

UNIVERSITY OF MICHIGAN
 Comprehensive Major Medical (CMM) ASC

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services



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 number on the back of your BCBSM ID card 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 <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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	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 preventive services .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan? (May include a <u>coinsurance</u> maximum)	\$3,000 Individual/ \$6,000 Family	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> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, any <u>pharmacy</u> penalty 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> .
Will you pay less if you use a network provider?	Yes	This <u>plan</u> does not use a <u>provider network</u> . You can receive covered services from any <u>provider</u> . However, you may experience lower out-of-pocket costs when using BCBS network providers.
Do you need a referral to see a specialist?	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: 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% <u>coinsurance</u>	None
If you visit a health care provider's office or clinic	<u>Specialist</u> visit	20% <u>coinsurance</u>	None
If you visit a health care provider's office or clinic	<u>Preventive care/screening</u> /immunization	Covered at 100%; <u>deductible</u> does not apply	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)	20% <u>coinsurance</u>	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	May require <u>preauthorization</u>
If you need drugs to treat your illness or condition	Generic or select prescribed over-the-counter drugs	N/A	Prime Therapeutics administers the U of M Prescription Drug Plan. Birdi Pharmacy Services administers mail order services. For more information about prescription drug coverage is available at Prescription Drug Plan
If you need drugs to treat your illness or condition	Preferred brand-name drugs	N/A	Prime Therapeutics administers the U of M Prescription Drug Plan. Birdi Pharmacy Services administers mail order services. For more information about prescription drug coverage is available at Prescription Drug Plan
If you need drugs to treat your illness or condition	Nonpreferred brand-name drugs	N/A	Prime Therapeutics administers the U of M Prescription Drug Plan. Birdi Pharmacy Services administers mail order services. For more information about prescription drug coverage is available at Prescription Drug Plan
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	<u>Preauthorization</u> may be required
If you have outpatient surgery	Physician/surgeon fees	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay: Participating Provider	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	Mileage limits apply
If you need immediate medical attention	<u>Urgent care</u>	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	<u>Preauthorization</u> is required
If you have a hospital stay	Physician/surgeon fee	20% <u>coinsurance</u>	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	20% <u>coinsurance</u>	None
If you need behavioral health services (mental health and substance use disorder)	Inpatient services	20% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	Prenatal and Postnatal: Covered at 100%;	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	20% <u>coinsurance</u>	None
If you are pregnant	Childbirth/delivery facility services	20% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Physician certification required.
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Habilitation services for Autism Spectrum Disorder</u>	20% <u>coinsurance</u>	Applied behavior analysis (ABA) treatment for Autism - when rendered by an approved licensed behavior analyst, subject to <u>preauthorization</u> .
If you need help recovering or have other special health needs	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> is required. Limited to 120 days per member per calendar year

Common Medical Event	Services You May Need	What You Will Pay: Participating Provider	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	<u>Durable medical equipment</u>	20% <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>	Covered at 100%	Physician certification required. Hospice room and board limited to 45 days per lifetime.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administration	Children's eye exam	20% <u>coinsurance</u>	Limited to one per year.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administration	Children's glasses	Not covered	None
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administration	Children's dental check-up	Not covered	None

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
- Routine foot care
- Dental 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
- Coverage provided outside the United States. See <http://provider.bcbs.com>

- Hearing aids
- Infertility treatment
- Non-Emergency care when traveling outside the U.S.
- Private-duty nursing
- 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: 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 [Michigan Department of Insurance and Financial Services](#) 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.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's overall deductible</u>	\$500
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

<u>Cost Sharing</u>	<u>Amount</u>
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,500
<u>What isn't covered</u>	<u>Amount</u>
Limits or exclusions	\$0
The total Peg would pay is	\$3,000

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's overall deductible</u>	\$500
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

<u>Cost Sharing</u>	<u>Amount</u>
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$500
<u>What isn't covered</u>	<u>Amount</u>
Limits or exclusions	\$0
The total Joe would pay is	\$1000

Mia's Simple Fracture

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

■ The <u>plan's overall deductible</u>	\$500
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

<u>Cost Sharing</u>	<u>Amount</u>
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$500
<u>What isn't covered</u>	<u>Amount</u>
Limits or exclusions	\$0
The total Mia would pay is	\$1,000

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.

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

stereotypes). Blue Cross Blue Shield of Michigan and Blue Care Network does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross Blue Shield of Michigan and Blue Care Network:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provide free language services to people whose primary language is not English, which may include qualified interpreters and information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call the Customer Service number on the back of your card. If you aren't already a member, call 877-469-2583 or, if you're 65 or older, call 888-563-3307, TTY: 711. Here's how you can file a civil right complaint if you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with:

Office of Civil Rights Coordinator
600 E. Lafayette Blvd., MC 1302

Detroit, MI 48226

Phone: 888-605-6461, TTY: 711

Fax: 866-559-0578

Email: CivilRights@bcbsm.com

If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the [Office for Civil Rights Complaint Portal website](https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf)

<https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>, or by mail, phone, or email at:

U.S. Department of Health & Human Services

200 Independence Ave, SW

Room 509, HHH Building

Washington, D.C. 20201

Phone: 800-368-1019, TTD: 800-537-7697

Email: OCRComplaint@hhs.gov

Complaint forms are available on the U.S. Department of Health & Human Services Office for Civil Rights website

<https://www.hhs.gov/ocr/complaints/index.html>.

[This notice is available at Blue Cross Blue Shield of Michigan and Blue Care Network's website:](#)

<https://www.bcbsm.com/important-information/policies-practices/nondiscrimination-notice/>

Questions: Call or visit us at www.bcbsm.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary to request a copy.