




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 healthcare 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 us at [www.UofMHealthPlan.org](http://www.UofMHealthPlan.org) or call 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 <a href="#">deductible</a> ?                                | \$7,000 individual / \$14,000 family   | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes, <a href="#">Preventive care</a> , services subject to copayments, and other services as noted are covered before you meet your <a href="#">deductible</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .   |
| Are there other <a href="#">deductibles</a> for specific services?              | No   | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$8,000 individual / \$16,000 family   | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.                                     | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.UofMHealthPlan.org">www.UofMHealthPlan.org</a> or call 1-800-832-9186 for a list of <a href="#">network providers</a> .             | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.  | You can see the network <a href="#">specialist</a> you choose without a <a href="#">referral</a> .  |

 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<br>(You will pay the least)   | Non-Network Provider<br>(You will pay the most) |  |
| If you visit a healthcare provider's office or clinic   | Primary care visit to treat an injury or illness       | \$45 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply                                   | Not covered                                     | Convenience care facilities are covered under this benefit. 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> for associated services.  |
|   | <a href="#">Specialist</a> visit                       | \$80 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply                                   | Not covered                                     | Allergy services (not including injections) are covered at 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> . 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> for associated services.  |
|   | <a href="#">Preventive care/screening/immunization</a> | No charge  | Not covered                                     | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.   |
| If you have a test  | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>   | Not covered                                     | None   |
|   | Imaging (CT/PET scans, MRIs)                           | \$150 <a href="#">copay</a> /procedure after <a href="#">deductible</a>  | Not covered                                     |  |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.express-scripts.com/rx">https://www.express-scripts.com/rx</a> | Preferred generic drugs (Tier 1A)                      | \$10 <a href="#">copay</a> / prescription (retail)<br>\$20 <a href="#">copay</a> / prescription (mail order)   | Not covered                                     | <a href="#">Deductible</a> does not apply to outpatient prescription drugs.<br>Covers up to a 31-day supply (retail)<br>Covers up to a 90-day supply (mail order)<br>Drugs on the Maintenance Drug List are covered up a 90-day supply for 3 copays (retail)<br>ACA-mandated preventive drugs such as select contraceptives and tobacco cessation medications are covered with no member cost share. Preferred Tobacco Cessation Products are only available from retail network pharmacies in up to 31-day supply.<br>If a brand-name drug has a generic drug that is chemically the same, you pay your applicable copay or coinsurance amount plus |
|   | Other generic drugs (Tier 1B)                          | \$30 <a href="#">copay</a> / prescription (retail)<br>\$60 <a href="#">copay</a> / prescription (mail order)   | Not covered                                     |  |
|   | Preferred brand drugs (Tier 2)                         | \$80 <a href="#">copay</a> / prescription (retail)<br>\$160 <a href="#">copay</a> / prescription (mail order)  | Not covered                                     |  |
|   | Non-preferred brand drugs (Tier 3)                     | \$200 <a href="#">copay</a> / prescription (retail)<br>\$400 <a href="#">copay</a> / prescription (mail order) | Not covered                                     |  |

For more information about limitations and exceptions, see the certificate of coverage at [www.UofMHealthPlan.org](http://www.UofMHealthPlan.org).

| Common Medical Event                           | Services You May Need                                  | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information  |
|--|--|---|---|---|
|  |  | Network Provider<br>(You will pay the least)  | Non-Network Provider<br>(You will pay the most) |   |
|  |  |   |   | the difference between the brand-name and generic price.<br>Some drugs require prior approval for coverage. Call Customer Service for more information.   |
|  | Preferred <a href="#">Specialty drugs</a> (Tier 4)     | Not available (retail)<br>20% <a href="#">coinsurance</a><br>(specialty mail-order) | Not covered                                     | Specialty Drugs:<br><a href="#">Deductible</a> does not apply to specialty drugs. All Specialty Drugs regardless of tier placement are only available from Accredo, a mail-order specialty pharmacy, in up to a 31-day supply.  |
|  | Non-Preferred <a href="#">Specialty drugs</a> (Tier 5) | Not available (retail)<br>40% <a href="#">coinsurance</a><br>(specialty mail-order) | Not covered                                     | If a brand-name drug has a generic drug that is chemically the same, you pay your applicable <a href="#">copay</a> or <a href="#">coinsurance</a> amount plus the difference between the brand-name and generic price.<br>Some drugs require prior approval for coverage. |
| <b>If you have outpatient surgery</b>          | Facility fee (e.g., ambulatory surgery center)         | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>                    | Not covered                                     | Female sterilization is covered at no member cost share when using network providers. Some surgeries are covered at 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .<br>Prior approval required for coverage of certain surgeries.                      |
|  | Physician/surgeon fees                                 | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>                    | Not covered                                     |   |
| <b>If you need immediate medical attention</b> | <a href="#">Emergency department care</a>              | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>                    | Same as network benefit                         | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> for associated services.<br>Prior approval is required for coverage, and the copay is waived if admitted from the Emergency Department for an inpatient stay.  |
|  | <a href="#">Emergency medical transportation</a>       | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>                    | Same as network benefit                         |   |
|  | <a href="#">Urgent care</a>                            | \$85 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply        | Same as network benefit                         |   |
| <b>If you have a hospital stay</b>             | Facility fee (e.g., hospital room)                     | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>                    | Not covered                                     | Some surgeries are covered at 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .<br>Prior approval required for coverage of inpatient stays. Transplants must be at   |
|  | Physician/surgeon fees                                 | 40% <a href="#">coinsurance</a> after   | Not covered                                     |   |

| Common Medical Event   | Services You May Need                     | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information   |
|--|---|--|---|--|
|  |   | Network Provider<br>(You will pay the least)                                 | Non-Network Provider<br>(You will pay the most) |  |
|  |   | <a href="#">deductible</a>   |   | Designated Facilities.   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$45 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply | Not covered                                     | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> for ABA services for autism treatment. Prior approval required for coverage of non-routine services, including ABA services and inpatient stays.  |
|  | Inpatient services                        | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>             | Not covered                                     |  |
| <b>If you are pregnant</b>   | Office visits                             | No Charge  | Not covered                                     | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> 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 | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>             | Not covered                                     |  |
|  | Childbirth/delivery facility services     | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>             | Not covered                                     |  |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>             | Not covered                                     | Prior approval required for coverage.  |
|  | <a href="#">Rehabilitation services</a>   | \$80 <a href="#">copay</a> /visit after <a href="#">deductible</a>           | Not covered                                     | There are separate limits for rehabilitative and habilitative services: PT & OT = 30 visits per calendar year; ST = 30 visits per calendar year; and cardiac & pulmonary rehab = 30 visits per calendar year. Covered services for treatment of autism are not included in above limits. Prior approval required for coverage of outpatient speech therapy.                  |
|  | <a href="#">Habilitation services</a>     | \$80 <a href="#">copay</a> /visit after <a href="#">deductible</a>           | Not covered                                     |  |
|  | <a href="#">Skilled nursing care</a>      | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>             | Not covered                                     |  |
|  | <a href="#">Durable medical equipment</a> | 50% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply  | Not covered                                     | Prior approval required for coverage of certain items of DME.  |
|  | <a href="#">Hospice services</a>          | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>             | Not covered                                     | Limit of 45 days per calendar year. Prior approval required for coverage.  |
| <b>If your child needs dental or eye care</b>                                    | Children's eye exam                       | No charge  | Not covered                                     | This is a preventive service. Limited to 1 routine exam per calendar year.   |
|  | Children's glasses                        | No charge  | Not covered                                     | Limited to 1 pair of glasses per calendar year.  |

| Common Medical Event | Services You May Need      | What You Will Pay                            |   | Limitations, Exceptions, & Other Important Information                 |
|----------------------|----------------------------|--|---|--|
|                      |                            | Network Provider<br>(You will pay the least) | Non-Network Provider<br>(You will pay the most) |  |
|                      | Children's dental check-up | Not covered                                  | Not covered                                     | Other limitations apply<br>This plan has no coverage for this service. |

**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](#).)**

|   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care</li> <li>• Elective abortion as defined by the State of Michigan</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids and services</li> <li>• Infertility treatment and medications to conceive a pregnancy</li> <li>• Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private duty nursing</li> <li>• Routine eye care (adult)</li> <li>• Routine foot care</li> </ul> |
|---|--|---|

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

|  |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Chiropractic care</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment to treat the underlying conditions that result in infertility only</li> <li>• Weight loss services other than surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Covered services through the Indian Health Service, and Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services-no charge, network only</li> </ul> |
|--|---|---|

**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](http://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](http://www.cciio.cms.gov). Other coverage options may be available to you through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://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: 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](http://www.dol.gov/ebsa/healthreform).

### **Does this plan provide Minimum Essential Coverage?**

Not applicable.

### **Does this plan meet the Minimum Value Standards?**

Not applicable.

### **Non-Discrimination:**

University of Michigan Health Plan (UM Health Plan) complies with applicable Federal civil rights laws and does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, age, disability, sex, pregnancy, sexual orientation, gender identity, gender expression, religion, height, weight or veteran status. UM Health Plan 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 UM Health Plan 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: 1-800-832-9186, (TTY 711), fax: 517-364-8406 email: [Compliance@UofMHealthPlan.org](mailto: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 1-800-832-9186 (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 1-800-832-9186 (TTY: 711).

### **Arabic**

إن كان لديك أو لدى شخص تساعد أسئلة UM Health Plan ، ف لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 1-800-832-9186 (TTY: 711).

**Chinese** 如果您，或是您正在協助的對象，有關於[插入 UM Health Plan項目的名稱 方面的問題，您有權免費獲得以您的語言提供的幫助和信息。洽詢一位翻譯員，請撥電話 [在此插入數字1-800-832-9186 (TTY: 711)。

For more information about limitations and exceptions, see the certificate of coverage at [www.UofMHealthPlan.org](http://www.UofMHealthPlan.org).





## 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](#) \$7,000
- [Specialist cost share](#) \$80
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$7,000        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$1,000        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$50           |
| <b>The total Peg would pay is</b> | <b>\$8,050</b> |

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$7,000
- [Specialist cost share](#) \$80
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$400          |
| <a href="#">Copayments</a>        | \$1,800        |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$2,200</b> |

### Mia's Simple Fracture

(network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$7,000
- [Specialist cost share](#) \$80
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,300        |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$100          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,600</b> |

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