




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 BCN 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?                             | \$0  | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. <b>There are no deductibles with this health plan.</b>  |
| Are there services covered before you meet your deductible? | No   | There are no deductibles for covered services   |
| Are there other deductibles for specific services?          | No   | There are no deductibles for covered services   |
| What is the out-of-pocket limit for this plan?              | \$3,000 Individual / \$6,000 Family for Level 1, Level 2 and Level 3 providers combined<br><br>\$500 individual / \$1,000 family for physical therapy visits<br><br>\$450 individual / \$900 family for behavioral health visits | 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 must meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met  |
| What is not included in the out-of-pocket limit?            | Premiums, balance-billing charges, any pharmacy penalty and health care this plan does not 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 <a href="http://www.bcbsm.com">www.bcbsm.com</a> or call the number on the back of your BCN 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?                 | Yes  | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist  |

 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   |
|--|--|----------------------|---|---|--|
|  |  | Level 1 Provider     | Level 2 Provider<br><i>Applicable to approved out-of-area academic study/field placement study only</i> | Level 3 Provider<br><i>Refer to Plan Documents for more information</i> |  |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness             | \$25 copay/visit     | \$25 copay/visit  | \$25 copay/visit  | May be responsible for the difference between the BCN fee schedule and the amount charged by a Level 3 Provider.   |
|  | <a href="#">Specialist</a> visit                             | \$30 copay/visit     | \$30 copay/visit  | \$30 copay/visit  | Referral required. May be responsible for the difference between the BCN fee schedule and the amount charged by a Level 3 Provider.  |
|  | <a href="#">Preventive care/screening/immunization</a>       | No charge            | No charge   | No charge   | You may have to pay for services that are not preventive.  |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)          | No charge            | No charge   | No charge   | May require prior authorization. May be responsible for the difference between the BCN fee schedule and the amount charged by a Level 3 Provider.  |
|  | Imaging (CT/PET scans, MRIs)                                 | No charge            | No charge   | No charge   | May require prior authorization. May be responsible for the difference between the BCN fee schedule and the amount charged by a Level 3 Provider.  |
| If you need drugs to treat your illness or condition                   | Generic drugs  |                      |   |   | Magellan RX administers the Uof M Prescription Drug Plan. Birdi Pharmacy Services administers mail order services. For more information about prescription drug coverage is available at <a href="https://hr.umich.edu/prescription-drug-plan">https://hr.umich.edu/prescription-drug-plan</a> |
|  | Preferred brand drugs  |                      |   |   |  |
|  | Non-preferred brand drugs<br><a href="#">Specialty drugs</a> |                      |   |   |  |
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center)               | No charge            | No charge   | No charge   | May require prior authorization. May be responsible for the difference between the BCN fee schedule and the amount charged by a Level 3 Provider   |
|  | Physician/surgeon fees                                       | No charge            | No charge   | No charge   |  |
| If you need immediate medical attention                                | <a href="#">Emergency room care</a>                          | \$100 co-pay / visit | \$100 co-pay / visit  | \$100 co-pay / visit  | Co-pay waived if admitted.   |
|  | <a href="#">Emergency medical</a>                            | No charge            | No charge   | No charge   | Non-emergency transport is not   |

| Common Medical Event  | Services You May Need   | What You Will Pay   |   |   | Limitations, Exceptions, & Other Important Information   |
|---|---|---------------------|---|---|--|
|   |   | Level 1 Provider    | Level 2 Provider<br><i>Applicable to approved out-of-area academic study/field placement study only</i> | Level 3 Provider<br><i>Refer to Plan Documents for more information</i> |  |
|   | <a href="#">transportation</a>  |                     |   |   | covered  |
|   | <a href="#">Urgent care</a>   | \$25 co-pay / visit | \$25 co-pay / visit   | \$25 co-pay / visit   |  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)  | No charge           | Covered*  | Covered*  | *Level 2 and Level 3 is covered at 100% for emergency admissions<br>Not covered for non-emergent admissions  |
|   | Physician/surgeon fees  | No charge           | Covered*  | Covered*  |  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services   | \$25 co-pay / visit | \$25 co-pay / visit   | \$25 co-pay / visit   | May be responsible for the difference between the BCN fee schedule and the amount charged by a Level 3 Provider.   |
|   | Inpatient services  | No charge           | No charge   | No charge   | 100% in an approved facility. No coverage out of area except for emergency admission   |
| If you are pregnant   | Prenatal and postnatal office visits  | No charge           | No charge   | No charge   | Requires prior authorization. May be responsible for the difference between the BCN fee schedule and the amount charged by a Level 3 Provider.   |
|   | Delivery inpatient services   | No charge           | Covered*  | Covered*  | *Level 2 and Level 3 is covered at 100% for emergency admissions<br>Not covered for non-emergent admissions  |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>  | \$30 copay / visit  | \$30 copay / visit  | \$30 copay / visit*   | May require prior authorization. Level 3 Member is responsible for any amount billed by the Provider that exceeds the Approved Amount  |
|   | <a href="#">Rehabilitation services</a><br>(physical, occupational, and speech therapy) | \$25 copay / visit  | \$25 copay / visit  | \$25 copay / visit  | Limited to 60 visits per medical episode per calendar year for any combination of therapies. Levels 1, 2, and 3 are combined. Level 3 - The Member is responsible for any amount billed by the Provider that exceeds the Approved Amount.<br><br>\$500 individual / \$1,000 family out-of-pocket maximum for physical therapy visits |

| Common Medical Event                   | Services You May Need                     | What You Will Pay  |   |   | Limitations, Exceptions, & Other Important Information  |
|--|---|--------------------|---|---|---|
|  |   | Level 1 Provider   | Level 2 Provider<br><i>Applicable to approved out-of-area academic study/field placement study only</i> | Level 3 Provider<br><i>Refer to Plan Documents for more information</i> |   |
|  | <a href="#">Habilitation services</a>     | \$25 copay / visit | \$25 copay / visit  | \$25 copay / visit  | Covered for autism spectrum disorder  |
|  | <a href="#">Skilled nursing care</a>      | No charge          | No charge   | No charge   | May be responsible for the difference between the BCN fee schedule and the amount charged by a Level 3 Provider.    |
|  | <a href="#">Durable medical equipment</a> | No charge          | No charge   | Covered*  | * Member may be responsible for the difference between the BCN fee schedule and the amount charged by the provider. |
|  | <a href="#">Hospice services</a>          | No charge          | Not covered   | Not covered   | Level 1: There is a 5th level of 45 days per lifetime that requires preauthorization                                |
| If your child needs dental or eye care | Children's eye exam                       | No charge          | Covered up to \$40  | Covered up to \$40  | Limited to one routine eye exam per calendar year   |
|  | Children's glasses                        | Not covered        | Not covered   | Not covered   |   |
|  | Children's dental check-up                | Not covered        | Not covered   | Not covered   |   |

### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>Acupuncture treatment</li> <li>Chiropractic care</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> </ul>   | <ul style="list-style-type: none"> <li>Glasses</li> <li>Long term care</li> <li>Non-emergency care when traveling outside of the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>Private duty nursing</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul> |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.) |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Habilitation</li> </ul>  | <ul style="list-style-type: none"> <li>Hearing aids</li> <li>Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>Routine eye care</li> <li>Gender affirming treatment</li> </ul> |

**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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 on how 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: [insert applicable contact information from instructions].

**Does this plan provide Minimum Essential Coverage? [Yes/No]**

[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/No/Not Applicable]**

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:**

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[insert telephone number].]

[Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

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

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## 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](#) \$
- [Specialist \[cost sharing\]](#) \$
- Hospital (facility) [\[cost sharing\]](#) %
- Other [\[cost sharing\]](#) %

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>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |           |
|-----------------------------------|-----------|
| <a href="#">Deductibles</a>       | \$        |
| <a href="#">Copayments</a>        | \$        |
| <a href="#">Coinsurance</a>       | \$        |
| What isn't covered                |           |
| Limits or exclusions              | \$        |
| <b>The total Peg would pay is</b> | <b>\$</b> |

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$
- [Specialist \[cost sharing\]](#) \$
- Hospital (facility) [\[cost sharing\]](#) %
- Other [\[cost sharing\]](#) %

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>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |           |
|-----------------------------------|-----------|
| <a href="#">Deductibles</a>       | \$        |
| <a href="#">Copayments</a>        | \$        |
| <a href="#">Coinsurance</a>       | \$        |
| What isn't covered                |           |
| Limits or exclusions              | \$        |
| <b>The total Joe would pay is</b> | <b>\$</b> |

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$
- [Specialist \[cost sharing\]](#) \$
- Hospital (facility) [\[cost sharing\]](#) %
- Other [\[cost sharing\]](#) %

This EXAMPLE event includes services like:

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

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |           |
|-----------------------------------|-----------|
| <a href="#">Deductibles</a>       | \$        |
| <a href="#">Copayments</a>        | \$        |
| <a href="#">Coinsurance</a>       | \$        |
| What isn't covered                |           |
| Limits or exclusions              | \$        |
| <b>The total Mia would pay is</b> | <b>\$</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.