Benefit Summary

University of Michigan Health Plan POS Gold Select

Medical: GFD01825 **RX: RX0HF032**

Embedded deductible and out-of-pocket maximum

UNIVERSITY OF MICHIGAN HEALTH PLAN
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TYPE OF BENEFITS	NETWORK		NON-NETWORK	
ANNUAL DEDUCTIBLE	$2,000	Individual	$5,000	Individual
	$4,000	Family	$10,000	Family
COINSURANCE (member responsibility after deductible, unless stated otherwise below)	20% after deductible		40% after deductible	
ANNUAL COINSURANCE MAXIMUM	$1,500	Individual	N/A	Individual
	$3,000	Family	N/A	Family
ANNUAL OUT-OF-POCKET MAXIMUM (includes deductible, coinsurance, coinsurance maximum & copays)	$8,000	Individual	$15,000	Individual
	$16,000	Family	$30,000	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)		$25 deductible waived	40% after deductible
Specialist		$50 deductible waived	40% after deductible
• Injections and infusions		20% after deductible	40% after deductible
• Allergy testing and therapy		50% after deductible	Not covered
• Allergy injections		20% after deductible	40% after deductible
• Associated services		20% after deductible	40% after deductible
Chiropractic services	Limit - 30 visits per calendar year	$30 after deductible	40% after deductible
PREVENTIVE HEALTH SERVICES - ***Including but not limited to:***		**NETWORK**	**NON-NETWORK**
• Physical exam - annual routine	• Tobacco cessation program	No charge	Not covered
• Well baby and well child care	• Immunizations		
• Laboratory services - routine	• Pap smears		
• Nutritional counseling	• Mammography - screening		
INPATIENT HOSPITAL		**NETWORK**	**NON-NETWORK**
• Surgery		20% after deductible	40% after deductible
• 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		50% after deductible	Not covered
• Bariatric surgery and qualified weight management programs		50% after deductible	Not covered
OUTPATIENT SERVICES		**NETWORK**	**NON-NETWORK**
• X-ray, tests and procedures - diagnostic		20% after deductible	40% after deductible
• Laboratory and pathology - diagnostic		20% after deductible	40% after deductible
• Surgery (all other)		20% after deductible	40% after deductible
• High tech radiology and nuclear medicine		$150 after deductible	40% after deductible
Outpatient Rehabilitation/Habilitation Therapy:			
• Physical	Combined limit - 30 visits per calendar year each for rehabilitation and habilitation	$50 after deductible	40% after deductible
• Occupational		$50 after deductible	40% after deductible
• Speech	Limit - 30 visits per calendar year each for rehabilitation and habilitation	$50 after deductible	40% after deductible
• Pulmonary	Combined limit - 30 visits per calendar year each for rehabilitation and habilitation	$50 after deductible	40% after deductible
• Cardiac		$50 after deductible	40% after deductible
EMERGENCY AND URGENT HEALTH SERVICES		**NETWORK**	**NON-NETWORK**
Emergency Health Services:			
• Emergency Department visit (copay waived if admitted inpatient)		20% after deductible	Same as network benefit
• Associated services		20% after deductible	
• Ambulance services		20% after deductible	
Urgent Health Services:			
• Urgent care center visit		$60 deductible waived	Same as network benefit
• Associated services		20% after deductible	
• Convenience care facility visit		$25 deductible waived	40% after deductible
• Associated services		20% after deductible	40% after deductible
• Telehealth visit - Amwell Acute Care		$5 deductible waived	N/A

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BEHAVIORAL HEALTH SERVICES		NETWORK	NON-NETWORK
• Therapy visits and testing - outpatient		$25 deductible waived	40% after deductible
• Inpatient treatment - including detoxification		20% after deductible	40% after deductible
• Residential treatment program and intermediate treatment		20% after deductible	40% after deductible
• All other outpatient services		20% after deductible	40% after deductible
• Telehealth visit - Amwell Behavioral Health		$25 deductible waived	N/A
OTHER SERVICES		**NETWORK**	**NON-NETWORK**
• Durable medical equipment (DME) and prosthetic devices		50% deductible waived	Not covered
• Home health care		20% after deductible	40% after deductible
• Hospice - facility	Limit - 45 days per calendar year	20% after deductible	40% after deductible
• Hospice - home		20% after deductible	40% after deductible
• Skilled nursing facility (SNF)	Limit - 45 days per calendar year	20% after deductible	40% after deductible
• IP rehabilitation facility	Limit - 45 day per calendar year	20% after deductible	40% after deductible
• Surgical sterilization - female		No charge	40% after deductible
• Surgical sterilization - male		20% after deductible	40% after deductible
• Infertility treatment (to treat the underlying conditions that result in infertility)		Covered as any other medical condition	40% after deductible
• ABA services for treatment of Autism Spectrum Disorders		20% after deductible	Not covered
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)		$10	Not covered
• Tier 1B - (up to 31-day supply)		$25	
• Tier 2 - (up to 31-day supply)		$60	
• Tier 3 - (up to 31-day supply)		$100	
• Tier 4 - (up to 31-day supply)		20% to a maximum of $200	
• Tier 5 - (up to 31-day supply)		20% to a maximum of $300	
• 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.