



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: \$500 per member; \$1000 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: \$3,000 per member; \$6,000 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 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 .

 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 copay	Not covered	_____none_____
	Specialist visit	\$30 copay	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 - 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 - 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.
	Preferred brand drugs	Retail/Mail Order - 34-day supply: 20% with \$30 min and \$100 max; RHM owned pharmacies - 34-day supply: 16% with \$24 min and \$80 max*; RHM owned pharmacies - 90-day supply: 16% with \$72 min and \$240 max*; Mail Order - 90-day supply: 20% with \$75 min and \$250 max	Retail/Mail Order - 34-day supply: 20% with \$30 min and \$100 max; RHM owned pharmacies - 34-day supply: 16% with \$24 min and \$80 max*; RHM owned pharmacies - 90-day supply: 16% with \$72 min and \$140 max*; Mail Order - 90-day supply: 20% with \$75 min and \$250 max	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 No contraceptive coverage. Step therapy program may apply. *Inclusive of colleague discount.
	Non-preferred brand drugs	Retail/Mail Order - 34-day supply: 40% with \$60 min	Retail/Mail Order - 34-day supply: 40% with \$60 min	Min/Max reduced by 50% for asthma and diabetes. No contraceptive coverage. Step therapy program may apply.

[* 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)	
		and \$150 max; RHM owned pharmacies - 34-day supply: 32% with \$48 min and \$120 max*; RHM owned pharmacies - 90-day supply: 32% with \$144 min and \$360 max*; Mail Order - 90-day supply: 40% with \$150 min and \$375max	and \$150 max; RHM owned pharmacies - 34-day supply: 32% with \$48 min and \$120 max*; RHM owned pharmacies - 90-day supply: 32% with \$144 min and \$360 max*; Mail Order - 90-day supply: 40% with \$150 min and \$375 max	*Inclusive of colleague discount.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 copay then 10% after deductible	Not covered	_____none_____
	Physician/surgeon fees	10% 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 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	0% after \$100 copay	0% after \$100 copay	_____none_____
	Facility Urgent care	\$35 copay	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	\$20 copay	Not covered	_____none_____
	Inpatient services	10% after deductible	Not covered	_____none_____
If you are pregnant	Office visits	0%, deductible waived	Not covered	_____none_____
	Childbirth/delivery professional services	10% after deductible	Not covered	_____none_____
	Childbirth/delivery facility services	10% after deductible	Not covered	_____none_____
If you need help	Home health care	10% after deductible	Not covered	120 maximum visits per member per calendar year.

[* 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)	
recovering or have other special health needs	Rehabilitation services (PT, OT & Speech Therapy)	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 (PT, OT & Speech Therapy)	10% after deductible	Not covered	60 maximum visits per member per calendar year all therapies combined (no visit limits for behavioral health/substance use disorder diagnosis). Precertification required.
	Skilled nursing care	10% after deductible	Not covered	120 maximum days per member per calendar year.
	Durable medical equipment	10% after deductible	Not covered	
	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 .)			
- 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.

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: 1-866-917-7537 or visit www.Preferredhealthchoices.com.

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, kwijijigo 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	\$500
■ Primary copay/Specialist copay	\$20/\$30
■ 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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$38
Coinsurance	\$954
What isn't covered	
Limits or exclusions	\$61
The total Peg would pay is	\$1553

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$500
■ Primary copay/Specialist Copay	\$20/\$30
■ 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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$120
Coinsurance	\$289
What isn't covered	
Limits or exclusions	\$22
The total Joe would pay is	\$931

Mia's Simple Fracture

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

■ The plan's overall deductible	500
■ Primary copay/Specialist copay	\$20/\$30
■ 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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$464
Copayments	\$330
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$794

Note: If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA) then 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.