University of Michigan: GradCare

Coverage Period: 01/01/2025 – 12/31/2025

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

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. **There are no deductibles with this health plan.**
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 $500 individual / $1,000 family for physical therapy visits $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 www.bcbsm.com 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, you're 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

Important Questions	Answers	Why This Matters:
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 *Applicable to approved out-of-area academic study/field placement study only*	Level 3 Provider *Refer to Plan Documents for coverage details*	
If you visit a health care provider's 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.
	Specialist 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.
	Preventive care/screening/ immunization	Covered 100%	Covered 100%	Covered 100%	You may have to pay for services that are not preventive.
If you have a test	Diagnostic test (x-ray, blood work)	Covered 100%	Covered 100%	Covered 100%	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)	Covered 100%	Covered 100%	Covered 100%	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				Prime Therapeutics administers the U-M Prescription Drug Plan. Birdi Pharmacy Services administers mail order services. For more information about prescription drug coverage is
	Preferred brand drugs				
	Non-preferred brand drugs				

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Provider	Level 2 Provider *Applicable to approved out-of-area academic study/field placement study only*	Level 3 Provider *Refer to Plan Documents for coverage details*	
	Specialty drugs				available at https://hr.umich.edu/prescription-drug-plan
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Covered 100%	Covered 100%	Covered*	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	Covered 100%	Covered 100%	Covered*	
If you need immediate medical attention	Emergency room care	$100 co-pay / visit	$100 co-pay / visit	$100 co-pay / visit	Co-pay waived if admitted.
	Emergency medical transportation	Covered 100%	Covered 100%	Covered 100%	Non-emergency transport is not covered
	Urgent care	$25 co-pay / visit	$25 co-pay / visit	$25 co-pay / visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	Covered 100%	Covered*	Covered*	*Level 2 and Level 3 is covered at 100% for emergency admissions Not covered for non-emergent admissions
	Physician/surgeon fees	Covered 100%	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	Covered 100%	Covered 100%	Covered 100%	100% in an approved facility. No coverage out of area except for emergency admission
If you are pregnant	Prenatal and postnatal office visits	Covered 100%	Covered 100%	Covered*	*May be responsible for the difference between the BCN fee schedule and the amount charged by a Level 3 Provider.
	Delivery inpatient services	Covered 100%	Covered*	Covered*	*Level 2 and Level 3 is covered at 100% for emergency admissions Not covered for non-emergent admissions
If you need help recovering or have other	Home health care	$30 copay / visit	$30 copay / visit	$30 copay / visit*	May require prior authorization. Level 3 Member is responsible for any

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Provider	Level 2 Provider *Applicable to approved out-of-area academic study/field placement study only*	Level 3 Provider *Refer to Plan Documents for coverage details*	
special health needs					amount billed by the Provider that exceeds the Approved Amount
	Rehabilitation services (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. $500 individual / $1,000 family out-of-pocket maximum for physical therapy visits
	Habilitation services	$25 copay / visit	$25 copay / visit	$25 copay / visit	Covered for autism spectrum disorder
	Skilled nursing care	Covered 100%	Covered 100%	Covered*	*May be responsible for the difference between the BCN fee schedule and the amount charged by a Level 3 Provider.
	Durable medical equipment	Covered 100%	Covered 100%	Covered*	* Member may be responsible for the difference between the BCN fee schedule and the amount charged by the provider.
	Hospice services	Covered 100%	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	Covered 100%	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture treatment
- Chiropractic care
- Glasses
- Long term care
- Private duty nursing
- Routine foot care

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery • Dental care	• Non-emergency care when traveling outside of the U.S.	• 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 • Habilitation	• Hearing aids • Infertility treatment	• Routine eye care • Gender affirming treatment

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 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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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 *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	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	$12,700

In this example, Peg would pay:

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

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	30$
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments x 4 visits	$120
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$120**

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

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

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$130
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$130**

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