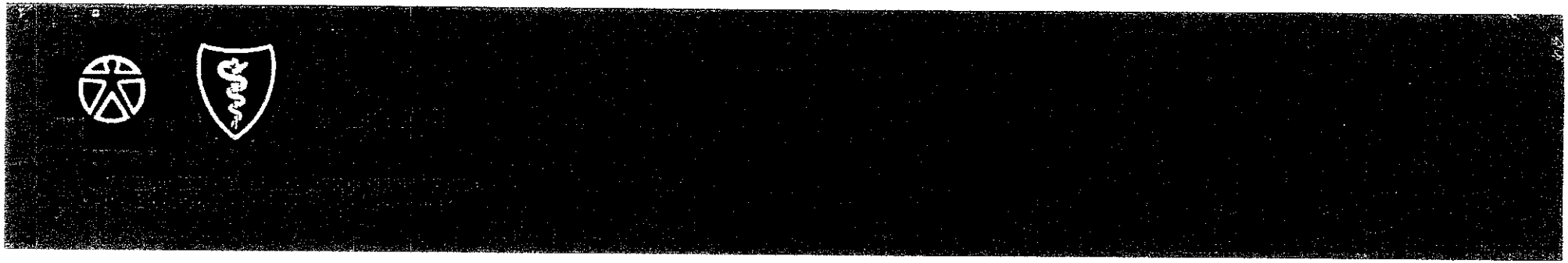


Blue Elect Plus HSA℠ POS $2,000/0% High Deductible Health Plan with Medical and Prescription Drug Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.

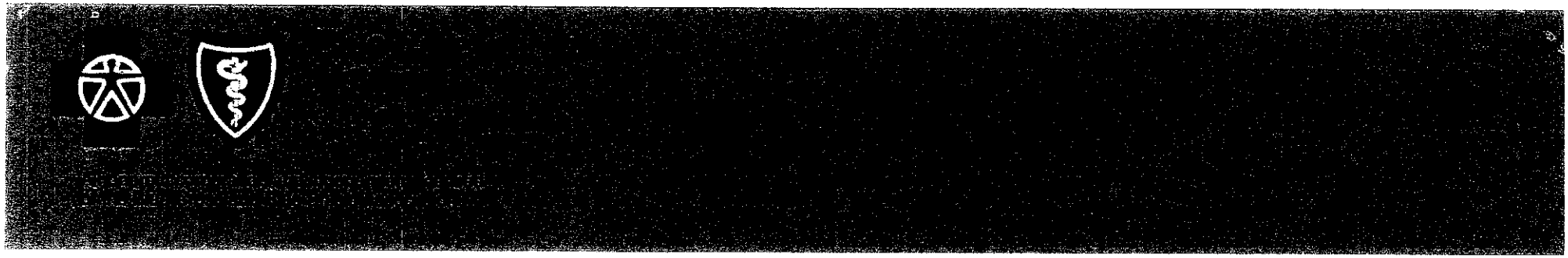
Preauthorization for Select Services - Services listed in this summary are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCN except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo.** Select ***Approving covered services.***

Member's Responsibility: Deductible, Copays, Coinsurance and Out-of-Pocket Maximums

Note: The **Deductible** will apply to all services except preventive services

	In Network	Out of Network
Deductible **Note:** deductible is combined for both medical and prescription drug coverage. The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract	$2,000 for a one-person contract, $4,000 for a family contract (2 or more members) each calendar year (No 4th quarter carryover)	$4,000 for a one-person contract, $8,000 for a family contract (2 or more members) each calendar year (No 4th quarter carryover)
Fixed dollar copays	None	None
Coinsurance **Note:** Copay amounts apply once the deductible has been met	0% and 50% of approved amount for select services	20% and 50% of approved amount for select services
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts.	$4,000 per member/$8,000 per family per calendar year	$8,000 per member/$16,000 per family per calendar year



	In Network	Out of Network

Preventive Services

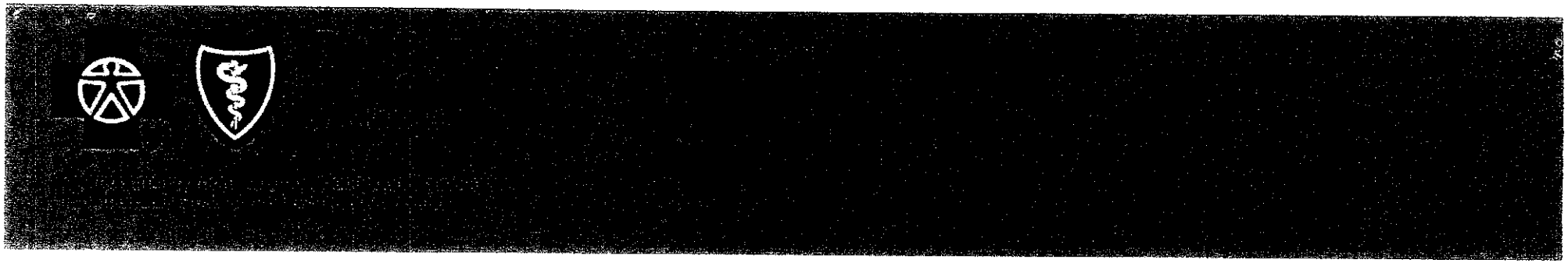
Health Maintenance Exam	Covered – 100%	Not Covered
Annual Gynecological Exam	Covered – 100%	Not Covered
Pap Smear Screening – laboratory services only	Covered – 100%	Not Covered
Well-Baby and Child Care	Covered – 100%	Not Covered
Immunizations – pediatric and adult	Covered – 100%	Not Covered
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%	Not Covered
Routine Colonoscopy	Covered – 100%	Covered - 80% after deductible
Mammography Screening	Covered – 100%	Covered - 80% after deductible
Voluntary Female Sterilization	Covered – 100%	Not Covered
Breast Pumps	Covered – 100%	Not Covered
Maternity Pre-Natal Care	Covered – 100%	Covered - 80% after deductible

Physician Office Services

PCP Office Visits	Covered - 100% after deductible	Not Applicable
Medical Online Visits	Covered - 100% after deductible	Covered - 80% after deductible
Consulting Specialist Care	Covered - 100% after deductible	Covered - 80% after deductible

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted, inpatient hospital benefit will apply	Covered - 100% after deductible	Covered - 100% after deductible
Urgent Care Center	Covered - 100% after deductible	Covered - 100% after deductible
Retail Health Clinic	Covered - 100% after deductible	Covered - 100% after deductible
Ambulance Services – medically necessary	Covered - 100% after deductible	Covered - 100% after deductible



	In Network	Out of Network
Diagnostic Services		
Laboratory and Pathology Tests	Covered - 100% after deductible	Covered - 80% after deductible
Diagnostic Tests and X-rays	Covered - 100% after deductible	Covered - 80% after deductible
High Tech Imaging	Covered - 100% after deductible	Covered - 80% after deductible
Radiation Therapy	Covered - 100% after deductible	Covered - 80% after deductible
Maternity Services Provided by a Physician		
Post-Natal Care. See Preventive Services section for Pre-Natal Care	Covered - 100%	Covered - 80% after deductible
Delivery and Nursery Care	Covered - 100% after deductible	Covered - 80% after deductible
Hospital Care		
General Nursing Care, Hospital Services and Supplies	Covered - 100% after deductible; unlimited days	Covered - 80% after deductible; unlimited days
Outpatient Facility Services	Covered - 100% after deductible	Covered - 80% after deductible
Alternatives to Hospital Care		
Skilled Nursing Care	Covered - 100% after deductible	Covered - 80% after deductible
	Up to 45 days per calendar year	
Hospice Care	Covered - 100% after deductible	Covered - 80% after deductible
Home Health Care	Covered - 100% after deductible	Covered - 80% after deductible

	In Network	Out of Network

Surgical Services

Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays	Covered - 100% after deductible	Covered - 80% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered - 100% after deductible	Not Covered
Elective Abortion	Covered - 100% after deductible	Covered - 50% after deductible
Human Organ Transplants (subject to medical criteria)	Covered - 100% after deductible	Covered - 100% after deductible – must be performed in approved designated facility
Reduction mammoplasty (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible	Covered – 50% after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 50% after deductible	Not Covered

Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)

Inpatient Mental Health Care	Covered - 100% after deductible	Covered - 80% after deductible
Residential Substance Use Disorder	Covered - 100% after deductible	Covered - 80% after deductible
Outpatient Mental Health Care includes online visits **Note:** For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	Covered - 100% after deductible	Covered - 80% after deductible
Outpatient Substance Use Disorder	Covered - 100% after deductible	Covered - 80% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment

	In Network	Out of Network
Applied behavioral analyses (ABA) treatment through age 18 **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCN approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - 100% after deductible	Covered - 80% after deductible
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18 Unlimited visits for physical, speech and occupational therapy with autism spectrum disorder diagnosis	Covered - 100% after deductible	Covered - 80% after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visits and preventive benefit	See your outpatient mental health, medical office visits and preventive benefit

Other Services

Allergy Testing and Therapy	Covered - 100% after deductible including allergy injections	Covered - 80% after deductible including allergy injections
Allergy Office Visits	Covered - 100% after deductible	Covered - 80% after deductible including allergy injections
Chiropractic Spinal Manipulation	Covered - 100% after deductible; up to 30 visits per calendar year	Not covered
Outpatient Therapy/Rehabilitation – subject to meaningful improvement within 60 days	Covered - 100% after deductible	Covered - 80% after deductible
	In Network/Out of Network limited to 60 visits per calendar year for any combination of therapies	
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible on all associated costs	Not Covered
Durable Medical Equipment	Covered – 50% after deductible	Not Covered
Prosthetic and Orthotic Appliances	Covered – 50% after deductible	Not Covered
Diabetic Supplies **Note**: Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable prescription drug cost-sharing will apply.	Covered - 100% after deductible	Not Covered

Note – You are responsible for any amount not approved by BCN when seeking services out of network. BCN authorization requirements apply to both in network and out of network services.

High Deductible Health Plan
Custom Drug List℠ $4/$15/$40/$80/20%/20%
Prescription Drug Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificate and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

Prescription Drugs

Deductible	The Deductible is combined for both medical and prescription drug coverage. The Deductible amount is listed with your medical benefits.
Tier 1A – Value Generics	$4 Copayment after Deductible
Tier 1B - Generics	$15 Copayment after Deductible
Tier 2 – Preferred Brand Drugs	$40 Copayment after Deductible
Tier 3 – Non-Preferred Drugs	$80 Copayment after Deductible
Tier 4 – Preferred Specialty	20% Coinsurance of the BCN Approved Amount after Deductible (Maximum Copayment $200) - Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.
Tier 5 Non-Preferred Specialty	20% Coinsurance of the BCN Approved Amount after Deductible (Maximum Copayment $300) - Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.
Sexual Dysfunction Drugs	50% Coinsurance of the BCN Approved Amount after Deductible
Contraceptives **Note:** Your cost sharing may be waived for Tier 1B, Tier 2 or Tier 3 contraceptive drugs if there are no appropriate generic products or preferred drugs available.	• Tier 1A – Covered in Full • Tier 1B – $15 Copay after Deductible • Tier 2 - $40 Copay after Deductible • Tier 3 - $80 Copay after Deductible
Diabetic Supplies	Select diabetic supplies and equipment are covered – applicable cost sharing will apply. Cost-sharing may not apply to certain preferred glucometers as defined on the drug list.
Preventive Medications	Covered in Full
31-90 day supply for Mail-Order Pharmacy	Three times applicable copay minus $10 after Deductible
84-90 day supply for Retail Pharmacy	Three times applicable copay minus $10 after Deductible
Out-of-Pocket Maximum	Your medical out-of-pocket maximum is integrated with your BCN covered Prescription Drugs. The out-of-pocket maximum amount is listed with your medical benefits.

Definitions

Brand Name Drug	Manufactured and marketed under a registered trade name and trademark. • Multi-source Brand Name Drug: a drug that is available from a brand name manufacturer and also has a generic version. • Single Source Brand Name Drug: the drug can only be produced by the company holding the patent; no generics are available.
Generic Drugs	Prescription drugs that have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark.
Non-Preferred Drugs	Prescription drugs that may not have a proven record for safety or their clinical record may not be as high as the BCN preferred alternatives.
Non-Preferred Specialty Drugs	Specialty drugs that may not have a proven record for safety or their clinical value may not be as high as the Specialty Drugs.
Out-of-Pocket Maximum	The highest amount of money you have to pay for covered services during the Calendar Year.
Preferred Brand Drugs	Prescription drugs that are Single Source Brand drugs that have a proven record for safety and effectiveness.
Preferred Specialty Drugs	Generic or Single Source Brand Specialty drugs that have a proven record for safety and effectiveness and offer the best value to our members.
Value Generic Drugs	Prescription drugs that have a proven clinical value essential for treatment of chronic conditions.