



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. 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 <u>deductible</u> ?	In-Network: \$1,250 per member; \$2,500 per family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services (in-network only) are covered before you meet your <u>deductible</u> .	This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this plan ?	In-Network: \$4,000 per member; \$8,000 per family	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , balance-billed charges, penalties for failure to obtain <u>pre-authorization</u> for services and healthcare the plan does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes, see www.bcbsm.com or call 1-866-917-7537 for a list of network providers.	You pay the least if you use an in-network <u>provider</u> . You pay more if you use an in-network <u>provider</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 (You will pay the least)	Out-of-Network Providers (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 deductible	Not covered	_____none_____
	Specialist visit	20% after deductible	Not covered	_____none_____
	Preventive care/screening/immunization	0%, deductible waived	Not covered	Age and frequency limits may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% after deductible	Not covered	_____none_____
	Imaging (CT/PET scans, MRIs)	20% after deductible	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 More information about prescription drug coverage is available at www.Optumrx.com	Generic drugs	Retail/Mail Order: 34-day supply - \$10 copay ; RHM owned pharmacies: 34-day supply - \$8 copay *; RHM owned pharmacies: 90-day supply - \$24 copay *; Mail Order: 90-day supply - \$25 copay	Retail/Mail Order: 34-day supply - \$10 copay ; RHM owned pharmacies: 34-day supply - \$8 copay *; RHM owned pharmacies: 90-day supply - \$24 copay *; Mail Order: 90-day supply - \$25 copay	No contraceptive coverage. Step therapy program may apply. *Inclusive of colleague discount. Copays & Coinsurance applies to the in-network OOPM.
	Preferred brand drugs	Retail/Mail Order - 34-day supply: 25% with \$30 min and \$100 max; RHM owned pharmacies - 34-day supply: 20% with \$24 min and \$80 max*; RHM owned pharmacies - 90-day supply: 20% with \$72 min and \$240 max*; Mail Order - 90-day supply: 25% with \$75 min and \$250 max	Retail/Mail Order - 34-day supply: 25% with \$30 min and \$100 max; RHM owned pharmacies - 34-day supply: 20% with \$24 min and \$80 max*; RHM owned pharmacies - 90-day supply: 20% with \$72 min and \$240 max*; Mail Order - 90-day supply: 25% with \$75 min and \$250 max	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. Copays & Coinsurance applies to the in-network OOPM.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
	Non-preferred brand drugs	Retail/Mail Order - 34-day supply: 50% with \$60 min and \$170 max; RHM owned pharmacies - 34-day supply: 40% with \$48 min and \$136 max*; RHM owned pharmacies - 90-day supply: 40% with \$144 min and \$408 max*; Mail Order - 90-day supply: 50% with \$150 min and \$425 max	Retail/Mail Order - 34-day supply: 50% with \$60 min and \$170 max; RHM owned pharmacies - 34-day supply: 40% with \$48 min and \$136 max*; RHM owned pharmacies - 90-day supply: 40% with \$144 min and \$408 max*; Mail Order - 90-day supply: 50% with \$150 min and \$425 max	No contraceptive coverage. Step therapy program may apply. *Inclusive of colleague discounts. Copays & Coinsurance applies to their-network OOPM.
	Specialty drugs	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. Copays & Coinsurance applies to the in-network OOPM.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 copay then 20% after deductible	Not covered	—————none—————
	Physician/surgeon fees	20% after deductible	Not covered	—————none—————
If you need immediate medical attention	Emergency room care	0% after \$200 copay	0% after \$200 copay	Copay waived if admitted. deductible, coinsurance and OOPM apply to both when ER visit results in admission. Applicable in-network or out-of-network deductible, coinsurance and OOPM will apply to non-emergency use of the emergency room.
	Emergency medical transportation	0% after \$100 copay	0% after \$100 copay	—————none—————
	Facility Urgent care Prof Urgent care	20% after in-network deductible for both Facility and Professional based Urgent Cares	Not covered	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible	Not covered	Unlimited days.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
	Physician/surgeon fees	20% after deductible	Not covered	_____none_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% after deductible	Not covered	_____none_____
	Inpatient services	20% after deductible	Not covered	_____none_____
If you are pregnant	Office visits	Initial visit to determine pregnancy 20% after deductible , then no charge, deductible waived for additional visits	Not covered	_____none_____
	Childbirth/delivery professional services	20% after deductible	Not covered	_____none_____
	Childbirth/delivery facility services	20% after deductible	Not covered	_____none_____
If you need help recovering or have other special health needs	Home health care	20% after deductible	Not covered	120 maximum visits per member per calendar year.
	Rehabilitation services	20% after deductible	Not covered	60 maximum visits per member, per therapy, per calendar year (no visit limit for behavioral health and substance use disorder diagnosis).
	Habilitation services	20% after deductible	Not Covered	60 maximum visits per member per calendar year all therapies combined (no visit limit for behavioral health and substance use disorder diagnosis). Pre-certification required.
	Skilled nursing care	20% after deductible	Not covered	120 maximum days per member per calendar year.
	Durable medical equipment	20% after deductible	Not covered	_____none_____
	Hospice services	0%, deductible waived	Not covered	Unlimited days.
If your child needs dental or eye care	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_____

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](#).)

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|------------------------------|-------------------------|--|
| • Children's dental check-up | • Cosmetic surgery | • Long-term care |
| • Children's eye exam | • Dental care (adult) | • Non-emergency care when traveling outside U.S. |
| • Children's glasses | • Hearing aids | • Routine eye care (adult) |
| | • Infertility treatment | • 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.)

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|---------------------------|------------------------|---|
| • Bariatric surgery | • Private-duty nursing | • Chiropractic care (20 max visits per calendar yr) |
| • Telehealth/Telemedicine | | |

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 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 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 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 plan's overall deductible	\$1250
■ Primary copay/Specialist copay	20%
■ Hospital (facility) coinsurance	20%
■ Other 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*)

Total Example Cost	\$12700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1250
Copayments	\$0
Coinsurance	\$2286
<i>What isn't covered</i>	
Limits or exclusions	\$61
The total Peg would pay is	\$3599

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1250
■ Primary copay/Specialist Copay	20%
■ Hospital (facility) coinsurance	20%
■ Other	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*)

Total Example Cost	\$5600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1250
Copayments	\$0
Coinsurance	\$1133
<i>What isn't covered</i>	
Limits or exclusions	\$22
The total Joe would pay is	\$2405

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1250
■ Primary copay/Specialist copay	20%
■ Hospital (facility) cost sharing	20%
■ Other [cost sharing]	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*)

Total Example Cost	\$2800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1250
Copayments	\$200
Coinsurance	\$1001
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1551

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.