




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?	\$1,500 individual / \$3,000 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?	\$7,800 individual / \$15,600 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 health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 copay /visit, deductible does not apply	Not covered	Convenience care facilities are covered under this benefit. 25% coinsurance after deductible for associated services.
	Specialist visit	\$60 copay /visit, deductible does not apply	Not covered	Allergy services (not including injections) are covered at 50% coinsurance after deductible . 25% 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)	25% coinsurance after deductible	Not covered	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance 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	Generic drugs (Tier 1)	\$15 copay / prescription (retail) \$30 copay / prescription (mail order)	Not covered	Deductible does not apply 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 contraceptive 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 the difference between the brand-name and
	Preferred brand drugs (Tier 2)	\$30 copay / prescription (retail) \$60 copay / prescription (mail order)	Not covered	
	Non-Preferred brand drugs (Tier 3)	\$60 copay /prescription (retail) \$120 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)	
				generic price. Some drugs require prior approval for coverage. Call Customer Service for more information.
	Specialty drugs (Tier 4)	Not available (retail) \$250 copay /prescription (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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% 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	25% coinsurance after deductible	Not covered	
If you need immediate medical attention	Emergency department care	25% coinsurance after deductible	Same as network benefit	25% coinsurance after deductible for associated services. Prior approval is required for coverage if admitted from the Emergency Department for an inpatient stay.
	Emergency medical transportation	25% coinsurance after deductible	Same as network benefit	
	Urgent care	\$45 copay /visit; deductible does not apply	Same as network benefit	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% 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 Designated Facilities.
	Physician/surgeon fees	25% coinsurance after deductible	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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay /visit; deductible does not apply	Not covered	25% 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	25% 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	25% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services	25% coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	25% coinsurance after deductible	Not covered	Prior approval required for coverage.
	Rehabilitation services	\$30 copay /visit; deductible does not apply	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	\$30 copay /visit; deductible does not apply	Not covered	
	Skilled nursing care	25% 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	25% 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.
	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 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.

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](#) \$1,500
- [Specialist cost share](#) \$60
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

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:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$10
Coinsurance	\$2,700
<i>What isn't covered</i>	
Limits or exclusions	\$50
The total Peg would pay is	\$4,260

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist cost share](#) \$60
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

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:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,300

Mia's Simple Fracture

(network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist cost share](#) \$60
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$200
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

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