, speech and/or occupational therapies limited to a combined 60 treatments/ condition/plan year. Outpatient physical therapy services must be received through TheraMatrix for coverage and to avoid cost share. If a network provider is not within a 25-mile radius of your home, contact TheraMatrix at **1-888-638-8786** before services begin.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Habilitation services	No charge for certain services; contact plan for details	10% coinsurance for certain services; contact plan for details	Limitations apply; contact plan for details.
	Skilled nursing care	No charge	Not covered	Preauthorization required. 2 visits for each unused day of hospital care at participating facilities, except psychiatric care, which is 365 days renewable after 60. Contact plan for limitations.
	Durable medical equipment	No charge	20% coinsurance, up to $500/year	Excludes repair charges that exceed the maximum allowance for the purchase of new equipment; deluxe equipment; exercise equipment, disposable supplies, etc.
	Hospice services	No charge	Not covered	Covered with a 12-month life expectancy. Hospice must participate with BCBSM or local plan.
If your child needs dental or eye care	Children's eye exam and glasses	Contact SVS, Inc. at **1-800-225-3095** or www.singlevisionsolution.com	Not covered	Not covered under medical plan.
	Children's dental check-up	Covered up to the maximum allowable under the Dental plan	Not covered	Not covered under medical plan.

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
- Chiropractic care (limited services available)
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- 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
- Hearing aids
- Non-emergency care when traveling outside the U.S., www.bcbsglobalcore.com

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 Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or www.dol.gov/ebsa/healthreform. 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 on how 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 Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)**, visit www.dol.gov/ebsa/healthreform, or contact the plan at **1-800-248-4444** or **www.myfordbenefits.com**.

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 **1-800-248-4444**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-248-4444**.

Chinese (中文): **如果需要中文的帮助**，请拨打这个号码**1-800-248-4444**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-248-4444**.

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	**$0**
Specialist copayment	**$20**
Hospital (facility) copayment	**$0**
Other	**$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:	
Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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

The plan's overall deductible	**$0**
Specialist copayment	**$20**
Hospital (facility) copayment	**$0**
Other	**$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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$520**

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

The plan's overall deductible	**$0**
Specialist copayment	**$20**
Hospital (facility) copayment	**$100**
Other	**$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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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