INSURANCE COMPANY: **RETAILERS EMPLOYEES BENEFIT TRUST (REBT)** Coverage Period: 1/1/2016 - 12/31/2016

PLAN: **BASE PLAN Plus MAJOR MEDICAL**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for**: Individual + Spouse / **Plan Type**: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan document at www.ifraonline.com or by calling 248-356-1682.

Important Questions	Answers	Why this Matters:
What is the overall deductible:	**None - Level 1** See Level 2 below.	You are not responsible to meet an overall deductible for covered services until you reach LEVEL 2.. See the chart starting on page 2 for how much you pay for covered services. **Maximum Level 1 (Basic)** benefits combined is estimated at $20,000/calendar year. Then a major medical deductible applies.
Are there other deductibles for specific services?	Major Medical **(Level 2)** **$8,000** per family	After Level 1: as Basic benefits reach their maximums, excess charges are applied to the Major Medical Deductible. NOTE: Dental (a $50 annual deductible) and vision coverages are free-standing and optional. If individuals do not elect dental or vision, there is no dental or vision provided.
Is there an out-of-pocket limit on my expenses?	Yes, **$12,000** per family (deductible and co-insurance) but excluding Base level co-pays. The Plan will pay 60% co-insurance for medical/ prescription benefits for the remainder of the year up to the out-of-pocket maximum, after which the Plan pays 100%	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. Coinsurance is what the Plan pays after you satisfy the Major Medical Deductible.
What is not included in the out-of-pocket limit?	Premium, balance billed charges, health care this plan does not cover office visit copays.	Even though you pay these expenses, they don't limit your annual out-of-pocket. This Plan is designed to cover an average year of medical expenses. It may not cover the full cost of a major illness or injury.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. Cofinity. See www.cofinity.net for participating providers or call 1-248-356-1682. **Most benefits are only available in Network. The only benefit available out-of-network is emergency care as described on page 3.**	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your Summary Plan Document ("SPD") for additional information about excluded services.

Questions: Call 1-248-356-1682 or visit us at www.ifraonline.com.If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.ifraonline.com or call 1-248-356-1682.

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. This Plan is designed to cover 90% of a calendar year's basic medical/prescription expense and 65% of the expenses of a Covered Person's major illness/injury. It may not cover the full cost of a major Illness or Injury but your out-of-pocket is limited to $12,000 of covered benefits for all family members combined, annually. For example: Allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 40% would be $400. This may change if you haven't met your deductible.
- The amount the plan pays for covered Network services is based on the allowed amount. If a network provider charges more than the allowed amount, you do not have to pay the difference. For example, if network hospital charges, $1,500 for an overnight stay and the allowed amount is $1,000, you do not have to pay the $500 difference. (This is called balance billing).
- This plan may encourage you to use participating providers by charging you lower deductibles, co-payments and co-insurance amounts**. Most Plan benefits are available only IN- NETWORK** so refer to your Network directory before scheduling appointments. Only emergency services from a Non-Network provider are covered so it is important to know your providers are in the Cofinity Network..

Common Medical Event	Services You May Need	Your cost if You Use A Participating Provider		Covered At Non-Network Provider?	Limits & Exclusions
		LEVEL 1/Base	**LEVEL 2/Major Medical**		
If you visit a health care provider's office or clinic. Physician visits: • Illness • Injury • Mental Health • Substance Abuses • Annual Wellness Checkup • Newborn & Infant Visits • Prenatal and postnatal care • Urgent Care Facility	Primary care visit to treat an injury or illness	$15 co-pay/visit to $1,000/year	Deductible & 40% co-insurance	No	
	Specialist visit	$15 co-pay/visit to $1,000/year	Deductible & 40% co-insurance	No	
	Other practitioner office visit	$15 co-pay/visit to $1,000/year	Deductible & 40% co-insurance	No	
	Preventive care/screening/immunization Mammography screening (see Preventive tests below also)	$15 co-pay/visit	Deductible & 40% coinsurance waived	No	1 annual visit per person, including covered tests.
If you have a test	Preventive screening test	Nothing	Deductible and 40% coinsurance waived	No	Mammograph screening for employee & spouse: 1 Screening between ages 35-40 and 1 annually at age 40 and thereafter.
	Diagnostic test (x-ray, blood work)				
	Imaging (CT/PET scans, MRIs) $50 co-pay on radiology testing/ $10 co-pay				All diagnostic test combined to a calendar year max of $1,000/person

Common Medical Event	Service You May Need	**Your Cost** If You Use A Participating Provider		Covered At Non-Network Provider?	Limits & Exclusions
		LEVEL 1, Basic, **No Deductible applies**	LEVEL 2 Major Medical **after MM Deductible**		
If you need drugs to treat your illness or condition	Generic, Brand or Non-Preferred Mail order	No copays for the first $250 of covered retail prescriptions No mail order program	40% reimbursed No mail order program	Does not apply to Prescription Drugs	You pay for your prescriptions and send the receipts in for reimbursement. Drug must be named as covered in the CareMark formulary. When coordinating with Medicare, Plan pays first for active employees/dependents.
If you have surgery	Anesthesiologist Physician/Surgeon	No cost up to the first $1,000 of All Other covered benefits combined. "All Other" services on page 4.	40% Coinsurance	No Coverage	All Other benefits include: Surgery, Physical, Speech and Occupational therapy, home health care, blood chemotherapy Hospice Durable Medical Equipment, blood and jaw treatment.
If you have an emergency	Emergency room service Emergency medical transportation (ambulance)	$50 copay/visit up to $1,000 for all covered emergency room and ambulance charges combined.	40% Coinsurance	Covered the same as In-Network	An emergency at a non-participating hospital may also require treatment that is not covered because it is not an ER room or ambulance charge.
	Urgent Care Center	See Physician Visits		No Coverage	
If You Have a Hospital Stay?	Semi-private Room and board and related treatment in a Hospital, Skilled Nursing Center, Burn Units, Intensive Care, Ambulatory Surgical Centers, etc.	$50 copay/stay Up to 5 days/calendar year, limited to $3,000/day.	40% Coinsurance	No Coverage	Balance of Basic (Level 1) charges are applied to Major Medical, Level 2 (as are all other Level 1 benefits)

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Common Medical Event	Service You May Need	**Your Cost** If You Use A Participating Provider		Covered at Nonparticipating Provider?	Limits & Exclusions
		LEVEL 1, Basic, **No Deductible applies**	LEVEL 2 Major Medical **after MM Deductible**		
If you have mental health, behavioral health or substance abuse needs	Outpatient Mental health or substance abuse treatment.	See Physician Visits	Deductible $ 40% coinsurance	No Coverage	Base coverage has maximums depending on the site of care, after which the Major Medical Deductible and o-insurance applies.
	In hospital Mental Health or Substance abuse treatment	See Hospital care	Deductible $ 40% coinsurance	No Coverage	
	Emergency Room treatment	See Emergency Benefits	Deductible $ 40% coinsurance	Covered as if In-Network	
If you are pregnant	Pre and post natal care; delivery and nursery care	See Physician Visits which cover pre & post-natal visits; See Hospital Care which covers In-hospital or birthing center care See Testing/Xray benefits which covers ultrasound and imaging tests	Deductible $ 40% coinsurance	No Coverage	
If you need help recovering or have other special health needs	Home Health Visits Rehab or therapy Blood Durable Medical Equipment Hospice Care Chemotherapy	No cost up to $1,000 for all treatment combined	Deductible $ 40% coinsurance	No Coverage	
If you or your covered child needs dental or eye care.	Eye Exams	$35 copay/visit	Does not apply to free-standing elected vision	Does not apply	One exam/year. You must elect Vision coverage
	Glasses	Balance after $50 contact lens; Balance after $30 all other lens; Balance after $40 for frames	Does not apply to free-standing elected vision	Does not apply	One pair of glasses/year if you have elected Vision
	Dental check-ups	No cost for exams. $50 Deductible for all other basic and major dental treatment, then, Basic treatment, you pay 20%; for Major; crowns, root canals and dentures you pay 50%	Does not apply to free-standing elected dental benefits	Does not apply	Free-standing Dental must be elected. Implants and braces are NOT covered

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Excluded Services & Other Services:

Services Your Plan Does NOT Cover (**This is not a complete list. Check your policy or plan document for other** excluded services.)

- Cosmetic surgery
- Dental Care (adult unless elected by employer)
- Infertility treatment
- Experimental Procedures
- Pre employment or physical not covered by Plan
- Injuries from automobiles or other motor craft and from any form equipment used in a business including farm equipment
- Claims submitted more than 365 days from date of service
- Certain drug, dental and vision benefits
- Acupuncture (if prescribed for rehabilitation purposes)
- Charges outside the scope of the provider's license
- Long term facility care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss and smoking cessation programs
- Outpatient family counseling
- Routine eye vision correction (adult unless elected by employer)
- Routine foot care
- Illness or injury covered by workers comp or
- Charges for more than usual and customary amounts

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Other Covered Services (**This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services**.)

- Bariatric surgery
- Outpatient hemodialysys
- Organ transplants
- Chiropractic care
- Hearing tests (not hearing aids)
- Infertility testing
- Most coverage provided Emergency services outside the United States. See www.infraonline.com

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Your Rights to Continue Coverage:

****Individual health insurance sample--**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 248-356-1682. You may also contact your state insurance department at Office of Insurance and Financial Regulation at 1-877-999-6442.

OR

****Group health coverage sample--**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay While covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 248-3556-1682. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Gail Edwards-Bryant, Plan Coordinator at 1-248-356-1682.

---------- *To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This Plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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About these Coverage Examples:

These examples show how this plan might cover medical are in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

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Having a baby (normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $7,415**
- **Patient pays $125**

Sample care costs:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:	
Deductibles	$0
Co-pays	$125
Co-insurance	$0
Limits or exclusions	$0
Total	**$125**

Managing Type II diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: $4,100**
- **Plan pays $3,040**
- **Patient pays $1,060**

Sample care costs:	
Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:	
Deductibles	$0
Co-pays	$470
Co-insurance	$0
Limits or exclusions	$590
Total	**$1,060**

Note: These numbers assume you elected prescription coverage

You can view the Glossary at www.ifraonline.com or call 1-248-356-1682.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples:

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

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What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles. Co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses:

No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to Accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.