University of Michigan: Comprehensive Major Medical (CMM) Coverage Period: 01/01/2022 – 12/31/2022

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Individual + Family | **Plan Type:** Traditional

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 https://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 https://www.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 deductible?	$500 Individual/ $1,000 Family	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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services 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?	$3,000 Individual / $6,000 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?	Not Applicable	This plan does not use a provider network. You can receive covered services from any provider.
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 Participating Provider	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	None
	Specialist visit	20% co-insurance	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.
	Preventive care/screening/ immunization	No charge; deductible does not apply	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)	20% co-insurance	None
	Imaging (CT/PET scans, MRIs)	20% co-insurance	May require preauthorization

Common Medical Event	Services You May Need	What You Will Pay Participating Provider	Limitations, Exceptions, & Other Important Information	
If you need drugs to treat your illness or condition **NOTE: Magellan RX Management 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) **Specialty Drug* co-pay:** $10 (1-34 day supply)	**If you Must use a Non-Participating Pharmacy**	**Quantity Limitations and Special Exceptions**
	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) **Specialty Drug* co-pay:** $20 (1-34 day supply)	- You will have to pay the full cost of the drug and file a claim with Magellan RX 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. - $0 co-pay for select insulin and preventive medications in compliance with the Affordable Care Act. Listing available at: hr.umich.edu/zero-copay-drug-list
	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 Drug* co-pay:** $45 (1-34 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.	

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% co-insurance	None
	Physician/surgeon fees	20% co-insurance	None
If you need immediate medical attention	Emergency room services	20% co-insurance	None
	Emergency medical transportation	20% co-insurance	Mileage limits apply.
	Urgent care	20% co-insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	Preauthorization may be required
	Physician/surgeon fee	20% co-insurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance	
	Inpatient services	20% co-insurance	Preauthorization is required
If you are pregnant	Office visits	Prenatal: No Charge; deductible does not apply Postnatal: 20% coinsurance	Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. Cost sharing does not apply to certain maternity services considered to be preventive.
	Childbirth/delivery professional services	20% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Preauthorization is required.
	Rehabilitation services	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay Participating Provider	Limitations, Exceptions, & Other Important Information
	Habilitation services	20% coinsurance for Applied Behavioral Analysis; 20% 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	20% coinsurance	Preauthorization is required. Limited to 120 days per member per calendar year
	Durable medical equipment	20% coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge; deductible does not apply	Preauthorization is required. Visit limits apply.
If your child needs dental or eye care	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, 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. 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

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the 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.

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	**$500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$70
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$2,970**

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

The plan's overall deductible	**$500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$600
Coinsurance	$380
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,480**

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

The plan's overall deductible	**$500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$460
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$960**

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