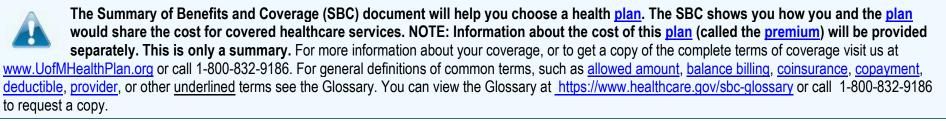
Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services University of Michigan Health Plan HMO Exclusive Bronze Standard – ZeroCS ENN00200-RX0HE018 University of Michigan Health Plan

Coverage for: Individual or Family | Plan Type: HMO



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 <u>deductible</u> ?	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 <u>deductibles</u> 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 <u>plan</u> 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</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>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 healthcare	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.	
lf you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Prior authorization required for some services.	
	Imaging (CT/PET scans, MRIs)	No charge	Not covered		
	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)	
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 brand drugs (Tier 2)	No charge	Not covered	Drugs on the Maintenance Drug List are covered up a 90-day supply (retail)	
	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.	
	<u>Specialty drugs</u> (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.	

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

Common Medical EventServices You May NeedNetwork Provider (You will pay the least)Non-Network Provider (You will pay the most)Limitations, Exceptions, & Or InformationImage: Services You May NeedNetwork Provider (You will pay the least)Non-Network Provider (You will pay the most)If a brand-name drug has a gen is chemically the same, you the between the brand-name and g Some drugs require prior appro- coverage.If you have outpatient surgeryFacility fee (e.g., ambulatory surgery center) Physician/surgeon feesNo chargeNot coveredPrior approval required for cove surgeries.Image: Some drugs required for cover surgeryNo chargeNot coveredSame as network henefit	neric drug that e difference generic price. oval for
If you have outpatient surgery Facility fee (e.g., ambulatory surgery center) No charge Not covered Prior approval required for coverage. If you have outpatient surgery Facility fee (e.g., ambulatory surgery center) No charge Not covered Prior approval required for coverage. If you have outpatient surgery Emergency department Same as network Same as network	e difference generic price. oval for
If you have outpatient surgery ambulatory surgery center) No charge Not covered Prior approval required for covered surgeries. Physician/surgeon fees No charge Not covered Same as network	erage of certain
Physician/surgeon fees No charge Not covered Emergency department Same as network	
Emergency department No charge Same as network	
If you need immediate medical attentionEmergency medical transportationNo chargeSame as network benefitPrior approval is required for co admitted from the Emergency II an inpatient stay.	
Urgent care No charge Same as network benefit	
If you have a hospital room)Facility fee (e.g., hospital room)No chargeNot coveredPrior approval required for cover inpatient stays. Transplants mut- inpatient stays.	
stay Physician/surgeon fees No charge Not covered Designated Facilities.	
If you need mental health, behavioralOutpatient servicesNo chargeNot coveredPrior approval required for cove routine services, including ABA	
health, or substance abuse servicesInpatient servicesNo chargeNot coveredNot covered	Services and
Office visits No charge Not covered Maternity care may include test	sts and services
If you are pregnantChildbirth/delivery professional servicesNo chargeNot covereddescribed elsewhere in the SBG ultrasound). Prior approval requ	uired for
Childbirth/delivery facility services No charge Not covered coverage if inpatient stay exceed established minimum time frame	,
Home health care No charge Not covered Prior approval required for covered	erage.
If you need help <u>Rehabilitation services</u> No charge Not covered There are separate limits for reh	
recovering or have other special health needsHabilitation servicesNo chargeNot coveredhabilitative services: PT & OT = calendar year; ST = 30 visits per year; and cardiac & pulmonary visits per calendar year. CoveredHabilitation servicesNo chargeNot coveredvisits per calendar year. Covered treatment of autism are not inclu-	er calendar rehab = 30 ed services for

		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	
				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.	
lfanning a bild an a da	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 <u>plan</u> document.)			
Bariatric surgeryChiropractic 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. Or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> 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: <u>Compliance@UofMHealthPlan.org</u>. 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).

<u>Arabic</u>

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إن كان لديك أو لدى شخص تساعده أسئلة UM Health Plan ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة التحدث معمتر جم اتصل. TTY: 711) .
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<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.

<u>German</u> 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 만약귀하또는귀하가돕고있는어떤사람이 UM Health Plan에 관해서질문이있다면귀하는그러한 도움과정보를비용부담없이귀하의 언어로얻을수있는권리가있습니다.정보를 얻기위해통역사와대화하려면1-800-832-9186 (TTY: 711)로전화하십시오.

<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).

<u>Russian</u> 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).

<u>Syriac</u>

ىپ ئېسلاف، تە ىبة فنى ەقەم تىۋىمەنەھر ملەن، مىلە لىمجەر جەقتىم جەت ، ئېسلەنر مىلە لىمجەر بۇجەتلەم تەختىلەن ھىنەتلەم مەھەتكىمەتلەم چىكىمىلە لىۋەدەھچە خەر ئىة ھالارچىختە، مەرە ھەر خار لۈلچەر جەيىتتە تە 1800-832-800 (TTY: 711)

<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).

<u>Bengali</u> 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।

<u>Albanian</u> 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 <u>plan</u> 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 deliverv)

\$0 \$0

0%

0%

The plan's overall deductible
Specialist cost share
Hospital (facility) coinsurance
Other coinsurance

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 share	\$0	
Hospital (facility) coinsurance	0%	
Other <u>coinsurance</u>	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)

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$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 plan's overall deductible	\$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)

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$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.