
 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 you can access our [Member Reference Desk](#) or by calling 1.800.832.9186. 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 1.800.832.9186 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible ? | \$0 individual / \$0 family | See the Common Medical Events chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible ? | Not applicable | Not applicable. |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | \$3,000 individual / \$6,000 family | 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 have to 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 and health care this plan doesn't 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.UofMHealthPlan.org or call 1.800.832.9186 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, unless stated otherwise.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|---|---|
| | | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$20 copay /visit | Not covered | Convenience care facilities are covered under this benefit. |
| | Specialist visit | \$20 copay /visit | Not covered | None |
| | Preventive care/screening/immunization | No charge | Not covered | You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | No charge | Not covered | |
| If you need drugs to treat your illness or condition. | Tier 1 drugs (generally Generic) | Not covered under this Plan | Not covered under this Plan | Please visit UM Prescription Drug Plan at https://hr.umich.edu/benefits-wellness/health-well-being/prescription-drug-plan |
| | Tier 2 drugs (generally Preferred brand-name) | Not covered under this Plan | Not covered under this Plan | |
| | Tier 3 drugs (generally Non-Preferred brand-name) | Not covered under this Plan | Not covered under this Plan | |
| | Specialty drugs | Not covered under this Plan | Not covered under this Plan | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | Not covered | Female sterilization is covered at no member cost share when using network providers. Prior approval required for coverage of certain surgeries. |
| | Physician/surgeon fees | No charge | Not covered | |
| If you need immediate medical attention | Emergency department care | \$75 copay /visit | Same as network benefit | Prior approval is required for coverage and the copay is waived if admitted directly from the Emergency Department for an inpatient stay |
| | Emergency medical transportation | No charge | Same as network benefit | |
| | Urgent care | \$20 copay /visit | Same as network benefit | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | Not covered | Prior approval required for coverage of inpatient stays. Transplants must be at Designated Facilities. |
| | Physician/surgeon fees | No charge | Not covered | |

* For more information about limitations and exceptions, see the certificate of coverage at www.UofMHealthPlan.org.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|---|---|--|
| | | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$20 copay /visit for therapy visits, ABA services, and testing. No charge for other outpatient services | Not covered | Prior approval required for coverage of non-routine services, including ABA services and inpatient stays. |
| | Inpatient services | No charge | Not covered | |
| If you are pregnant | Office visits | No charge | Not covered | Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Prior approval required for coverage if inpatient stay exceeds federally established minimum time frames. |
| | Childbirth/delivery professional services | No charge | Not covered | |
| | Childbirth/delivery facility services | No charge | Not covered | |
| If you need help recovering or have other special health needs | Home health care | No charge | Not covered | Prior approval required for coverage. |
| | Rehabilitation services | PT/OT/ST: \$20 copay /visit Cardiac/pulmonary: no charge | Not covered | Limits: PT/OT/ST = 60 visits per calendar year; cardiac rehab = 36 visits per calendar year, pulmonary rehab = 12 visits per calendar year. Covered services for treatment of autism are not included in above limits. |
| | Habilitation services for treatment of Autism Spectrum Disorders | \$20 copay /visit | Not covered | Prior approval required for coverage of outpatient physical, occupational and speech therapy. |
| | Skilled nursing care | No charge | Not covered | Limited to 120 days per calendar year. Prior approval required for coverage. |
| | Durable medical equipment | No charge | Not covered | Prior approval required for coverage of certain items of DME. Limitations apply. |
| | Hospice services | No charge | Not covered | Respite care is limited to 5 days per calendar year. |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | This is a preventive service. Limited to 1 routine exam per calendar year. |
| | Children's glasses | Not covered | Not covered | This plan has no coverage for this service. |
| | Children's dental check-up | Not covered | Not covered | This plan has no coverage for this service. |

* For more information about limitations and exceptions, see the certificate of coverage at www.UofMHealthPlan.org.

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
- Cosmetic surgery
- Dental care
- Habilitation services except to treat Autism Spectrum Disorders
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care – other than eye exam (see below)
- 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 if meet criteria-50% [coinsurance](#) up to \$1,000 [copay](#), network only, prior approval required for coverage
- Gender Affirming services are covered with office visit copay. Prior authorization and medical necessity criteria apply.
- Hearing services-no charge up to allowed amount, limitations apply, network only
- Infertility/fertility treatment-diagnosis and treatment of underlying conditions: covered as any other medical condition, IVF/fertility preservation: 20% [coinsurance](#) (limitations apply), fertility preservation services require prior approval for coverage, network only
- Routine eye care – routine eye exam only: no charge, to limit of 1 exam per calendar year, network only
- Spinal treatment by chiropractor or D.O.-\$20 copay/visit, to combined limit of 24 visits per calendar year, network only
- Weight loss services other than surgery-covered as any other medical condition, network only
- 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, copays, or coinsurance, or benefits not otherwise covered. Contact your employer for details.

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: the Michigan Department of Insurance & Financial Services (DIFS), the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 us at 1.800.832.9186. You may also contact the Michigan Department of Insurance & Financial Services (DIFS), the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 the 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](#).

Non-Discrimination:

University of Michigan Health Service Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. University of Michigan Health Service Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. University of Michigan Health Service Company provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters; written information in other formats (large print, audio, accessible electronic formats, other formats); and provides free language services to people whose primary language is not English, such as qualified interpreters; and information written in other languages. If you need these services, contact Customer Service at 800.832.9186 (TTY 711). If you believe that University of Michigan Health Service Company 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 with our Civil Rights Coordinator, mailing address: PO Box 30377 Lansing MI 48909-7877, phone: 800.832.9186, (TTY 711), fax: 517.364.8406 email: compliance@uofmhealthplan.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1.800.368.1019, 800.537.7697 (TTD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Access Services:

If you, or someone you are helping, has questions about UM Health Plan, you have the right to get help and information in your language at no cost. To talk to an interpreter, call our Customer Service Department at 517.364.8500 or 800.832.9186 (TTY: 711).

Spanish Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de UM Health Plan, tiene derecho a acceder a ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al Departamento de Atención al Cliente al 517.364.8500 - 800.832.9186 (TTY: 711).

Arabic

إن كان لديك أو لدى شخص تساعدك أسئلة UM Health Plan ، فليدرك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ - 517.364.8500 (TTY: 711). 800.832.9186

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 network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist cost sharing](#) \$20
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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 | \$50 |
| The total Peg would pay is | \$50 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist cost sharing](#) \$20
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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 | \$5,500 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$200 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$3,800 |
| The total Joe would pay is | \$4,000 |

Mia's Simple Fracture

(network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist cost sharing](#) \$20
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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 | \$200 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$10 |
| The total Mia would pay is | \$210 |

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