

**Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services**

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

**Plan:** DAS02701-RX0AR309 | **Group Number:** L0001269

**Coverage for:** Individual or Family | **Plan Type:** PPO

**University of Michigan Health-Sparrow PPO PLUS Plan** – Non-Union, SEIU RN and Service & Tech Unions, IUE RN and Service & Tech Unions, MNA Home Care Rehab, UAW, Carson

**University of Michigan Health Service Company**



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 health care 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 you can access our [Member Reference Desk](#) or by calling 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:
<b>What is the overall <a href="#">deductible</a>?</b>	For in-network <a href="#">providers</a> : \$250 individual / \$500 family For out-of-network <a href="#">providers</a> : \$1,000 individual / \$2,000 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes, <a href="#">Preventive care</a> , services subject to <a href="#">copayments</a> , and other services as noted are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For in-network <a href="#">providers</a> : \$6,000 individual / \$12,000 family For <a href="#">out-of-network providers</a> : \$6,000 individual / \$12,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Caregiver contributions, <a href="#">balance-billing</a> charges, certain out-of-network services (see SPD for full details), and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. For a list of <a href="#">network providers</a> click <a href="#">SPN Provider Directory</a> or call	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a

Important Questions	Answers	Why This Matters:
	1-800-832-9186.	<a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the network <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	SCN Provider: No charge SPN Provider: \$15 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Convenience care facilities are covered under this benefit.
	<a href="#">Specialist</a> visit	SCN Provider: \$15 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply SPN Provider: \$30 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Imaging (CT/PET scans, MRIs)	No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.express-">https://www.express-</a>	Tier 1 drugs (mostly Generic)  Tier 2 drugs (mostly Preferred brand-name)	\$10 <a href="#">copay</a> /prescription (up to 34-day supply) \$20 <a href="#">copay</a> /prescription (up to 90-day supply) \$40 <a href="#">copay</a> /prescription (up to 34-day supply) \$80 <a href="#">copay</a> /prescription (up to 90-	Only covered for emergent/urgent condition  Only covered for emergent/urgent condition	<a href="#">Deductible</a> does not apply to outpatient prescription drugs. Covers up to a 34-day supply (retail prescription); 35-90-day supply (mail order or retail prescription). ACA mandated preventive drugs such as select contraceptive and tobacco cessation

\* For more information about limitations and exceptions, see the certificate of coverage at [www.UofMHealthPlan.org](http://www.UofMHealthPlan.org).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<a href="https://www.umhealth.com/scripts.com/rx">scripts.com/rx</a>		day supply)		<p>medications are covered with no member cost share.</p> <p>Preferred Tobacco Cessation Products are only available from retail network pharmacies in up to 34-day supply.</p> <p>All Specialty Drugs regardless of tier placement are only available from UM Health Sparrow Specialty Pharmacy in up to a 31-day supply.</p> <p>If a brand-name drug has a generic drug that is chemically the same, you pay your applicable <a href="#">copay</a> plus the difference between the brand-name and generic price.</p> <p>Some drugs require prior approval for coverage.</p>
	Tier 3 drugs (mostly Non-Preferred brand-name)	\$80 <a href="#">copay</a> /prescription (up to 34-day supply) \$160 <a href="#">copay</a> /prescription (up to 90-day supply)	Only covered for emergent/urgent condition	
	<a href="#">Specialty drugs</a>	Tier level depends on the drug. Please see the drug formulary list available on the UM Health-Sparrow Benefits website, <a href="http://www.sparrowbenefits.org">www.sparrowbenefits.org</a>	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<p>Female sterilization is covered at no member cost share when using in-network providers. Pregnancy termination is covered with \$100 <a href="#">copay</a>, limited to 1 per lifetime. Prior approval required for coverage of certain surgeries.</p>
	Physician/surgeon fees	SCN Provider: No charge SPN Provider: No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency department care</a>	UM Health-Sparrow Hospitals: \$100 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply. All other in-network hospitals: \$200 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply.	\$200 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	<p>Prior approval is required for coverage and the copay is waived if admitted directly from the Emergency Department for an inpatient stay.</p>
	<a href="#">Emergency medical transportation</a>	No charge after <a href="#">deductible</a>	Same as in-network benefit	
	<a href="#">Urgent care</a>	UM Health-Sparrow Facilities: \$25 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply.	\$50 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		All other Network Facilities: \$50 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply.		
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Prior approval required for coverage of inpatient stays. Transplants must be at Designated Facilities.
	Physician/surgeon fees	SCN Provider: No charge SPN Provider: No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<u>Therapy visits &amp; testing, ABA services</u> SCN Provider: No charge SPN Provider: \$15 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply <u>Other services and supplies</u> No charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> ABA services not covered	Prior approval required for coverage of non-routine services, including ABA services and inpatient stays.
	Inpatient services	No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you are pregnant	Office visits	Included in professional services below	Included in professional services below	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . 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	SCN Provider: No charge SPN Provider: No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
	Childbirth/delivery facility services	No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Combined in-network/out-of-network limit of 60 visits per calendar year. Prior approval required for coverage.
	<a href="#">Rehabilitation services</a>	\$15 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Combined in-network/out-of-network limits: PT/OT/ST/pulmonary = 36 visits per calendar year; cardiac rehab = 36 visits per calendar year. Covered services for
	<a href="#">Habilitation services</a> for treatment of Autism	\$15 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	Not covered	

\* For more information about limitations and exceptions, see the certificate of coverage at [www.UofMHealthPlan.org](http://www.UofMHealthPlan.org).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Spectrum Disorders			treatment of autism are not included in above limits. Prior approval required for coverage of outpatient speech therapy.
	<a href="#">Skilled nursing care</a>	No charge after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Combined in-network/out-of-network limit of 100 days per calendar year. Prior approval required for coverage.
	<a href="#">Durable medical equipment</a>	No charge after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Prior approval required for coverage of certain items of DME.
	<a href="#">Hospice services</a>	No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Prior approval required for coverage.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	This plan has no coverage for this service.
	Children's glasses	Not covered	Not covered	This plan has no coverage for this service.
	Children's dental check-up	Not covered	Not covered	This plan has no coverage for this service.

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic surgery</li> <li>Dental care</li> <li>Habilitation services except to treat Autism Spectrum Disorders</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids and services</li> <li>Infertility treatment and medications to conceive a pregnancy</li> <li>Long term care</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private duty nursing</li> <li>Routine eye care (adult)</li> <li>Routine foot care</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Bariatric surgery if meet criteria-10% <a href="#">coinsurance</a> up to \$1,000 <a href="#">copay</a>, <a href="#">deductible</a> does not apply, in-network only, prior approval required for coverage</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic care combined with osteo-manipulation by D.O.-in-network: No charge after <a href="#">deductible</a>; -out-of-network: 30% <a href="#">coinsurance</a> after <a href="#">deductible</a>, to combined limit of 24 visits per calendar year</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment to treat the underlying conditions that result in infertility only-Covered as any other medical condition</li> <li>Weight loss services other than surgery-40% <a href="#">coinsurance</a> after <a href="#">deductible</a> for most services, in-network only</li> </ul>

**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](http://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](http://www.cciio.cms.gov). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#),

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visit [www.HealthCare.gov](http://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](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Non-Discrimination:** University of Michigan Health Service Company (UM Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UM Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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 the Civil Rights Coordinator, mailing address: PO Box 30377 Lansing MI 48909-7877, phone: 800-832-9186, (TTY 711), fax: 517-364-8406 email: [Compliance@UofMHealthPlan.org](mailto:Compliance@UofMHealthPlan.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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 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 800-832-9186 (TTY: 711).

**Arabic**

إن كان لديك أو لدى شخص تساعد أسئلة UM Health Plan ، فلدك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 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800-832-9186 (TTY: 711)。

**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 800-832-9186 (TTY: 711) an.

**Italian** Se Lei o qualcuno che sta aiutando avete domande su UM Health Plan, avete il diritto di ricevere assistenza e informazioni nella vostra lingua gratuitamente. Per parlare con un interprete, può chiamare 800-832-9186 (TTY: 711).



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 in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$250
- [Specialist cost sharing](#) \$15
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$50
<b>The total Peg would pay is</b>	<b>\$310</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist cost sharing](#) \$15
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,130</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$250
- [Specialist cost sharing](#) \$15
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$450</b>

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