

Benefit Summary

University of Michigan Health Plan HMO Exclusive Gold Classic Plus H.S.A.

Medical: GFE00325

RX: RX09F725

Aggregate deductible and out-of-pocket maximum



TYPE OF BENEFITS	NETWORK		NON-NETWORK	
ANNUAL DEDUCTIBLE	\$1,650	Single	N/A	Single
	\$3,300	Family	N/A	Family
COINSURANCE (member responsibility after deductible, unless stated otherwise below)	10% after deductible		N/A	
ANNUAL COINSURANCE MAXIMUM	N/A	Single	N/A	Single
	N/A	Family	N/A	Family
ANNUAL OUT-OF-POCKET MAXIMUM (includes deductible, coinsurance, coinsurance maximum & copays)	\$4,025	Single	N/A	Single
	\$8,050	Family	N/A	Family
This Benefit plan does not contain an annual or lifetime limit on the dollar amount of Essential Health Benefits.				
BENEFIT	MEMBER COST SHARE			
PHYSICIAN OFFICE VISITS	NETWORK		NON-NETWORK	
Physician (includes PCP, OB/GYN and behavioral health)	10% after deductible		N/A	
Specialist	10% after deductible		N/A	
• Injections and infusions	10% after deductible		N/A	
• Allergy testing and therapy	10% after deductible		N/A	
• Allergy injections	10% after deductible		N/A	
• Associated services	10% after deductible		N/A	
Chiropractic services Limit - 30 visits per calendar year	10% after deductible		N/A	
PREVENTIVE HEALTH SERVICES - <i>Including but not limited to:</i>	NETWORK		NON-NETWORK	
• Physical exam - annual routine	No charge		Not covered	
• Well baby and well child care				
• Laboratory services - routine				
• Nutritional counseling				
• Tobacco cessation program				
• Immunizations				
• Pap smears				
• Mammography - screening				
INPATIENT HOSPITAL	NETWORK		NON-NETWORK	
• Surgery	10% after deductible		N/A	
• Semi-private room or special care unit (unlimited days)				
• Anesthesia - including administration				
• Physician services - including consultation				
• Necessary ancillary hospital services				
SPECIAL SURGERIES AND SERVICES	NETWORK		NON-NETWORK	
• Breast reduction, orthognathic, TMJ, male mastectomy	10% after deductible		Not covered	
• Bariatric surgery and qualified weight management programs	10% after deductible		Not covered	
OUTPATIENT SERVICES	NETWORK		NON-NETWORK	
• X-ray, tests and procedures - diagnostic	10% after deductible		N/A	
• Laboratory and pathology - diagnostic	10% after deductible		N/A	
• Surgery (all other)	10% after deductible		N/A	
• High tech radiology and nuclear medicine	10% after deductible		N/A	
Outpatient Rehabilitation/Habilitation Therapy:				
• Physical	Combined limit - 30 visits per calendar year each for rehabilitation and habilitation	10% after deductible	N/A	
• Occupational		10% after deductible	N/A	
• Speech	Limit - 30 visits per calendar year each for rehabilitation and habilitation	10% after deductible	N/A	
• Pulmonary	Combined limit - 30 visits per calendar year each for rehabilitation and habilitation	10% after deductible	N/A	
• Cardiac		10% after deductible	N/A	
EMERGENCY AND URGENT HEALTH SERVICES	NETWORK		NON-NETWORK	
Emergency Health Services:				
• Emergency Department visit (copay waived if admitted inpatient)	10% after deductible		Same as network benefit	
• Associated services	10% after deductible			
• Ambulance services	10% after deductible			
Urgent Health Services:				
• Urgent care center visit	10% after deductible		Same as network benefit	
• Associated services	10% after deductible			
• Convenience care facility visit	10% after deductible		N/A	
• Associated services	10% after deductible		N/A	
• Telehealth visit - Amwell Acute Care	10% after deductible		N/A	

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BEHAVIORAL HEALTH SERVICES		NETWORK	NON-NETWORK
• Therapy visits and testing - outpatient		10% after deductible	N/A
• Inpatient treatment - including detoxification		10% after deductible	N/A
• Residential treatment program and intermediate treatment		10% after deductible	N/A
• All other outpatient services		10% after deductible	N/A
• Telehealth visit - Amwell Behavioral Health		10% after deductible	N/A
OTHER SERVICES		NETWORK	NON-NETWORK
• Durable medical equipment (DME) and prosthetic devices		10% after deductible	N/A
• Home health care		10% after deductible	N/A
• Hospice - facility	Limit - 45 days per calendar year	10% after deductible	N/A
• Hospice - home		10% after deductible	N/A
• Skilled nursing facility (SNF)	Limit - 45 days per calendar year	10% after deductible	N/A
• IP rehabilitation facility	Limit - 45 day per calendar year	10% after deductible	N/A
• Surgical sterilization - female		No charge	N/A
• Surgical sterilization - male		10% after deductible	N/A
• Infertility treatment (to treat the underlying conditions that result in infertility)		Covered as any other medical condition	N/A
• ABA services for treatment of Autism Spectrum Disorders		10% after deductible	N/A
Pediatric Vision Services:			
• Pediatric routine eye exam	Limit - 1 exam per calendar year	No charge	Not covered
• Pediatric glasses	Limit - 1 pair per calendar year	No charge (up to allowed amount)	Not covered
• Pediatric contacts	Limit - 1 year's supply in lieu of glasses	No charge	Not covered
PHARMACY BENEFITS		NETWORK	NON-NETWORK
*Outpatient Prescription Drugs:		per order or refill	
• Tier 1A - (up to 31-day supply)		\$15 after deductible	Not covered
• Tier 1B - (up to 31-day supply)		\$40 after deductible	
• Tier 2 - (up to 31-day supply)		\$80 after deductible	
• Tier 3 - (up to 31-day supply)		\$200 after deductible	
• Tier 4 - (up to 31-day supply)		20% to a maximum of \$200 after deductible	
• Tier 5 - (up to 31-day supply)		20% to a maximum of \$300 after deductible	
• Specialty medications (up to 31-day supply)		Accredo Specialty mail-order only	
• Select prescription drugs for ACA preventive coverage		No charge	
• 90-day supply of non-specialty drugs from Express Scripts (ESI) mail order		2 copays	
• 90-day supply of non-specialty maintenance drugs at retail		3 copays	

*Brand Generic Difference (RX): If you or your physician wants you to have a brand-name drug that has a generic drug that is chemically the same, you pay your applicable copay or coinsurance amount plus an ancillary charge (the difference between the cost of the brand-name drug and the generic drug).

Associated services: charges for diagnostic or supportive services (ex., lab/path, radiology, professional fees, medical supplies)

Certain covered health services must be approved in advance by University of Michigan Health Plan (UM Health Plan). The phone number to call to request approval is on the member ID card. Covered Health Services must be medically necessary as determined by UM Health Plan medical policy and nationally recognized guidelines. Member materials, including the Certificate of Coverage, can be found online at our Member Reference Desk. Members may access benefit information on the Member Reference Desk through our website at UofMHealthPlan.org. Exclusions include:

- Experimental or investigational procedures or services
- Custodial care, bed care, convenience care, day care, domiciliary care
- Hearing aids and services
- Routine dental care
- Cosmetic surgery
- Elective abortion

For additional information about Exclusions, contact Customer Service or review the Certificate of Coverage for this Policy. This Summary of Benefits is intended only to highlight the Benefits provided under University of Michigan Health Plan (UM Health Plan) and should not be relied upon to fully determine coverage. This health plan may not cover all health care expenses. If this description conflicts in any way with the Policy issued to the Enrolling Group, the Policy will prevail. For answers to questions about information which appears in the summary, call Customer Service at 800-832-9186.

Important Notice on Patient Protection Provisions Included in Your Plan as Part of the Affordable Care Act

You do not need authorization from us or from any other person in order to obtain access to obstetrical or gynecological care from a Network Provider who specializes in obstetrics or gynecology. However, the Network provider may be required to obtain authorization prior to certain services, which are listed in your Certificate of Coverage. Your Plan covers Emergency Health Services in any hospital emergency department. Your Plan will not require prior authorization or impose any other administrative requirements or benefit limitations that are more restrictive if you receive Emergency Health Services at a Non-Network facility. However, a Non-Network provider may send you a bill for any charges remaining after your Plan has paid.