**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 deductible?** | IN-Network: $1,250 per member; $2,500 per family | 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: $4,000 per member; $8,000 per family | 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 am 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**. |

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 out-of-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 | 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 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. In-network **deductible, coinsurance** and OOPM apply to all tiers when ER visit results in admission. Applicable in 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 | 20% after in-network **deductible** fo | Not covered | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% after **deductible** | Not covered | Unlimited days. |
| | Physician/surgeon fees | 20% after **deductible** | Not covered | ——————none—————— |
| **If you need mental** | Outpatient services | 20% after **deductible** | Not covered | ——————none—————— |

[* 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) | |
| **health, behavioral health, or substance abuse services** | Inpatient services | 20% after **deductible** | Not covered | ————none———— |
| **If you are pregnant** | Office visits | 0%, waived | 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 (PT, OT, Speech Therapy) | 20% 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 (PT, OT, Speech Therapy) | 20% 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). 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.)** | |
|---|---|
| • Cosmetic surgery | • Long-term care |

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

| 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 | • Dental care (adult) | • Non-emergency care when traveling outside U.S. |
| • Children's eye exam | • Hearing aids | • Routine eye care (adult) |
| • Children's glasses | • 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.) | | |
|---|---|---|
| • 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, 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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[* For more information about limitations and exceptions, see the plan or policy document at www/bcbsm.com.]

## 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** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1250 |
| Copayments | $0 |
| Coinsurance | $2286 |
| *What isn't covered* | |
| Limits or exclusions | $61 |
| **The total Peg would pay is** | **$3597** |

### 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** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1250 |
| Copayments | $0 |
| Coinsurance | $1133 |
| *What isn't covered* | |
| 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** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1250 |
| Copayments | $200 |
| Coinsurance | $101 |
| *What isn't covered* | |
| 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.