



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 [hr.umich.edu/health-plan-forms-documents](http://hr.umich.edu/health-plan-forms-documents) or call the number on the back of your BCBSM ID card. 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 [healthcare.gov/sbc-glossary](http://healthcare.gov/sbc-glossary) or call the SSC Contact Center at 1-866-647-7657 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$500 Individual/ \$1,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://healthcare.gov/coverage/preventive-care-benefits/">healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> limit for this <u>plan</u> ?	\$3,000 Individual / \$6,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
	A separate <u>out-of-pocket limit</u> applies only to <u>prescription drug co-pays</u> : \$2,500 Individual / \$5,000 Family	A separate annual <u>out-of-pocket limit</u> applies only to covered <u>Prescription Drug co-pays</u> and is separate from the <u>out-of-pocket limit</u> for the medical plan. It does not include infertility medications, product selection penalty, or any health plan expenses such as doctor office visits.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, any <u>pharmacy</u> penalty and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Not Applicable	This <u>plan</u> does not use a <u>provider network</u> . You can receive covered services from any <u>provider</u> .
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 Participating Provider	Limitations, Exceptions, & Other Important Information
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>co-insurance</u>	None
	<u>Specialist</u> visit	20% <u>co-insurance</u>	None
	Other practitioner office visit	20% co-insurance for chiropractic and osteopathic manipulative therapy.	Limited to a combined maximum of 38 visits per member per calendar year for chiropractic and osteopathic manipulative therapy. Acupuncture not covered.
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% co-insurance	None
	Imaging (CT/PET scans, MRIs)	20% co-insurance	May require <u>preauthorization</u>

Common Medical Event	Services You May Need	What You Will Pay Participating Provider	Limitations, Exceptions, & Other Important Information	
<p><b>If you need drugs to treat your illness or condition</b></p> <p><b>NOTE: MedImpact Healthcare Systems, Inc. administers the University of Michigan Prescription Drug Plan. NoviXus Pharmacy Services administers mail order services.</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://hr.umich.edu/prescription-drug-plan">hr.umich.edu/prescription-drug-plan</a></p>	Generic drugs	<p><b>Retail <u>co-pay</u>:</b>            \$7 (1-34 day supply)            \$14 (35-60 day supply)            \$21 (61-90 day supply)  <b>Mail order <u>co-pay</u>:</b>            \$14 (61-90 day supply)</p>	<p><b>If you Must use a Non-Participating Pharmacy</b></p>	<p><b>Quantity Limitations and Special Exceptions</b></p>
	Preferred brand drugs	<p><b>Retail <u>co-pay</u>:</b>            \$15 (1-34 day supply)            \$30 (35-60 day supply)            \$45 (61-90 day supply)  <b>Mail order <u>co-pay</u>:</b>            \$30 (61-90 day supply)</p>	<ul style="list-style-type: none"> <li>- You will have to pay the full cost of the drug and file a claim with MedImpact for reimbursement.</li> <li>- Claims must be filed within 90 days of fill.</li> <li>- Non-network reimbursement is limited to a 34-day supply.</li> <li>- You will be reimbursed based on the contracted price that a participating pharmacy would charge for the same drug, minus your <u>co-pay</u> amount.</li> </ul>	<ul style="list-style-type: none"> <li>- You may purchase up to 90 day supplies of medication from NoviXus mail order or a retail pharmacy.</li> <li>- Prescriptions cannot be refilled before 75% use.</li> <li>- Some drugs are subject to quantity limits.</li> <li>- Certain drugs and supplies are excluded from the plan or require prior authorization.</li> <li>- 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.</li> <li>- \$0 <u>co-pay</u> for insulin and preventive medications in compliance with the Affordable Care Act. Listing available at: <a href="http://hr.umich.edu/zero-copay-drug-list">hr.umich.edu/zero-copay-drug-list</a></li> </ul>
	Non-preferred brand drugs	<p><b>Retail <u>co-pay</u>:</b>            \$30 (1-34 day supply)            \$60 (35-60 day supply)            \$90 (61-90 day supply)  <b>Mail order <u>co-pay</u>:</b>            \$60 (61-90 day supply)</p>		
	Specialty drugs	<p>Medications indicated as Specialty on the U-M <u>Prescription Drug Plan Formulary</u> will only be covered when filled at a designated Specialty pharmacy. <a href="http://hr.umich.edu/formulary">hr.umich.edu/formulary</a></p>		

Common Medical Event	Services You May Need	What You Will Pay Participating Provider	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., participating ambulatory surgery center)	20% <u>co-insurance</u>	None
	Physician/surgeon fees	20% <u>co-insurance</u>	None
If you need immediate medical attention	<u>Emergency room services</u>	20% <u>co-insurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>co-insurance</u>	Mileage limits apply.
	<u>Urgent care</u>	20% <u>co-insurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>co-insurance</u>	Preauthorization may be required
	Physician/surgeon fee	20% <u>co-insurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>co-insurance</u>	
	Inpatient services	20% <u>co-insurance</u>	Preauthorization is required
If you are pregnant	Office visits	Prenatal: No Charge; <u>deductible</u> does not apply Postnatal: 20% <u>coinsurance</u>	Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. <u>Cost sharing</u> does not apply to certain maternity services considered to be <u>preventive</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay Participating Provider	Limitations, Exceptions, & Other Important Information
	<u>Habilitation services</u>	20% <u>coinsurance</u> for Applied Behavioral Analysis; 20% <u>coinsurance</u> for Physical, Speech and Occupational Therapy	Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to <u>preauthorization</u> .
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> is required. Limited to 120 days per member per calendar year
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	<u>Hospice services</u>	No Charge; <u>deductible</u> does not apply	<u>Preauthorization</u> is required. Visit limits apply.
<b>If your child needs dental or eye care</b>	Eye exam	No charge	Limited to one routine eye exam per calendar year.
	Glasses	Not covered	None
	Dental check-up	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
- Cosmetic surgery
- Dental care (Adult)
- Glasses
- Long-term care
- 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
- Chiropractic care
- Coverage provided while traveling outside the United States. See <http://provider.bcbs.com>
- Habilitation
- Hearing aids
- Infertility treatment
- Private-duty nursing
- Routine eye care (Adult)

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov) or by calling the number on the back of your BCBSM ID card. 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](http://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® of Michigan by calling the number on the back of your BCBSM ID card. For questions about your prescription drug plan you can contact MedImpact at 1-800-681-9578.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or <http://www.michigan.gov/difs> or [difs-HICAP@michigan.gov](mailto:difs-HICAP@michigan.gov)

#### **Does this plan 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 plan meet 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. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

#### **Language Access Services:**

For assistance in a language below please call the number on the back of your BCBSM ID card.

SPANISH (Español): Para ayuda en español, llame al número de servicio al cliente que se encuentra en este aviso ó en el reverso de su tarjeta de identificación.

TAGALOG (Tagalog): Para sa tulong sa wikang Tagalog, mangyaring tumawag sa numero ng serbisyo sa mamimili na nakalagay sa likod ng iyong pagkakakilanlan kard o sa paunawang ito.

CHINESE (中文): 要获取中文帮助，请致电您的身份识别卡背面或本通知提供的客户服务号码。

NAVAJO (Dine): Taa'dineji'keego shii'kaa'ahdool'wool ninizin'goo, beesh behane'e naal'tsoos bikii sin'dahiigii bini'deehgo eeh'doodago di'naaltsoo bikaigi bichi'hoodillnii.

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

## 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 <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$40
Coinsurance	\$2,160
What isn't covered	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$2,710</b>

### Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$220
Coinsurance	\$320
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,040</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This **EXAMPLE** event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic tests (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$280
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$780</b>

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