Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage Period: 01/01/2025-12/31/2025**
Plan: DAS02801-RX0AR307 | **Group Number:** L0001269 **Coverage for:** Individual or Family | **Plan Type:** PPO
University of Michigan Health-Sparrow PPO BASE Plan – Non-Union, SEIU RN and Service & Tech Unions, UAW, IUE RN and Service & Tech Unions, MNA Home Care Rehab, 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:
What is the overall deductible?	For in-network providers: $500 individual / $1,000 family For out-of-network providers: $2,000 individual / $4,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, Preventive care, services subject to copayments, and other services as noted are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: $3,000 individual / $6,000 family For out-of-network providers: $6,000 individual / $12,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Caregiver contributions, balance-billing charges, certain out-of-network services (see SPD for full details), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of network providers click SPN Provider Directory or call	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a

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

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 provider's office or clinic	Primary care visit to treat an injury or illness	SCN Provider: $15 copay/visit, deductible does not apply SPN Provider: $20 copay/visit, deductible does not apply	40% coinsurance after deductible	Convenience care facilities covered under this benefit.
	Specialist visit	SCN Provider: $25 copay/visit, deductible does not apply SPN Provider: $40 copay/visit, deductible does not apply	40% coinsurance after deductible	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	40% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	$75 copay/procedure after deductible	40% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Tier 1 drugs (mostly Generic)	$10 copay/prescription (up to 34-day supply) $20 copay/prescription (up to 90-day supply)	Only covered for emergent/urgent condition	Deductible 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
	Tier 2 drugs (mostly Preferred brand-name)	$40 copay/prescription (up to 34-day supply)	Only covered for emergent/urgent	

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)	
https://www.express-scripts.com/rx		$80 copay/prescription (up to 90-day supply)	condition	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 34-day supply. All Specialty Drugs regardless of tier placement are only available from UM Health-Sparrow Specialty Pharmacy in up to a 31-day supply. If a brand-name drug has a generic drug that is chemically the same, you pay your applicable copay plus the difference between the brand-name and generic price. Some drugs require prior approval for coverage.
	Tier 3 drugs (mostly Non-Preferred brand-name)	$80 copay/prescription (up to 34-day supply) $160 copay/prescription (up to 90-day supply)	Only covered for emergent/urgent condition	
	Tier 4 Non-Preferred Specialty drugs	$100 copay/prescription (up to 31-day supply) Not available (up to 90-day supply)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	40% coinsurance after deductible	Female sterilization is covered at no member cost share when using in-network providers. Pregnancy termination is covered with $100 copay, limited to 1 per lifetime. Prior approval required for coverage of reconstructive procedures.
	Physician/surgeon fees	SCN Provider: No charge SPN Provider: No charge after deductible	40% coinsurance after deductible	
If you need immediate medical attention	Emergency department care	UM Health-Sparrow Hospitals: $150 copay/visit; deductible does not apply. All other in-network hospitals: $250 copay/visit; deductible does not apply.	$250 copay/visit, deductible does not apply	Prior approval is required for coverage and the copay is waived if admitted directly from the Emergency Department for an inpatient stay.
	Emergency medical transportation	10% coinsurance after deductible	Same as in-network benefit	
	Urgent care	UM Health-Sparrow Facilities: $25	$50 copay/visit;	

* For more information about limitations and exceptions, see the certificate of coverage at 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)	
		copay/visit; deductible does not apply. All other Network Facilities: $50 copay/visit; deductible does not apply.	deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	40% coinsurance after deductible	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 deductible	40% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy visits & testing, ABA services SCN Provider: $15 copay/visit; deductible does not apply SPN Provider: $20 copay/visit; deductible does not apply	40% coinsurance after deductible ABA services not covered	Prior approval required for coverage of non-routine services, including ABA services and inpatient stays.
	Inpatient services	No charge after deductible	40% coinsurance after deductible	
If you are pregnant	Office visits	Included in professional services below	Included in professional services below	Cost sharing does not apply for preventive services. 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 deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	No charge after deductible	40% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	50% coinsurance after deductible	Combined in-network/out-of-network limit of 60 visits per calendar year. Prior approval required for coverage.
	Rehabilitation services	10% coinsurance after deductible	40% coinsurance after deductible	Combined in-network/out-of-network limits: PT/OT/ST/pulmonary = 36 visits per calendar year; cardiac rehab = 36 visits
	Habilitation services for	10% coinsurance after deductible	Not covered	

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)	
	treatment of Autism Spectrum Disorders			per calendar year. Covered services for treatment of autism are not included in above limits. Prior approval required for coverage of outpatient speech therapy.
	Skilled nursing care	No charge after deductible	50% coinsurance after deductible	Combined in-network/out-of-network limit of 100 days per calendar year. Prior approval required for coverage.
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	Prior approval required for coverage of certain items of DME.
	Hospice services	10% coinsurance after deductible	40% coinsurance after deductible	Prior approval required for coverage.
If your child needs dental or eye care	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 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
- Habilitation services except to treat Autism Spectrum Disorders
- 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 if meet criteria-10% coinsurance up to $1,000 copay, deductible does not apply, in-network only, prior approval required for coverage
- Chiropractic care combined with osteo-manipulation by D.O.-in-network: 10% coinsurance after deductible; out-of-network: 40% coinsurance after deductible, to combined limit of 24 visits per calendar year
- Infertility treatment to treat the underlying conditions that result in infertility only-covered as any other medical condition
- Weight loss services other than surgery-40% coinsurance after deductible for most services, in-network only

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, too, including buying individual insurance coverage 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 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.

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. 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 تساعده أسئلة UM Health Plan ، فلديك 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).

* 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 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 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、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 대화하려면800-832-9186 (TTY: 711)로 전화하십시오.

Polish 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 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 800-832-9186 (TTY 711).

Syriac

[illegible] 800-832-9186 (TTY: 711)

Tagalog 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 800-832-9186 (TTY: 711).

Vietnamese 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 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 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 800-832-9186 (TTY: 711).

Serbo-Croatian 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 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 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	**$500**
Specialist cost sharing	**$25**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**10%**

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	$500
Copayments	$10
Coinsurance	$80
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$640**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$500**
Specialist cost sharing	**$25**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**10%**

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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$900
Coinsurance	$60
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,480**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$500**
Specialist cost sharing	**$25**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**10%**

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	
Deductibles	$500
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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