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 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 deductible?	$150 individual / $300 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, Preventive care, services subject to copayments, and other services as noted are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	$1,100 individual / $2,200 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, balance-billing charges, 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?	No.	You can see the network specialist you choose without a referral.

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 healthcare provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay/visit, deductible does not apply	Not covered	Convenience care facilities are covered under this benefit. 10% coinsurance after deductible for associated services.
	Specialist visit	$15 copay/visit, deductible does not apply	Not covered	Allergy services (not including injections) are covered at 50% coinsurance after deductible. 10% coinsurance after deductible for associated services.
	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)	10% coinsurance after deductible	Not covered	None
	Imaging (CT/PET scans, MRIs)	$150 copay/procedure after deductible	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.express-scripts.com/rx	Preferred generic drugs (Tier 1A)	$5 copay/ prescription (retail) $10 copay/ prescription (mail order)	Not covered	Deductible does not apply to outpatient prescription drugs. Covers up to a 31-day supply (retail) Covers up to a 90-day supply (mail order) Drugs on the Maintenance Drug List are covered up a 90-day supply for 3 copays (retail) 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. 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)	$15 copay/ prescription (retail) $30 copay/ prescription (mail order)	Not covered	
	Preferred brand drugs (Tier 2)	$40 copay/ prescription (retail) $80 copay/ prescription (mail order)	Not covered	
	Non-preferred brand drugs (Tier 3)	$80 copay/ prescription (retail) $160 copay/ prescription (mail order)	Not covered	

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)	
				the difference between the brand-name and generic price. Some drugs require prior approval for coverage. Call Customer Service for more information.
	Preferred Specialty drugs (Tier 4)	Not available (retail) 20% coinsurance (specialty mail-order)	Not covered	Specialty Drugs: Deductible 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. If a brand-name drug has a generic drug that is chemically the same, you pay your applicable copay or coinsurance amount plus the difference between the brand-name and generic price. Some drugs require prior approval for coverage.
	Non-Preferred Specialty drugs (Tier 5)	Not available (retail) 40% coinsurance (specialty mail-order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	Not covered	Female sterilization is covered at no member cost share when using network providers. Some surgeries are covered at 50% coinsurance after deductible. Prior approval required for coverage of certain surgeries.
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	
If you need immediate medical attention	Emergency department care	10% coinsurance after deductible	Same as network benefit	10% coinsurance after deductible for associated services. Prior approval is required for coverage, and the copay is waived if admitted from the Emergency Department for an inpatient stay.
	Emergency medical transportation	10% coinsurance after deductible	Same as network benefit	
	Urgent care	$50 copay/visit, deductible does not apply	Same as network benefit	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	Not covered	Some surgeries are covered at 50% coinsurance after deductible. Prior approval required for coverage of inpatient stays. Transplants must be at
	Physician/surgeon fees	10% coinsurance after	Not covered	

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)	
		deductible		Designated Facilities.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 copay/visit, deductible does not apply	Not covered	10% coinsurance after deductible for ABA services for autism treatment. Prior approval required for coverage of non-routine services, including ABA services and inpatient stays.
	Inpatient services	10% coinsurance after deductible	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	10% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services	10% coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	Not covered	Prior approval required for coverage.
	Rehabilitation services	$15 copay/visit after deductible	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.
	Habilitation services	$15 copay/visit after deductible	Not covered	
	Skilled nursing care	10% coinsurance after deductible	Not covered	Limit of 45 days per calendar year. Prior approval required for coverage.
	Durable medical equipment	50% coinsurance; deductible does not apply	Not covered	Prior approval required for coverage of certain items of DME.
	Hospice services	10% coinsurance after deductible	Not covered	Limit of 45 days per calendar year. Prior approval required for coverage.
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.

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)	
	Children's glasses	No charge	Not covered	Limited to 1 pair of glasses per calendar year. Other limitations apply
	Children's dental check-up	Not covered	Not covered	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.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Elective abortion as defined by the State of Michigan
- Hearing aids and services
- Infertility treatment and medications to conceive a pregnancy
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (adult)
- 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
- Infertility treatment to treat the underlying conditions that result in infertility only
- Weight loss services other than surgery

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 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: 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?
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. 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 تساعده أسئلة UM Health Plan ، فلديك 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).

German Falls Sie oder jemand, dem Sie helfen, Fragen zum UM Health Plan haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-800-832-9186 (TTY: 711) an.

Italian Se Lei o qualcuno che sta aiutando aveste domande su UM Health Plan, avete il diritto di ricevere assistenza e informazioni nella vostra lingua gratuitamente. Per parlare con un interprete, può chiamare 1-800-832-9186 (TTY: 711).

Japanese ご本人様、またはお客様の身の回りの方でも、UM Health Planについてご質問がございましたら、無料でご希望の言語でサポートを受けたり、情報を入手したりすることができます。通訳とお話される場合、1-800-832-9186 (TTY: 711) までお電話ください。

Korean 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 UM Health Plan에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 비용 부담없이 귀하의 언어로 얻을 수 있는 권리가 있습니다. 정보를 얻기 위해 통역사와 대화하려면1-800-832-9186 (TTY: 711)로 전화하십시오.

Polish Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie UM Health Plan, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-832-9186 (TTY :711).

Russian Если у вас или лица, которому вы помогаете, имеются вопросы по поводу UM Health Plan, вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-832-9186 (TTY 711).

Syriac

ܐܢ ܐܢܫܘܟܘܢ، ܐܘ ܚܕ ܦܠܢܝ ܦܠܢ ܕܡܣܝܥܘܢ ܠܗܘܢ، ܐܝܬ ܠܗܘܢ ܡܘܩܪ̈ܐ ܒܘܕ ، ܐܢܫܘܟܘܢ ܐܝܬ ܠܗܘܢ ܫܘܠܛܢܐ ܕܩܒܠܬܘܢ ܡܥܕܪܢܘܬܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܡܓܢܐܝܬ.
ܠܡܡܠܠܘܟܘܢ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘ ܠܟܘܢ ܥܠ ܛܠܝܦܘܢ ܒܡܢܝܢܐ : 1-800-832-9186 (TTY: 711)

Tagalog Kung ikaw, o ang iyong tinutulungan ay may mga katanungan tungkol sa UM Health Plan, may karapatan ka na makakuha ng tulong at impormasyon na nasa iyong wika nang walang bayad. Para makipag-usap sa isang tagapagsalin-wika, tumawag sa 1-800-832-9186 (TTY: 711).

Vietnamese Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về UM Health Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-832-9186 (TTY: 711).

Bengali যদি আপনার, বা আপনি সাহায্য করছেন এমন কারোও UM Health Plan সম্পর্কে প্রশ্ন থাকে, তাহলে নিখরচায় আপনার ভাষায় সাহায্য এবং তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলতে, আমাদের গ্রাহক পরিষেবা বিভাগকে 517.364.8500 বা 1-800-832-9186 (TTY: 711) নম্বরে কল করুন।

Albanian Nëse ju, ose dikush që po e ndihmoni, keni pyetje për UM Health Plan, keni të drejtë të merrni ndihmë dhe informacione falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi Departamentin e Shërbimeve për Klientë në numrin 1-800-832-9186 (TTY: 711).

Serbo-Croatian Ukoliko Vi ili netko kome Vi pomažete ima pitanje o UM Health Plan -u, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-800-832-9186 (TTY: 711).

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 network pre-natal care and a hospital delivery)

The plan's overall deductible	$150
Specialist cost share	$15
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:	
Cost Sharing	
Deductibles	$150
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$1,200**

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

The plan's overall deductible	$150
Specialist cost share	$15
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:	
Cost Sharing	
Deductibles	$150
Copayments	$800
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$980**

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

The plan's overall deductible	$150
Specialist cost share	$15
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$150
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

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