As a self-funded group, you are solely responsible for compliance with the federal Summary of Benefit and Coverage (SBC) rules, including SBC creation and distribution. BCBSM does not assume any responsibility for SBC rule compliance relating to your group health plan, or for creation or disclosure of compliant SBCs. This SBC template document is being provided as an example that may contain useful information concerning your BCBSM administered coverage as you create your own group health plan's SBC. This SBC template document being provided is not fully compliant with the SBC federal rules. It is your responsibility to work with your legal counsel to ensure proper compliance with the federal SBC rules. This SBC template document does not constitute legal, tax, actuarial, accounting, benefit design, compliance or other advice. BCBSM disclaims any liability or responsibility for any non-compliance by your group health plan with SBC rules and regulations relating to creation, disclosure or other requirements. You should also note that there may be additional special circumstances which may be applicable to your specific group health plan situation which may affect SBC content, including but not limited to account type arrangements such as flexible spending accounts (FSA), health reimbursement arrangements (HRA), and health savings accounts, (HSA), or for example, wellness programs, reference based pricing or benefits, or coverage not administered by BCBSM, or whether the coverage provides minimum essential coverage. If you have an ASC Plan Modification, it may be defined here in only a limited way.

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

Faculty Admin Hourly Orange

Simply BlueSM HSA PPO ASC

Coverage Period: Beginning on or after 07/01/2024

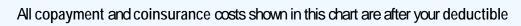
Note to ASC groups: Before completing this template, please reference the disclaimer on the attached cover page.

Coverage for: Individual/Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>www.bdssm.com</u> or call the number on the back

Group Number 007013084-0012





Limitations, Exceptions, & Other Important

For more information on pediatric vision or dental, contact your plan administrator

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 Hearing aids Routine eye care (Adult)

Cosmetic surgery Infertility treatment Routine foot care

Dental care (Adult) Long term care 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 Coverage provided outside the United States.

Chiropractic care See http://provider.bdbs.com

own are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different amples are based on self-only coverage.

