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 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 deductible?	In Network: $1,750 per member; $3,500 per family (One family member may meet the full family deductible)	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes. **Preventive care** services (In-Network only) are covered before you meet your **deductible**.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost sharing** and before you meet your **deductible.** See a list of covered **preventive services** at **https://www.healthcare.gov/coverage/preventive-care-benefits/.**
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: $3,100 per member; $6,200 per family Out-of-Network: $7,000 per member; $14,000 per family (For family coverage, the noted per member out-of-pocket limits do not apply. Instead, the out-of-pocket limit for any single member is $8,500. Additionally, all members on the contract can contribute to the family out of pocket maximum.)	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?	**Premiums**, balance-billed charges, penalties for failure to obtain **pre-authorization** for services and healthcare the **plan** does not 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 1-866-917-7537 for a list of network providers.	You pay the least if you use an In-Network **provider**. You pay more if you use an Out-of-Network **provider**. 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?	No	You can see the **specialist** you choose without a **referral**.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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	10% after **deductible**	Not covered	——————none——————
	Specialist visit	10% 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)	10% after **deductible**	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	10% 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 (34-90 day supply) 20% after deductible, RHM owned pharmacies (34 to 90-day supply) 16% after **deductible**.	Retail/Mail Order (34-90 day supply) 20% after deductible, RHM owned pharmacies (34 to 90-day supply) 16% after **deductible**.	Certain generic preventive drugs are covered at 100%. No contraceptive coverage. Step therapy program applies. Colleague discounts may apply when prescriptions filled at Trinity Health on-site pharmacies. **Deductible** and OOPM based on In-Network benefit level
	Preferred brand drugs	Retail/Mail Order (34-90 day supply) 20% after deductible, RHM owned pharmacies (34 to 90-day supply) 16% after **deductible**.	Retail/Mail Order (34-90 day supply) 20% after deductible, RHM owned pharmacies (34 to 90-day supply) 16% after **deductible**.	Certain generic preventive drugs are covered at 100%. No contraceptive coverage. Step therapy program applies. Colleague discounts may apply when prescriptions filled at Trinity Health on-site pharmacies. **Deductible** and OOPM based on In-Network benefit level
	Non-preferred brand drugs	Retail/Mail Order (34-90 day supply) 20% after deductible, RHM owned pharmacies (34 to 90-day supply) 16% after **deductible**.	Retail/Mail Order (34-90 day supply) 20% after deductible, RHM owned pharmacies (34 to 90-day supply) 16% after **deductible**.	Certain generic preventive drugs are covered at 100%. No contraceptive coverage. Step therapy program applies. Colleague discounts may apply when prescriptions filled at Trinity Health on-site pharmacies. **Deductible** and OOPM based on In-Network benefit level

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)	
	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 are limited to a 30-day supply. Step therapy program may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% after **deductible**	Not covered	——————none——————
	Physician/surgeon fees	10% after **deductible**	Not covered	——————none——————
If you need immediate medical attention	Emergency room care	10% after In-Network **deductible**	10% after In-Network **deductible**	In-Network **deductible**, coinsurance and OOPM apply to all networks 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	10% after In--Network **deductible**	10% after In-Network **deductible**	. ——————none——————
	Facility Urgent care Prof Urgent care	10% 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)	10% after **deductible**	Not covered	Unlimited days.
	Physician/surgeon fees	10% after **deductible**	Not covered	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% after **deductible**	Not covered	——————none——————
	Inpatient services	10% after **deductible**	Not covered	——————none——————
If you are pregnant	Office visits	Initial visit to determine pregnancy 10% after **deductible**, then no charge, **deductible** waived for additional visits	Not covered	——————none——————
	Childbirth/delivery professional services	10% after **deductible**	Not covered	——————none——————
	Childbirth/delivery facility services	10% after **deductible**	Not covered	——————none——————

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 need help recovering or have other special health needs	Home health care	10% after **deductible**	Not covered	120 maximum visits per member per calendar year.
	Rehabilitation services	10% after **deductible**	Not covered	60 maximum visits per member, per therapy, per calendar year (no visit limit for behavioral health/substance use disorder diagnosis).
	Habilitation services	10% after **deductible**	Not covered	60 maximum visits per member per calendar year all therapies combined (no visit limit for behavioral health/substance use disorder diagnosis).
	Skilled nursing care	10% after **deductible**	Not covered	120 maximum days per member per calendar year.
	Durable medical equipment	10% after **deductible**	Not covered	————————none————————
	Hospice services	0%, after **deductible**	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.)

- Children's dental check-up
- Children's eye exam
- Children's glasses
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside U.S.
- 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
- Telehealth/Telemedicine
- Private-duty nursing
- Chiropractic care (20 max visits per calendar yr)

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.

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

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, kwiijigo 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	**$1,750**
Primary copay/Specialist copay	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1750
Copayments	$0
Coinsurance	$1092
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$2903**

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

The plan's overall deductible	**$1,750**
Primary copay/Specialist Copay	**10%**
Hospital (facility) coinsurance	**10%**
Other	**10%**

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	**$5400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1750
Copayments	$0
Coinsurance	$524
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$2296**

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

The plan's overall deductible	**$1750**
Primary copay/Specialist copay	**10%**
Hospital (facility) cost sharing	**10%**
Other *[cost sharing]*	**10%**

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	**$1925**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1750
Copayments	$0
Coinsurance	$28
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1778**

Note: If you are also covered by an account-type plan such a health savings account (HSA), 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.