

UNIVERSITY OF MICHIGAN

Consumer-Directed Health Plan

Coverage for: Individual/Family |
Plan Type: CDHP



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 www.bcbsm.com 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](#) or call the SSC Contact Center at 1-866-647-7657 to request a copy.

Important Questions	Answers: In-Network	Answers: Out-of-Network	Why this Matters:
What is the overall <u>deductible</u>?	\$1,700 Individual/ \$3,400 Family (combined medical and Rx)	\$1,700 per contract/ \$3,400 Family (combined medical and Rx)	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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay. In-network and out-of-network deductibles accumulate separately.
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> .	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 Preventive health services .
Are there other <u>deductibles</u> for specific services?	Yes	Yes	<u>Deductibles</u> must be met before the health plan will pay, unless otherwise indicated.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>? (May include a <u>coinsurance</u> maximum)	\$5,500 Individual/ \$10,600 Family (combined medical and Rx)	\$11,000 Individual/ \$21,200 Family (combined medical and Rx)	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> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	<u>Premiums</u> , <u>balance-billing</u> charges, 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> .

Important Questions	Answers: In-Network	Answers: Out-of-Network	Why this Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbsm.com or call the number on the back of your BCBSM ID card for a list of <u>network providers</u> .	Yes. See www.bcbsm.com or call the number on the back of your BCBSM ID card for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	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: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	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	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you visit a health care <u>provider's</u> office or clinic	<u>Specialist</u> visit	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you visit a health care <u>provider's</u> office or clinic	<u>Preventive care</u> / screening/ immunization	Covered 100%	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed 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)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a test	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	May require <u>preauthorization</u>

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Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition	Generic or select prescribed over-the-counter drugs	N/A	N/A	Prime Therapeutics administers the U-M Prescription Drug Plan. Birdi Pharmacy Services administers mail order services. Read information about prescription drug coverage .
If you need drugs to treat your illness or condition	Preferred brand-name drugs	N/A	N/A	Prime Therapeutics administers the U-M Prescription Drug Plan. Birdi Pharmacy Services administers mail order services. Read information about prescription drug coverage .
If you need drugs to treat your illness or condition	Nonpreferred brand-name drugs	N/A	N/A	Prime Therapeutics administers the U-M Prescription Drug Plan. Birdi Pharmacy Services administers mail order services. Read information about prescription drug coverage .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have outpatient surgery	Physician/surgeon fees	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Mileage limits apply. Non-emergency transport is not covered.
If you need immediate medical attention	<u>Urgent care</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required
If you have a hospital stay	Physician/surgeon fee	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None

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Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Outpatient services are covered at participating facility only. Your cost share may be different for services performed in an office setting.
If you need behavioral health services (mental health and substance use disorder)	Inpatient services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	Prenatal and postnatal Covered 100%	Prenatal and postnatal: 50% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services <u>cost share</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> .
If you are pregnant	Childbirth/delivery professional services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you are pregnant	Childbirth/delivery facility services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Physician certification required.
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
If you need help recovering or have other special health needs	<u>Habilitation services</u> for Autism Spectrum Disorder	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Applied behavior analysis (ABA) treatment for Autism - when rendered by an approved licensed behavior analyst - subject to <u>preauthorization</u> .

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Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Preauthorization</u> is required. Limited to a maximum of 120 days per member, per calendar year
If you need help recovering or have other special health needs	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
If you need help recovering or have other special health needs	<u>Hospice services</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Physician certification required. Visit limits apply.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	10% <u>coinsurance</u>	50% coinsurance up to \$40	Basic eye exam per calendar year
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's glasses	Not covered	Not covered	None
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's dental check-up	Not covered	Not covered	None

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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
- Long term care
- Dental care
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Gender affirming care
- Hearing aids
- Infertility treatment
- Private-duty nursing
- Non-emergency care when traveling outside the U.S.
- [Coverage provided outside the United States](#)

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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 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 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: See Addendum

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.

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Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,700
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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:	
<u>Cost Sharing</u>	Cost
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$800
<u>What isn't covered</u>	Cost
Limits or exclusions	\$0
The total Peg would pay is	\$2,500

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

- The plan's overall deductible \$1,700
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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:	
<u>Cost Sharing</u>	Cost
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$100
<u>What isn't covered</u>	Cost
Limits or exclusions	\$0
The total Joe would pay is	\$1,800

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

- The plan's overall deductible \$1,700
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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:	
<u>Cost Sharing</u>	Cost
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$100
<u>What isn't covered</u>	Cost
Limits or exclusions	\$10
The total Mia would pay is	\$1,800

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or coinsurance, or benefits not otherwise covered.

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