

 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](http://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 <https://www.healthcare.gov/sbc-glossary/> or call 1-866-917-7537 to request a copy.

| Important Questions   | Answers  | Why This Matters:  |
|---|--|--|
| What is the overall <b>deductible</b> ?                             | IN-Network: \$1,150 per member; \$2,300 per family   | Generally, you must pay all of the costs from <b>providers</b> up to the <b>deductible</b> amount before this <b>plan</b> begins to pay. If you have other family members on the <b>plan</b> , each family member must meet their own individual <b>deductible</b> until the total amount of <b>deductible</b> expenses paid by all family members meets the overall family <b>deductible</b> .  |
| Are there services covered before you meet your <b>deductible</b> ? | Yes. <b>Preventive care</b> services (In-Network only) are covered before you meet your <b>deductible</b> .  | This <b>plan</b> covers some items and services even if you haven't yet met the <b>deductible</b> amount. But a <b>copayment</b> or <b>coinsurance</b> may apply. For example, this <b>plan</b> covers certain <b>preventive services</b> without <b>cost sharing</b> and before you meet your <b>deductible</b> . See a list of covered <b>preventive services</b> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                     |
| Are there other <b>deductibles</b> for specific services?           | No   | You don't have to meet <b>deductibles</b> for specific services.   |
| What is the <b>out-of-pocket limit</b> for this <b>plan</b> ?       | In-Network: \$3,500 per member; \$7,000 per family   | The <b>out-of-pocket limit</b> 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 <b>out-of-pocket limit</b> has been met.   |
| What is not included in the <b>out-of-pocket limit</b> ?            | <b>Premiums</b> , balance-billed charges, penalties for failure to obtain <b>pre-authorization</b> for services and healthcare the <b>plan</b> does not cover. | Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .   |
| Will you pay less if you use a <b>network provider</b> ?            | Yes, see <a href="http://www.bcbsm.com">www.bcbsm.com</a> or call 1-866-917-7537 for a list of network providers.  | You pay the least if you use an in-network <b>provider</b> . You pay more if you use an out-of-network <b>provider</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware, your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services. |
| Do you need a <b>referral</b> to see a <b>specialist</b> ?          | No   | You can see the <b>specialist</b> you choose without a <b>referral</b> .   |

 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 Providers<br>(You will pay the least)   | Out-of-Network Providers<br>(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% after <b>deductible</b>  | Not covered  | —————none—————  |
|  | <a href="#">Specialist</a> visit                       | 20% after <b>deductible</b>  | Not covered  | —————none—————  |
|  | <a href="#">Preventive care/screening/immunization</a> | 0%, <b>deductible</b> waived   | Not covered  | Age and frequency limits may apply.   |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 20% after <b>deductible</b>  | Not covered  | —————none—————  |
|  | Imaging (CT/PET scans, MRIs)                           | 20% after <b>deductible</b>  | Not covered  | To be eligible for coverage, these services may require approval before they are provided.  |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.Optumrx.com">www.Optumrx.com</a> | Generic drugs  | Retail: 34-day supply - \$10 <b>copay</b> ; RHM owned pharmacies: 34-day supply - \$8 <b>copay</b> *; RHM owned pharmacies: 90-day supply - \$24 <b>copay</b> *; Mail Order: 90-day supply - \$25 <b>copay</b>   | Retail: 34-day supply - \$10 <b>copay</b> ; RHM owned pharmacies: 34-day supply - \$8 <b>copay</b> *; RHM owned pharmacies: 90-day supply - \$24 <b>copay</b> *; Mail Order: 90-day supply - \$25 <b>copay</b>   | No contraceptive coverage. Step therapy program may apply. *Inclusive of colleague discount. <b>Copays &amp; Coinsurance</b> applies to the out-of-network OOPM.  |
|  | Preferred brand drugs                                  | Retail - 34-day supply: 25% with \$30 min and \$80 max; RHM owned pharmacies - 34-day supply: 20% with \$24 min and \$64 max*; RHM owned pharmacies - 90-day supply: 20% with \$72 min and \$192 max*; Mail Order - 90-day supply: 25% with \$75 min and \$200 max | . Retail - 34-day supply: 25% with \$30 min and \$80 max; RHM owned pharmacies - 34-day supply: 20% with \$24 min and \$64 max*; RHM owned pharmacies - 90-day supply: 20% with \$72 min and \$192 max*; Mail Order - 90-day supply: 25% with \$75 min and \$200 max | Min/Max reduced by 50% for asthma and diabetes. No contraceptive coverage. Step therapy program may apply. *Inclusive of colleague discounts. If a brand drug has a specific equivalent generic drug available and the plan participant receives the brand then in addition to the copay, the plan participant must also pay the difference between the ingredient cost of the brand drug and the generic drug. <b>Copays &amp; Coinsurance</b> applies to the in-network OOPM. |

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www/bcbsm.com](http://www/bcbsm.com).]

| Common Medical Event                    | Services You May Need  | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information  |
|---|--|---|---|---|
|   |  | In-Network Providers<br>(You will pay the least)  | Out-of-Network Providers<br>(You will pay the most)   |   |
|   | Non-preferred brand drugs  | Retail - 34-day supply: 50% with \$60 min and \$120 max; RHM owned pharmacies - 34-day supply: 40% with \$48 min and \$96 max*; RHM owned pharmacies - 90-day supply: 40% with \$144 min and \$288 max*; Mail Order - 90-day supply: 50% with \$150 min and \$300 max | Retail - 34-day supply: 50% with \$60 min and \$120 max; RHM owned pharmacies - 34-day supply: 40% with \$48 min and \$96 max*; RHM owned pharmacies - 90-day supply: 40% with \$144 min and \$288 max*; Mail Order - 90-day supply: 50% with \$150 min and \$300 max | Min/Max reduced by 50% for asthma and diabetes. No contraceptive coverage. Step therapy program may apply. *Inclusive of colleague discounts. <b>Copays &amp; Coinsurance</b> applies to the in-network OOPM.   |
|   | <a href="#">Specialty drugs</a>  | Same as non-preferred brand drugs   | Not covered   | Specialty medications must be filled at a Trinity Health pharmacy or through the OptumRx Specialty program. Specialty drug prescriptions limited to a 30-day supply. Step therapy program applies. <b>Copays &amp; Coinsurance</b> applies to the in-network OOPM.        |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center)                           | \$50 <b>copay</b> then 20% after <b>deductible</b>  | Not covered   | —————none—————  |
|   | Physician/surgeon fees   | 20% after <b>deductible</b>   | Not covered   | —————none—————  |
| If you need immediate medical attention | <a href="#">Emergency room care</a>                                      | 0% after \$200 <b>copay</b>   | 0% after \$200 <b>copay</b>   | <b>Copay</b> waived if admitted. In-network <b>deductible, coinsurance</b> and OOPM apply to all tiers when ER visit results in admission. Applicable in or out-of-network <b>deductible, coinsurance and OOPM</b> will apply to non-emergency use of the emergency room. |
|   | <a href="#">Emergency medical transportation</a>                         | 0% after \$100 <b>copay</b>   | 0% after \$100 <b>copay</b>   | —————none—————  |
|   | Facility <a href="#">Urgent care</a><br>Prof <a href="#">Urgent care</a> | 20% after in-network <b>deductible</b> for both Facility and Professional Urgent Cares  | Not covered<br>Not covered  | —————none—————  |
| If you have a hospital stay             | Facility fee (e.g., hospital room)                                       | 20% after <b>deductible</b>   | Not covered   | Unlimited days.   |

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www/bcbsm.com](http://www/bcbsm.com).]

| Common Medical Event   | Services You May Need                     | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|--|---|---|---|--|
|  |   | In-Network Providers<br>(You will pay the least)  | Out-of-Network Providers<br>(You will pay the most) |  |
|  | Physician/surgeon fees                    | 20% after <b>deductible</b>   | Not covered   | —————none—————   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | 20% after <b>deductible</b>   | Not covered   | —————none—————   |
|  | Inpatient services                        | 20% after <b>deductible</b>   | Not covered   | —————none—————   |
| <b>If you are pregnant</b>   | Office visits                             | Initial visit to determine pregnancy 20% after <b>deductible</b> , then no charge, <b>deductible</b> waived for additional visits | Not covered   | —————none—————   |
|  | Childbirth/delivery professional services | 20% after <b>deductible</b>   | Not covered   | —————none—————   |
|  | Childbirth/delivery facility services     | 20% after <b>deductible</b>   | Not covered   | —————none—————   |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | 20% after <b>deductible</b>   | Not covered   | 120 maximum visits per member per calendar year.   |
|  | <a href="#">Rehabilitation services</a>   | 20% after <b>deductible</b>   | Not covered   | 60 maximum visits per member, per therapy, per calendar year.  |
|  | <a href="#">Habilitation services</a>     | 20% after <b>deductible</b>   | Not covered   | 60 maximum visits per member per calendar year all therapies combined. Pre-certification required. No coverage out-of-network except for autism diagnosis 40% after deductible |
|  | <a href="#">Skilled nursing care</a>      | 20% after <b>deductible</b>   | Not covered   | 120 maximum days per member per calendar year.   |
|  | <a href="#">Durable medical equipment</a> | 20% after <b>deductible</b>   | Not covered   | —————none—————   |
|  | <a href="#">Hospice services</a>          | 0%, <b>deductible</b> waived  | Not covered   | Unlimited days.  |
| <b>If your child needs dental or eye care</b>                                    | 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—————   |

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www/bcbsm.com](http://www/bcbsm.com).]

## 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](#).)

- |   |   |   |
|---|---|---|
| <ul style="list-style-type: none"><li>• Children's dental check-up</li><li>• Children's eye exam</li><li>• Children's glasses</li></ul> | <ul style="list-style-type: none"><li>• Cosmetic surgery</li><li>• Dental care (adult)</li><li>• Hearing aids</li><li>• Infertility treatment</li></ul> | <ul style="list-style-type: none"><li>• Long-term care</li><li>• Non-emergency care when traveling outside U.S.</li><li>• Routine eye care (adult)</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul> |
|---|---|---|

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"><li>• Bariatric surgery</li><li>• Telehealth/Telemedicine</li></ul> | <ul style="list-style-type: none"><li>• Private-duty nursing</li></ul> | <ul style="list-style-type: none"><li>• Chiropractic care (20 max visits per calendar yr)</li></ul> |
|---|--|---|

**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: 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or you may contact the plan at 1-866-917-7537. 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](http://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: [www.BCBSM.com](http://www.BCBSM.com) or call 1-866-917-7537.

### 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 1-866-917-7537.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-917-7537.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-917-7537.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-917-7537.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1150 |
| ■ Primary copay/Specialist copay                                | 20%    |
| ■ <b>Hospital (facility)</b> coinsurance                        | 20%    |
| ■ <b>Other</b> coinsurance                                      | 20%    |

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$12700</b> |
|---------------------------|----------------|

In this example, Peg would pay:

|                                   |               |
|-----------------------------------|---------------|
| <i>Cost Sharing</i>               |               |
| <a href="#">Deductibles</a>       | \$1150        |
| <a href="#">Copayments</a>        | \$0           |
| <a href="#">Coinsurance</a>       | \$2286        |
| <i>What isn't covered</i>         |               |
| Limits or exclusions              | \$61          |
| <b>The total Peg would pay is</b> | <b>\$3497</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|   |        |
|---|--------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1150 |
| ■ Primary copay/Specialist Copay                                | 20%    |
| ■ <b>Hospital (facility)</b> coinsurance                        | 20%    |
| ■ <b>Other</b>  | 20%    |

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*)

|                           |               |
|---------------------------|---------------|
| <b>Total Example Cost</b> | <b>\$5600</b> |
|---------------------------|---------------|

In this example, Joe would pay:

|                                   |               |
|-----------------------------------|---------------|
| <i>Cost Sharing</i>               |               |
| <a href="#">Deductibles</a>       | \$1150        |
| <a href="#">Copayments</a>        | \$0           |
| <a href="#">Coinsurance</a>       | \$1133        |
| <i>What isn't covered</i>         |               |
| Limits or exclusions              | \$22          |
| <b>The total Joe would pay is</b> | <b>\$2305</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|   |        |
|---|--------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1150 |
| ■ Primary copay/Specialist copay                                | 20%    |
| ■ <b>Hospital (facility)</b> cost sharing                       | 20%    |
| ■ <b>Other</b> [ <a href="#">cost sharing</a> ]                 | 20%    |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |               |
|---------------------------|---------------|
| <b>Total Example Cost</b> | <b>\$2800</b> |
|---------------------------|---------------|

In this example, Mia would pay:

|                                   |               |
|-----------------------------------|---------------|
| <i>Cost Sharing</i>               |               |
| <a href="#">Deductibles</a>       | \$1150        |
| <a href="#">Copayments</a>        | \$200         |
| <a href="#">Coinsurance</a>       | \$101         |
| <i>What isn't covered</i>         |               |
| Limits or exclusions              | \$0           |
| <b>The total Mia would pay is</b> | <b>\$1451</b> |

Note: If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), you may have access to additional funds to help cover certain out-of-pocket expenses like the deductible, copays, or coinsurance, or benefits not otherwise covered.