This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at hr.umich.edu/benefits-wellness or by calling the SSC Contact Center at 1-866-647-7657.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network 1 providers: **$0** Network 2 providers: **$2,000** Individual / **$4,000** Family Does not apply to lab, preventive care, DME, and some select services.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$3,000** Individual / **$6,000** Family for Network 1 and 2 **providers** combined.	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. This limit helps you plan for health care expenses.
	A separate **out-of-pocket limit** applies only to prescription drug co-pays: **$2,500** Individual / **$5,000** Family	A separate annual **out-of-pocket limit** applies only to covered prescription drug co-pays and does not include infertility medications, product selection penalty, or any health plan co-pays or expenses such as doctor office visits.
What is not included in the out–of–pocket limit?	Co-pays that apply to the separate prescription drug **out-of-pocket limit,** premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. A separate annual **out-of-pocket limit** applies only to covered prescription drug co-pays as described above.
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. For a list of in-network providers, see www.BCBSM.com or calling the number on the back of your BCN ID card.	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 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. Written or oral approval is required.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may 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**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a:			Limitations & Exceptions
		Network 1 Provider	Network 2 Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-pay	Covered at 100% after deductible. Requires a referral from a Network 1 Provider.	Not covered	
	Specialist visit	$30 co-pay	Covered at 100% after deductible. Requires a referral from a Network 1 Provider.	Not covered	Referral required.
	Other practitioner office visit	Not covered	Not covered	Not covered	Acupuncture not covered. Chiropractic care is not covered.
	Preventive care/screening/ immunization	No charge	No charge	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Covered at 100% after deductible (see exceptions.) Requires a referral from a Network 1 Provider.	Not covered	May require prior authorization. Note: Deductible does not apply to some lab services when provided by a Network 2 provider. Check with plan.
	Imaging (CT/PET scans, MRIs)	No charge	Covered at 100% after deductible (see exceptions.) Requires a referral from a Network 1 Provider.	Not covered	May require prior authorization. Note: Deductible does not apply to some select services when provided by a Network 2 provider. Check with plan.

Common Medical Event	Services You May Need	Your Cost If You Use a:		Limitations & Exceptions
		Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition **NOTE: MedImpact Healthcare Systems, Inc. administers the University of Michigan Prescription Drug Plan. NoviXus Pharmacy Services administers mail order services.** More information about **prescription drug coverage** is available at hr.umich.edu/prescription-drug-plan.	Generic drugs	**Retail co-pay:** $10 (1-34 day supply) $20 (35-60 day supply) $30 (61-90 day supply) **Mail order co-pay:** $20 (61-90 day supply)	- You will have to pay the full cost of the drug and file a claim with MedImpact for reimbursement. - Claims must be filed within 90 days of fill. - Non-network reimbursement is limited to a 34-day supply. - You will be reimbursed based on the contracted price that a participating pharmacy would charge for the same drug, minus your co-pay amount.	- You may purchase up to 90 day supplies of medication from NoviXus mail order or a retail pharmacy. - Prescriptions cannot be refilled before 75% use. - Some drugs are subject to quantity limits. - Certain drugs and supplies are excluded from the plan or require prior authorization. - Coverage is available for a select list of self-administered fertility agents (oral and injectable) subject to a maximum of five prescription fills per eligible member per lifetime. - $0 co-pay for insulin and preventive medications in compliance with the Affordable Care Act. Listing available at: hr.umich.edu/zero-copay-drug-list.pdf
	Preferred brand drugs	**Retail co-pay:** $20 (1-34 day supply) $40 (35-60 day supply) $60 (61-90 day supply) **Mail order co-pay:** $40 (61-90 day supply)		
	Non-preferred brand drugs	**Retail co-pay:** $45 (1-34 day supply) $90 (35-60 day supply) $135 (61-90 day supply) **Mail order co-pay:** $90 (61-90 day supply)		
	Specialty drugs	Specialty drugs are limited to 34 day supplies subject to the 1-34 day retail co-pay level.	Medications on the U-M Formulary indicated as Specialty will only be covered when filled at a designated Specialty pharmacy.	Specialty drugs are limited to 34 day supplies. Exception: a 90-day supply is allowed for immunosuppressives subject to 61-90 day retail co-pay level.

Common Medical Event	Services You May Need	Your Cost If You Use a:			Limitations & Exceptions
		Network 1 Provider	Network 2 Provider	Out-of-Network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Covered at 100% after deductible. Requires a referral from a Network 1 Provider.	Not covered	May require prior authorization.
	Physician/surgeon fees	No charge	Covered at 100% after deductible. Requires a referral from a Network 1 Provider.	Not covered	May require prior authorization.
If you need immediate medical attention	Emergency room services	$100 co-pay	$100 co-pay	$100 co-pay	Co-pay waived if admitted.
	Emergency medical transportation	No charge	No charge	No charge	Non-emergency transport is not covered.
	Urgent care	$25 co-pay	$25 co-pay	$25 co-pay	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Covered at 100% after deductible. Requires a referral from a Network 1 Provider.	Not covered	Requires prior authorization; $1,000 co-pay for all fees associated with weight reduction procedure for Network 1 Providers. Weight reduction is not covered for Network 2 Providers.
	Physician/surgeon fee	No charge	Covered at 100% after deductible. Requires a referral from a Network 1 Provider.	Not covered	Same as Facility fee (e.g., hospital room) for hospital stay noted above.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 co-pay	Covered at 100% after deductible	Not covered	Requires prior authorization.
	Mental/Behavioral health inpatient services	No charge	Covered at 100% after deductible	Not covered	Requires prior authorization.
	Substance use disorder outpatient services	$25 co-pay	Covered at 100% after deductible	Not covered	Requires prior authorization.
	Substance use disorder inpatient services	No charge	Covered at 100% after deductible	Not covered	Requires prior authorization.

Common Medical Event	Services You May Need	Your Cost If You Use a:			Limitations & Exceptions
		Network 1 Provider	Network 2 Provider	Out-of-Network Provider	
If you are pregnant	Prenatal and postnatal care	No charge	Prenatal visit: No charge Postnatal visit: Covered at 100% after deductible and requires a referral from a Network 1 Provider.	Not covered	
	Delivery and all inpatient services	No charge	Covered at 100% after deductible. Requires a referral from a Network 1 Provider.	Not covered	Requires prior authorization.
If you need help recovering or have other special health needs	Home health care	No charge	Covered at 100% after deductible. Requires a referral from a Network 1 Provider.	Not covered	Services must be provided by a BCN participating home health care agency.
	Rehabilitation services	$25 co-pay/visit	Covered at 100% after deductible. Requires a referral from a Network 1 Provider.	Not covered	Requires prior authorization. Physical, Occupational, Speech therapy is limited to a combined maximum of 60 visits per member, per calendar year for Major Diagnoses; 15 visits per member, per calendar year for Minor Diagnoses.
	Habilitation services	$25 co-pay for physicians, Applied Behavioral Analysis (ABA), Physical, Occupational and Speech therapy	Covered at 100% after deductible for Applied Behavioral Analysis (ABA); Physical, Speech and Occupational Therapy. Requires a referral from a Network 1 Provider.	Not covered	Requires prior authorization. Treatment of Applied Behavioral Analysis (ABA) for Autism through age 18. ABA services not available outside of Michigan.
	Skilled nursing care	No charge	Covered at 100% after deductible. Requires a referral from a Network 1 Provider.	Not covered	Requires prior authorization. Limited to a maximum of 120 days per member per calendar year.

Common Medical Event	Services You May Need	Your Cost If You Use a:			Limitations & Exceptions
		Network 1 Provider	Network 2 Provider	Out-of-Network Provider	
	Durable medical equipment	No charge	Covered in full. Requires a referral from a Network 1 Provider.	Not covered	Requires prior authorization
	Hospice service	No charge	Covered at 100% after deductible, Requires a referral from a Network 1 Provider.	Not covered	Requires prior authorization.
If your child needs dental or eye care	Eye exam	No charge	Covered up to $40 per exam	Covered up to $40 per exam	Limited to one routine eye exam per calendar year.
	Glasses	Not covered	Not covered	Not covered	——————none——————
	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
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Glasses
- Long-term care
- Non emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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
- Habilitation
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

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 SSC Contact Center at 1-866-647-7657. 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.

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 Blue Care Network, a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association, by calling 1-800-658-8878.
- For questions about your rights, this notice or assistance about your prescription drug plan you can contact **MedImpact** at 1-800-681-9578.
- Or, you can contact Michigan Department of Insurance and Financial Services at https://www.michigan.gov/difs or 1-877-999-6442.
- Or, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-866-647-7657.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-647-7657.
如果需要中文的帮助，**请拨打这个号码**1-866-647-7657.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-647-7657.

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

About these Coverage Examples:

These examples show how this plan might cover medical care 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.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,450
- **Patient pays** $90

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
Copays	$60
Coinsurance	$0
Limits or exclusions	$30
Total	**$90**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,960
- **Patient pays** $440

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$440
Coinsurance	$0
Limits or exclusions	$0
Total	**$440**

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.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

Questions: Call the number on the back of your BCN ID card or visit www.BCBSM.com**.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at hr.umich.edu/uniform-glossary.pdf or call the SSC Contact Center at 734-615-2000 or 1-866-647-7657 (toll free) to request a copy.