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, 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 http://www.dol.gov/ebsa/healthreform or call 866-917-7537 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Tier 1: $1,500 per member/$3,000 per family; Tier 2: $2,500 per member; $5,000 per family; Tier 3: $3,500 per member; $7,000 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 policy, the overall family **deductible** must be met before the **plan** begins to pay.
Are there services covered before you meet your deductible?	Yes. **Preventive care** services (Tier 1 and Tier 2 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?	Tier 1: $2,600 per member; $5,200 per family; Tier 2: $5,000 per member; $10,000 per family; Tier 3: $7,000 per member; $14,000 per family All members on the contract can contribute to the family out of pocket maximum; however, a single member will not exceed the individual IRS maximum of $7,900 for Tier 2.	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**, the overall family **out-of-pocket limit** must be 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 866-917-7537 for a list of network providers.	You pay the least if you use a **provider** in Tier 1. You pay more if you use a **provider** in Tier 2. 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
		Tier 1 Provider (You will pay the least)	Tier 2 Provider	Tier 3 Provider (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**	20% after **deductible**	40% after **deductible**	——none——
	Specialist visit	10% after **deductible**	20% after **deductible**	40% after **deductible**	——none——
	Preventive care/**screening**/ immunization	0%; **deductible** waived	0%; **deductible** waived	40% after **deductible**	Age and frequency limits may apply.
If you have a test	**Diagnostic test** (x-ray, blood work)	10% after **deductible**	20% after **deductible**	40% after **deductible**	——none——
	Imaging (CT/PET scans, MRIs)	10% after **deductible**	20% after **deductible**	40% after **deductible**	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.caremark.com.	Generic drugs	Retail (34-day supply), RHM owned pharmacies (34- and 90-day supply) and Mail Order (90-day supply): 20% after **deductible**	Retail (34-day supply), RHM owned pharmacies (34- and 90-day supply) and Mail Order (90-day supply): 20% after **deductible**	Retail (34-day supply), RHM owned pharmacies (34- and 90-day supply) and Mail Order (90-day supply): 20% 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 Tier 1 benefit level.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider	Tier 3 Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Preferred brand drugs	Retail (34-day supply), RHM owned pharmacies (34- and 90-day supply) and Mail Order (90-day supply) 20% after **deductible**.	Retail (34-day supply), RHM owned pharmacies (34- and 90-day supply) and Mail Order (90-day supply) 20% after **deductible**.	Retail (34-day supply), RHM owned pharmacies (34- and 90-day supply) and Mail Order (90-day supply) 20% 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 Tier 1 benefit level.
	Non-preferred brand drugs	Retail (34-day supply), RHM owned pharmacies (34- and 90-day supply) and Mail Order (90-day supply) 20% after **deductible**.	Retail (34-day supply), RHM owned pharmacies (34- and 90-day supply) and Mail Order (90-day supply) 20% after **deductible**.	Retail (34-day supply), RHM owned pharmacies (34- and 90-day supply) and Mail Order (90-day supply) 20% 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 Tier 1 benefit level.
	Specialty drugs	Same as Non-preferred brand drugs	Same as Non-preferred brand drugs	Not Covered	Specialty medications must be filled at a Trinity Health pharmacy or through the CVS Caremark Specialty program. Specialty drug prescriptions limited to a 30-day supply. Step therapy program applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider	Tier 3 Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% after **deductible**	$100 **copay**, then 20% after **deductible**	$200 **copay**, then 40% after **deductible**	none
	Physician/surgeon fees	10% after **deductible**	20% after **deductible**	40% after **deductible**	none
If you need immediate medical attention	**Emergency room care**	10% after tier 1 **deductible**	10% after tier 1 **deductible**	10% after tier 1 **deductible**	Tier 1 **deductible**, **coinsurance** and OOPM apply to all tiers when ER visit results in admission. Applicable tier **deductible**, **coinsurance** and OOPM will apply to non-emergency use of the emergency room.
	Emergency medical transportation	10% after tier 1 **deductible**	10% after tier 1 **deductible**	10% after tier 1 **deductible**	Tier 1 **deductible**, **coinsurance** and OOPM apply to all tiers.
	Urgent care	10% after tier 1 **deductible**	10% after tier 1 **deductible**	10% after tier 1 **deductible**	Tier 1 **deductible**, **coinsurance** and OOPM apply to all tiers.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% after **deductible**	$500 **copay**, then 20% after **deductible**	$1,000 **copay**, then 40% after **deductible**	Unlimited days.
	Physician/surgeon fee	10% after **deductible**	20% after **deductible**	40% after **deductible**	none
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% after **deductible**	10% after **deductible***	40% after **deductible**	*Tier 1 **deductible**, **coinsurance** and OOPM apply when Tier 2 **providers** are used.
	Inpatient services	10% after **deductible**	10% after **deductible***	$1,000 **copay**, then 40% after **deductible**	*Tier 1 **deductible**, **coinsurance** and OOPM apply when Tier 2 **providers** are used.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider	Tier 3 Provider (You will pay the most)	
If you are pregnant	Office visits	Initial visit to determine pregnancy 10% after **deductible**, then no charge, **deductible** waived for additional visits	Initial visit to determine pregnancy 20% after **deductible**, then no charge, **deductible** waived for additional visits	40% after **deductible** per visit	none
	Childbirth/delivery professional services	10% after **deductible**	20% after **deductible**	40% after **deductible**	none
	Childbirth/delivery facility services	10% after **deductible**	$500 **copay**, then 20% after **deductible**	$1,000 **copay**, then 40% after **deductible**	none
If you need help recovering or have other special health needs	**Home health care**	10% after **deductible**	20% after **deductible**	40% after **deductible**	120 maximum visits per member per calendar year.
	Rehabilitation services	10% after **deductible**	20% after **deductible**	40% after **deductible**	60 maximum visits per member, per therapy, per calendar year.
	Habilitation services	10% after **deductible**	20% after **deductible**	40% after **deductible**	60 maximum visits per member per calendar year all therapies combined. Pre-certification required. No coverage under Tier 3 except for autism diagnosis.
	Skilled nursing care	10% after **deductible**	$500 **copay**, then 20% after **deductible**	$1,000 **copay**, then 40% after **deductible**	120 maximum days per member per calendar year.
	Durable medical equipment	10% after **deductible**	10% after **deductible**	40% after **deductible**	Tier 1 **deductible**, **coinsurance** and OOPM apply when Tier 2 DME **providers** are used.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider	Tier 3 Provider (You will pay the most)	
If you need help recovering or have other special health needs	**Hospice services**	0% after **deductible**	0% after **deductible**	40% after **deductible**	none
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	none
	Children's glasses	Not Covered	Not Covered	Not Covered	none
	Children's dental check-up	Not Covered	Not Covered	Not Covered	none

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- 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 the 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
- Chiropractic care (20 visit maximum per calendar year)
- Private-duty nursing

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 1-877-502-6272. 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 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: Blue Cross and Blue Shield Association, at 1-866-917-7537.

Does this Coverage Provide Minimum Essential Coverage? Yes.
If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? 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 page.

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	**$1500**
Specialist coinsurance	**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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,660**

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

The plan's overall deductible	**$1500**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,660**

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

The plan's overall deductible	**$1500**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,540**

The plan would be responsible for the other costs of these EXAMPLE covered services.