Coverage Period: 01/01/2025-12/31/2025

Coverage for: Individual or Family | Plan Type: HMO

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? | \$0 individual / \$0 family | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. |
| Are there services covered before you meet your deductible? | Yes. | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. |
| Are there other deductibles for specific services? | No | You don't have to meet deductibles for specific services. |
| What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ? | \$0 individual / \$0 family | This <u>plan</u> does not have an <u>out–of–pocket limit</u> on your expenses. |
| What is not included in the <u>out-of-pocket limit</u> ? | Premiums, balance-billing charges, and health care this plan doesn't cover. | This <u>plan</u> does not have an <u>out–of–pocket limit</u> on your expenses. |
| Will you pay less if you use a <u>network provider</u> ? | Yes. See www.UofMHealthPlan.org or call 1-800-832-9186 for a list of network providers. | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No. | You can see the network specialist you choose without a referral. |

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies, unless stated otherwise.

| | | What You Will Pay | | Limitations, Exceptions, & Other Important | |
|--|--|--|--|--|--|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | Information | |
| If you visit a health care | Primary care visit to treat an injury or illness | No charge | Not covered | None. | |
| provider's office or | Specialist visit | No charge | Not covered | None. | |
| clinic | Preventive care/screening/ immunization | No charge | Not covered | None. | |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | No charge | Not covered | Prior authorization required for some services. Contact Customer Service for more | |
| · | Imaging (CT/PET scans, MRIs) | No charge | Not covered | information. | |
| | Generic drugs (Tier 1) | No charge | Not covered | 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 (retail) | |
| | Preferred brand drugs (Tier 2) | No charge | 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 | Non-preferred brand drugs (Tier 3) | No charge | Not covered | 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 the difference between the brand-name and generic price. Some drugs require prior approval for coverage. Call Customer Service for more information. | |
| | Specialty drugs (Tier 4) | Not available (retail) No charge | Not covered | 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. | |

| | What You Will Pay | | Limitations Expontions ? Other Important | | |
|---|--|---|--|---|--|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information | |
| | | | | If a brand-name drug has a generic drug that is chemically the same, you the difference between the brand-name and generic price. Some drugs require prior approval for coverage. | |
| If you have outpatient | Facility fee (e.g., ambulatory surgery center) | No charge | Not covered | Prior approval required for coverage of certain | |
| surgery | Physician/surgeon fees | No charge | Not covered | surgeries. | |
| | Emergency department care | No charge | Same as network benefit | | |
| If you need immediate medical attention | Emergency medical transportation | No charge | Same as network benefit | Prior approval is required for coverage if admitted from the Emergency Department for | |
| | Urgent care | No charge | Same as network benefit | an inpatient stay. | |
| If you have a hospital | Facility fee (e.g., hospital room) | No charge | Not covered | Prior approval required for coverage of inpatient stays. Transplants must be at | |
| stay | Physician/surgeon fees | No charge | Not covered | Designated Facilities. | |
| If you need mental health, behavioral | Outpatient services | No charge | Not covered | Prior approval required for coverage of non- routine services, including ABA services and | |
| health, or substance abuse services | Inpatient services | No charge | Not covered | inpatient stays. | |
| | Office visits | No charge | Not covered | Maternity care may include tests and services | |
| If you are pregnant | Childbirth/delivery professional services | No charge | Not covered | described elsewhere in the SBC (i.e., ultrasound). Prior approval required for | |
| | Childbirth/delivery facility services | No charge | Not covered | coverage if inpatient stay exceeds federally established minimum time frames. | |
| | Home health care | No charge | Not covered | Prior approval required for coverage. | |
| If you need help | Rehabilitation services | No charge | Not covered | There are separate limits for rehabilitative and | |
| recovering or have other special health needs | Habilitation services | No charge | Not covered | 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 | |

| | | What You Will Pay | | Limitations Evacations 9 Other Important |
|--|----------------------------|--|--|--|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| | | | | limits. Prior approval required for coverage of outpatient speech therapy. |
| | Skilled nursing care | No charge | Not covered | Limit of 45 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. |
| | Hospice services | No charge | Not covered | Limit of 45 days per calendar year. Prior approval required for coverage. |
| Marana de la marada | Children's eye exam | No charge | Not covered | This is a preventive service. Limited to 1 routine exam per calendar year. |
| If your child needs dental or eye care | 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 <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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 filling 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).

<u>Arabic</u>

إن كان لديك أو لدى شخص تساعده أسئلة UM Health Plan ، فلديك الحق في الحصول على المساعدة والمعلومات الضررورية بلغتك من دون اية تكلفة التحدث مع مترجم اتصل ب-918-832-800-1 (TTY: 711).

<u>Chinese</u>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.

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.

<u>Italian</u> 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).

<u>Japanese</u> 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.

<u>Polish</u> 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

<u>Tagalog</u> 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).

<u>Vietnamese</u> 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).

<u>Serbo-Croatian</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 share | \$0 |
| ■ 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 | | | |
| <u>Deductibles</u> | \$0 | | |
| <u>Copayments</u> | \$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 <u>plan's</u> overall <u>deductible</u> | \$0 |
|---|-----|
| ■ Specialist cost share | \$0 |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other coinsurance | 0% |

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

| Total Example Cost | \$5,600 | |
|---------------------------------|---------|--|
| In this example, Joe would pay: | | |
| Cost Sharing | | |
| <u>Deductibles</u> | \$0 | |
| Copayments | \$0 | |
| Coinsurance | \$0 | |
| What isn't covered | | |
| Limits or exclusions | \$0 | |
| The total Joe would pay is | \$0 | |

Mia's Simple Fracture

(network emergency room visit and follow up care)

| ■ The <u>plan's</u> overall <u>deductible</u> | \$0 |
|---|-----|
| ■ Specialist cost share | \$0 |
| ■ 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 | | |
| <u>Deductibles</u> | \$0 | |
| Copayments | \$0 | |
| Coinsurance | \$0 | |
| What isn't covered | | |
| Limits or exclusions | \$0 | |
| The total Mia would pay is | \$0 | |

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