The information contained in this communication is privileged and confidential and is intended solely for the use of the individual(s) to whom this communication is directed. If you are not the intended recipient, you are hereby notified that any viewing, copying, disclosure or distribution of this information may be subject to legal restriction or sanction. Please notify the sender, by electronic mail or telephone, of any unintended recipients and delete the original message without making any copies. Thank you. "

As a self-funded group, you are solely responsible for compliance with the federal Summary of Benefit and Coverage (SBC) rules, including SBC creation and distribution. BCBSM does not assume any responsibility for SBC rule compliance relating to your group health plan, or for creation or disclosure of compliant SBCs. This SBC template document is being provided as an example that may contain useful information concerning your BCBSM administered coverage as you create your own group health plan's SBC. This SBC template document being provided is not fully compliant with the SBC federal rules. It is your responsibility to work with your legal counsel to ensure proper compliance with the federal SBC rules. This SBC template document does not constitute legal, tax, actuarial, accounting, benefit design, compliance or other advice. BCBSM disclaims any liability or responsibility for any non-compliance by your group health plan with SBC rules and regulations relating to creation, disclosure or other requirements. You should also note that there may be additional special circumstances which may be applicable to your specific group health plan situation which may affect SBC content, including but not limited to account type arrangements such as flexible spending accounts (FSA), health reimbursement arrangements (HRA), and health savings accounts, (HSA), or for example, wellness programs, or coverage not administered by BCBSM."

CHARLEVOIX EMMET ISD
007016227 0002

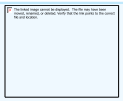
Coverage Period: 01-01-2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual / Family **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsm.com or by calling 877-354-2583.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	**$0 Individual/$0 Family**	**$250 Individual/$500 Family**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	No	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes		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
	$600 Individual/$1200 Family	**$2,250 Individual/$4,500 Family**	
What is not included in the out-of-pocket limit?	Copayments, deductibles, 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**.
Is there an overall annual limit on what the plan pays?	No		The Common Medical Events chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.bcbsm.com or call the number on the back of your BCBSM ID card.		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 the Common Medical Events chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No		You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes		Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Group Number: 007016227 0002
Questions: Call the number on the back of your BCBSM ID card or visit us at www.bcbsm.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the number on the back of your BCBSM ID card to request a copy.



- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network	Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay	20% co-insurance after deductible	---none---
	Specialist visit	$20 co-pay	20% co-insurance after deductible	---none---
	Chiropractor visit	$20 co-pay	20% co-insurance after deductible for chiropractor	Limited spinal manipulation to a maximum of 24 visits per member per calendar year
	Preventive care / screening / immunization	No Charge	Not Covered	---none---
If you have a test	Diagonstic test (x-ray, blood work)	No Charge	20% co-insurance after deductible	---none---
	Imaging (CT/PET scans, MRIs)	No Charge	20% co-insurance after deductible	---none---

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network	Out-of-Network	
If you need drugs to treat your illness or condition **For more information about prescription drug coverage (if applicable), contact your employer.**	Generic drugs or prescribed over-the-counter drugs	$15 co-pay for retail 30-day supply. $30 co-pay for retail 90-day supply.	In-network co-pay **plus** an additional 25% of BCBSM approved amount for the drug.	For information on women's contraceptive coverage, contact your employer. Mail order drugs are not covered out-of-network. Specialty drugs limited to a 30-day supply per fill.
	Formulary (preferred) brand-name drugs	$30 co-pay for retail 30-day supply. $60 co-pay for retail 90-day supply.	In-network co-pay **plus** an additional 25% of BCBSM approved amount for the drug.	Mail order drugs are not covered out-of-network. Specialty drugs limited to a 30-day supply per fill.
	Nonformulary (nonpreferred) brand-name drugs	$60 co-pay for retail 30-day supply. $120 co-pay for retail 90-day supply.	In-network co-pay **plus** an additional 25% of BCBSM approved amount for the drug.	Mail order drugs are not covered out-of-network. Specialty drugs limited to a 30-day supply per fill.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% co-insurance after deductible	---none---
	Physician/surgeon fees	No Charge	20% co-insurance after deductible	---none---
If you need immediate medical attention	Emergency room services	$100 co-pay	$100 co-pay	Co-pay waived if admitted or for an accidental injury.
	Emergency medical transportation	No Charge	No Charge	---none---
	Urgent care	$20 co-pay	20% co-insurance after deductible	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% co-insurance after deductible	---none---
	Physician/surgeon fee	No Charge	20% co-insurance after deductible	---none---

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network	Out-of-Network	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	20% co-insurance after deductible	Cost share may be different for services rendered in an office setting.
	Mental/Behavioral health inpatient services	No Charge	20% co-insurance after deductible	---none---
	Substance use disorder outpatient services	No Charge	20% co-insurance after deductible	---none---
	Substance use disorder inpatient services	No Charge	20% co-insurance after deductible	---none---
If you are pregnant	Prenatal and postnatal care	No Charge	20% co-insurance after deductible	---none---
	Delivery and all inpatient services	No Charge	20% co-insurance after deductible	---none---
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	---none---
	Rehabilitation services	No Charge	20% co-insurance after deductible	Physical, Occupational, and Speech therapy is limited to a combined maximum of 60 visits per member, per calendar year
	Habilitation services	No Charge for Physical, Occupational, and Speech therapy	20% co-insurance after deductible for Physical, Occupational, and Speech therapy	Physical, Occupational, and Speech limits are combined with Rehabilitation service limits.
	Skilled nursing care	No Charge	No Charge	Limited to a maximum of 120 days per member per calendar year
	Durable medical equipment	No Charge	No Charge	---none---
	Hospice care	No Charge	No Charge	---none---
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	---none---
	Glasses	Not Covered	Not Covered	---none---
	Dental check-up	Not Covered	Not Covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See http://provider.bcbs.com
- If you are also covered by an account-type plan such as 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.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan by calling the number on the back of your BCBSM ID card. You may also contact your state insurance department, 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Blue Cross and Blue Shield of Michigan by calling the number on the back of your BCBSM ID card. Or, you can contact Michigan Office of Financial and Insurance Regulation at www.michigan.gov/ofir or 1-877-999-6442. For group health coverage subject to ERISA, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides. (IMPORTANT: Blue Care Network 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 EBH categories, for example prescription drugs, through another carrier. In these situations you will need to contact your plan administrator for information on whether your plan meets the minimum value standard for the benefits it provides.)

Language Access Services

For assistance in a language below, please call the number on the back of your BCBSM ID card.

SPANISH (Español): Para ayuda en español, llame al número de servicio al cliente [customer service] que se encuentra en este aviso ó en el reverso de su tarjeta de identificación.
TAGALOG (Tagalog): Para sa tulong sa wikang Tagalog, mangyaring tumawag sa numero ng serbisyo sa mamimili [customer service] na nakalagay sa likod ng iyong pagkakakilanlan kard o sa paunawang ito.

NAVAJO (Dine): Taa'dineji'keego shii'kaa'ahdool'wool ninizin'goo [customer service], beesh behane'e naal'tsoos bikii sin'dahiigii binii'deehgo eeh'doodago di'naaltsoo bikaiigii bichi'hoodillnii.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much insurance protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Please note: Coverage Examples are calculated based on individual coverage.

Having a baby

(normal delivery)

Amount owed to providers: $7,540
Plan pays $7,370
You pay $170

Sample care costs:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**
Patient pays:	
Deductibles	$0
Co-pays	$20
Co-insurance	$0
Limits or exclusions	$150
Total:	**$170**

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

Amount owed to providers: $4,100
Plan pays $3,420
You pay $680

Sample care costs:	
Prescriptions	$1,200
Medical Equipment & Supplies	$1,700
Office Visits & Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$4,100**
Patient pays:	
Deductibles	$0
Co-pays	$600
Co-insurance	$0
Limits or exclusions	$80
Total	**$680**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the number on the back of your BCBSM ID card to request a copy.