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/benefits-wellness/health-well-being/health-plans/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 or call the SSC Contact Center at 1-866-647-7657 to request a copy.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$0	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.		See the Common Medical Events chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services. See the Common Medical Events chart below for your costs for services this plan covers.
What is the out-of-pocket limit for this plan?	$3,000 Individual/ $6,000 Family	$5,000 Individual/ $10,000 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.
	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 is separate from the out-of-pocket limit 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 out-of-pocket limit?	Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn't 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 the number on the back of your BCBSM ID card for a list of network providers.		This plan uses a provider network. You will pay less if you use a provider in the plan's network. 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 Provider (You will pay the least)	Out-of-Network 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	$20 copay/visit	50% coinsurance	None
	Specialist visit	$20 copay/visit	50% coinsurance	None
	Other practitioner office visit	$20 copay/office visit for chiropractic and osteopathic manipulative therapy	50% coinsurance for chiropractic and osteopathic manipulative therapy	Limited to a combined maximum of 24 visits per member per calendar year for chiropractic and osteopathic manipulative therapy. Acupuncture not covered.
	Preventive care/ screening/ immunization	No Charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No Charge	50% coinsurance	May require preauthorization

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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:** $7 (1-34 day supply) $14 (35-60 day supply) $21 (61-90 day supply) **Mail order co-pay:** $14 (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 family** per lifetime. *(rev. 09/07/2018)** - $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 * Corrected to indicate "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 family** per lifetime." Prior to this correction, this document incorrectly stated "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."
	Preferred brand drugs	**Retail co-pay:** $15 (1-34 day supply) $30 (35-60 day supply) $45 (61-90 day supply) **Mail order co-pay:** $30 (61-90 day supply)		
	Non-preferred brand drugs	**Retail co-pay:** $30 (1-34 day supply) $60 (35-60 day supply) $90 (61-90 day supply) **Mail order co-pay:** $60 (61-90 day supply)		
	Specialty drugs	Medications indicated as Specialty on the U-M Prescription Drug Plan Formulary will only be covered when filled at a designated Specialty pharmacy. hr.umich.edu/formulary	Specialty drugs are limited to 34 day supplies. Exception: a 90-day supply is allowed for immunosuppressives and antiretroviral medications.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	50% coinsurance	None
	Physician/surgeon fees	No Charge	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$75 copay/visit	$75 copay/visit	Copay waived if admitted or for an accidental injury.
	Emergency medical transportation	No Charge	No Charge	Mileage limits apply

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	$20 copay/visit	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	50% coinsurance	Preauthorization may be required
	Physician/surgeon fee	No Charge	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	50% coinsurance	Your cost share may be different for services performed in an office setting
	Inpatient services	No Charge	50% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	Prenatal: No Charge Postnatal: No Charge	Prenatal: 50% coinsurance Postnatal: 50% coinsurance	Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply.
	Childbirth/delivery professional services	No Charge	50% coinsurance	None
	Childbirth/delivery facility services	No Charge	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Preauthorization is required.
	Rehabilitation services	$20 copay/visit	50% coinsurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	No Charge for Applied Behavioral Analysis; $20 copay for physicians; No Charge for Physical, Speech and Occupational Therapy	No Charge for Applied Behavioral Analysis; 50% coinsurance 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 preauthorization.
	Skilled nursing care	No Charge	No Charge	Preauthorization is required. Limited to 120 days per member per calendar year
	Durable medical equipment	No Charge	No Charge	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge	No Charge	Preauthorization is required. Visit limits apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	No charge	50% coinsurance up to annual maximum of $40 per exam	Limited to one routine eye exam per calendar year
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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.)

- Acupuncture treatment
- Cosmetic surgery
- Dental care (Adult)
- Glasses
- Long term care
- 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
- Coverage provided outside the United States. See http://provider.bcbs.com
- Habilitation
- Hearing aids
- Infertility treatment
- Private-duty nursing
- Routine eye care

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, 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 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 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.

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

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 binii'deehgo eeh'doodago di'naaltsoo bikaiigii bichi'hoodillnii.

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 plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$0
Other copayment	$0

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	$0
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$50**

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$0
Other copayment	$0

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	$0
Copayments	$340
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$340**

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$0
Other copayment	$0

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies)*
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$100**

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