PLAN DOCUMENT
FOR
MICHIGAN CARE

DAS08001

Effective January 1, 2021, restated January 1, 2022, January 1, 2023, January 1, 2024, January 1, 2025

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INTRODUCTION

This Plan Document describes your Benefits available under the Plan, as well as, for example, who is eligible for Benefits, when eligibility begins and how to file claims.
The Plan is self-funded, which means that Benefits are paid from University of Michigan funds and are not provided through an insurance contract. University of Michigan Health Service Company, as the Claims Administrator, provides administrative claims payment services.
The University of Michigan, as the Plan Administrator, has delegated the responsibility and discretionary authority to provide a full and fair review of Benefit claims to the Claims Administrator; however, neither University of Michigan Health Service Company nor its subcontractors, are responsible for insuring coverage for your Benefits under Michigan Care.

How to Use this Plan Document.

You are responsible for understanding all provisions of this Plan Document, including Amendments.
Follow this Plan Document if it is different from any summaries given to you by University of Michigan Health Service Company or your employer.
Your health care provider does not have a copy of your Plan Document. Health care providers are not responsible for knowing or communicating your Benefits.

Defined Terms.

Certain capitalized words have special meanings. These words are defined in the chapter, DEFINED TERMS.
When the Plan Document uses the words, "we," "us," and "our" it means University of Michigan. When the Plan Document uses the words, "you" and "your" it means people who are Covered Persons under the Plan.
When the Plan Document uses the words “UM Health Service Company” it means University of Michigan Health Service Company.

Contact Information.

Please read the Plan Document carefully and keep it with your personal records for future reference. This Plan Document, policies, booklets, and/or guidelines may be accessed at University of Michigan Benefits Office website at http://www.benefits.umich.edu. The University of Michigan Benefits Office reserves the right to interpret and resolve conflicts between any statements in this Michigan Care Plan Document that conflict with University of Michigan Benefits Office policies, booklets, summaries, or other benefit related documents.
If you have questions about coverage under the Plan contact Customer Service at 1-833-484-8450.
Let University of Michigan Shared Services Center know if you have a change in address, get married or divorced, have changes in eligibility of your Dependents, or if you get other health care coverage. The Shared Services Center can be contacted at 734-615-2000 or ssc.umich.edu.

The Affordable Care Act (ACA).

University of Michigan Health Service Company follows all relevant provisions of the ACA mandated for self-funded group health plans. The Plan includes but is not necessarily limited to, the following:

- No dollar limitations on Essential Health Benefits.
- No pre-existing limitation exclusions for any members.
- All member cost share in the form of Annual Deductibles, Copayments and Coinsurance amounts go toward satisfaction of the Annual Out-of-Pocket Maximum.

DEFINED TERMS

These defined terms can help you understand certain capitalized words used in the Plan Document and they apply to the entire document. Additional defined terms can be found in subsequent sections, as necessary.

Agent for Service of Legal Process. Legal process may be served on the Plan Administrator at the address indicated in Attachment I.

Alternate Facility. A freestanding health care facility that is:

- Not a Hospital.
- Not a facility that is attached to a Hospital.
- Designated by the Hospital as an Alternate Facility.

Amendment. Any attached written description of additional or alternative provisions to the Plan. Amendments are subject to all terms of the Plan, except for those that are specifically amended.

Annual Deductible. The amount you may pay in a calendar year before we begin paying for Benefits. The Plan does not have an Annual Deductible.

Annual Out-of-Pocket Maximum. The maximum amount you pay for your share of Covered Health Services every calendar year. Once you reach the Annual Out-of-Pocket Maximum, Benefits are paid at 100% of Eligible Expenses for the rest of that calendar year.

The following costs don't apply to the Annual Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services.
- Charges above Eligible Expenses.

Applied Behavioral Analysis (ABA). The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Autism Diagnostic Observation Schedule. The protocol available through Western psychological services for diagnosing and assessing Autism Spectrum Disorders or any other standardized diagnostic measure for Autism Spectrum disorders that is approved by the Director of the Department of Insurance and Financial Services, if the Director determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

Autism Spectrum Disorders. Any of the following pervasive developmental disorders as defined by the Diagnostic and Statistical Manual:

- Autistic disorder.
- Asperger's Disorder.
- Pervasive developmental disorder not otherwise specified.

Autism Treatment Plan. A written, comprehensive, and individualized intervention plan that incorporates specific treatment goals and objectives and that is developed by a board certified or licensed Network health care provider who has the appropriate credentials and who is operating within his or her scope of

practice, when the treatment of an Autism Spectrum Disorder is first prescribed or ordered by a licensed Physician or licensed psychologist.

Behavioral Analyst. A board certified therapist who directly supervises and is responsible for acquiring, training, and overseeing the work of lay workers who deliver the intensive behavioral/educational interventions.

Behavioral Health Services. Covered Health Services for the diagnosis and treatment of mental illnesses, alcoholism and substance use disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a condition or disorder is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Benefits. Your right to payment for Covered Health Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations and Exclusions of the Plan, including this Plan Document and any Amendments.

Claims Administrator. The firm providing administrative services to the employer in connection with the operation of the Plan and performing certain functions, including underwriting, enrollment applications, maintaining current Plan data, billing, processing, and payment of claims and providing the employer with any other information deemed necessary by the Third-Party Administrator.

Coinsurance. The charge stated as a percentage of Eligible Expenses that you are required to pay for certain Covered Health Services.

Congenital Anomaly. A physical developmental defect that is present at birth, and is identified within the first 12 months of birth.

Copayment. A flat dollar amount that you may be required to pay when you receive services such as Physician office visits, outpatient behavioral health visits, Emergency Department visits, Urgent Care Center visits, or outpatient rehabilitation therapy visits. If the Eligible Expense of a service, or supply is lower than the Copayment, you pay the Eligible Expense.

Cosmetic Procedures. Non-covered procedures or services that change or improve appearance without significantly improving physiological function, as determined by University of Michigan Health Service Company.

Covered Health Service(s). Those health services determined to be Medically Necessary per University of Michigan Health Service Company medical policy and nationally recognized guidelines. They are any of the following:

- Provided to prevent, diagnose, or treat a Sickness, Injury, mental illness, substance use disorder, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines.
- Not provided for the convenience of the Covered Person, Physician, facility, or any other person.
- Stated as covered in this Plan Document.
- Not stated as excluded in this Plan Document.

Covered Person. Either the Subscriber or an Enrolled Dependent, who is covered under the Plan. References to "you" and "your" throughout this Plan Document are references to a Covered Person.

Custodial Care. Non-covered services that:

- Are non-health related services.
- Do not seek to cure.
- Are provided when the medical condition of the patient is not changing.
- Do not require trained medical personnel.
- Are provided after stated clinical goals have been achieved.

Designated Facility. A facility that has entered into an agreement with University of Michigan Health Service Company or with an organization contracting on its behalf, to provide Covered Health Services for the treatment of specified diseases or conditions, such as transplants. A Designated Facility may or may not be located within your geographic area or the Service Area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Detoxification (Detox). Medical treatment and management of a person during withdrawal from physiological dependence on alcohol or drugs or both. Detox can occur in an inpatient, outpatient, or residential setting.

Domiciliary Partial for Substance Use Disorders Treatment. Partial Hospitalization combined with an unsupervised overnight stay (Residential) component.

Durable Medical Equipment (DME). Medical equipment that is all the following:

- Can withstand repeated use.
- Is not disposable (unless stated as covered).
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury, or their symptoms.
- Is of use to a person who has a disease or physical disability.
- Is appropriate for use in the home.

Eligible Expenses. The amount we pay for Covered Health Services, incurred while the Plan is in effect. When Covered Health Services are received from Network health care providers, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. When Covered Health Services are received from Non-Network health care providers, except for Emergency Department services and Urgent Care Center visits, even when paid at the Network Benefit level, you may be responsible for paying, directly to the Non-Network health care provider, any difference between the amount the provider bills you and the amount we pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with University of Michigan Health Service Company reimbursement policy guidelines, as described in this Plan Document and in the Payment Reimbursement Policies available on michigancare.com. Network Eligible Expenses are based on one of the following:

- When Covered Health Services are received from Network health care providers, Eligible Expenses are University of Michigan Health Service Company's contracted fee(s) with that provider.
- When the plan has approved Covered Health Services at a Non-Network provider, the Non-Network health care providers may bill you for any portion of their charges not covered by the Plan, including the difference between their billed charges and the

Eligible Expense, which is based on a percentage of Medicare reference-based pricing, unless a lower amount is negotiated by the Plan

Note: Non-Network providers may not balance bill you for charges from an Emergency Department or Urgent Care Center visit. Under the No Surprises Act, Non-Network providers at a Network facility cannot bill you more than the Network cost sharing amount for some services (like anesthesiology or radiology) received at a Network facility unless you consent by signing the notice and consent form waiving your protections.
If possible, you may want to verify whether services are available from Network health care providers. Call the Plan to verify Network participation status.

Non-Network Eligible Expenses are determined based on the lesser of the following:

- Fee(s) that are negotiated with the health care provider.
- A fee schedule developed as follows:
  - Except for services from the specific health care providers identified below, Eligible Expenses are based on a percentage of Medicare reference-based pricing for the same or similar service within the geographic market.
  - For Covered Health Services received at Network facilities on a non-Emergency basis from a radiologist, anesthesiologist, and pathologist, the Eligible Expense is based on a percentage of Medicare reference-based pricing for the same or similar service within the geographic market.
  - When a rate is not published by CMS for the service, an available gap methodology is used to determine a rate for the service as follows:
    - For services other than pharmaceutical products, the Plan uses a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk, and resources of the service.
    - When a rate is not published by CMS for the service and a gap methodology does not apply to the service, or the health care provider does not submit sufficient information on the claim to pay it under CMS published rates or a gap methodology, the Eligible Expense is based on 50 percent of the provider's billed charge.

University of Michigan Health Service Company updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 90 days after CMS updates its data.
Eligible Person. An active employee of University of Michigan or other persons all of whom meet the eligibility requirements as described in the Plan. An Eligible Person must reside within the Service Area. Dependents living outside the Service Area may register for the out of area coverage provision. Please see page 15 on how to register.
Emergency. An illness, injury or symptom that requires immediate medical attention to avoid permanent damage, severe harm, or loss of life.
Enrolled Dependent. A Dependent who is properly enrolled under the Plan.
Exclusions. Those health care services that are not Covered Health Services.

Experimental or Investigational Services. Health care services or supplies that are any of the following:

- Not approved by the FDA to be lawfully marketed for the proposed use.
- Not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use (except for devices that are FDA approved under the Humanitarian Use Device exemption).
- Any service billed with a temporary procedure code.

This does not include any off-label usage of a Prescription Drug Product if its use meets criteria for coverage.

Fraud. Intentionally, or knowingly and willfully attempting to execute or participate in a scheme to falsely receive unfair or unlawful financial or personal gain from any health care benefit program. Fraud may include, but is not limited to:

- Seeking reimbursement for services not rendered.
- Selling prescription drugs to someone they were not prescribed for.
- Misrepresenting the date that a service was provided.
- Misrepresentation of services such as, misrepresenting who rendered the service, the condition or diagnosis of the patient, the charges involved, or the identity of the health care provider or recipient.
- Seeking reimbursement for excessive, inappropriate, or unnecessary testing or other services.
- Receiving kickbacks for making a referral or for receiving services related to the referral.
- Altering claim forms, electronic records, or medical documentation.
- Improper use of your identification (ID) card.
- Providing false information or withholding accurate information relating to eligibility for coverage under the Plan.

Gender Dysphoria. Involves a conflict between a person's physical or assigned sex and the gender with which he/she/they identify.

Genetic Counseling. Services provided by a health care professional specially trained in genetics and counseling to give information and support to people who have, or may be at risk for genetic disorders or having a baby at risk for a genetic disorder.

Genetic Test. The analysis of human DNA, RNA, chromosomes, and those proteins and metabolites used to detect heritable or somatic disease-related genotypes or karyotypes for clinical purposes.

Group Health Plan. Means the medical Benefits plan provided by the University of Michigan.

Habilitative Services. Health care services that help a person keep, learn, or improve skills and functioning for daily living. An example is therapy for a child who isn't walking or talking at the expected age. These services may include physical

and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Home Health Agency. A program or organization authorized by law to provide health care services in the home.
Hospital. An institution operated as required by law that is all the following:

- Primarily engaged in providing health services on an inpatient basis.
- Provides acute care (including at a long-term acute care facility).
- Care is provided through medical, diagnostic, and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24-hour nursing services.
- Is not a nursing home, convalescent home or similar institution.

Injury. Bodily damage other than Sickness, including all related conditions and recurrent symptoms.
Inpatient Rehabilitation Facility. A Hospital (or a special unit of a Hospital that provides inpatient services such as:

- Physical therapy.
- Occupational therapy.
- Speech therapy.

Inpatient Stay. After formal admission, time spent in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.
Intensive Outpatient Mental Health. Acute care services provided on an outpatient basis. They consist of a minimum of three hours per day, two days per week and may include but are not limited to individual, group and family counseling, medical testing, diagnostic evaluation, and/or referral to other services in a treatment plan.
Intensive Outpatient Substance use Treatment. Day treatment that is provided on an outpatient basis. Intensive Outpatient services consists of a minimum of three hours per day, two days per week and might include but are not limited to individual, group and family counseling, medical testing, diagnostic evaluation, and/or referral to other services specified in a treatment plan.
Intermediate Care. Substance Use Disorders Treatment that has a Residential (overnight) component and includes Detox, Domiciliary Partial and Residential (including inpatient and “rehab” services).
Marketplace. An on-line service utilizing websites, call centers, and in-person assistance that helps people shop for and enroll in affordable health insurance. The federal government operates the Marketplace, available at HealthCare.gov, for most states. Some states run their own Marketplaces,
Medically Necessary, Medical Necessity. Coverage of health care services and supplies determined to be medically appropriate per University of Michigan Health Service Company medical policy and nationally recognized guidelines, and are:

- Not Experimental or Investigational Services.
- Necessary to meet the basic health needs of the Covered Person.
- Delivered in the most cost-efficient manner and type of setting that is appropriate.

- Consistent in type, amount, frequency, level, setting, and duration of treatment with scientifically based guidelines that are accepted by University of Michigan Health Service Company.
- Consistent with the diagnosis of the condition.
- Not done for reasons of convenience.
- Demonstrated through current peer-reviewed medical literature to be safe and effective.

Even if you have already received treatment or services, or even if your health care provider has determined that a particular health care service or supply is medically appropriate, it does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Medicare. Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1395, et seq. and as later amended.

Named Fiduciary. The employer is the named fiduciary of the Plan.

The employer may delegate certain of its fiduciary responsibilities under the Plan to persons who are not named fiduciaries of the Plan. If the employer delegates its fiduciary responsibilities to another person, the delegation shall be made in writing by the employer, and a copy of the delegation is kept with the records of the Plan. Each fiduciary is solely responsible for its own acts or omissions. No fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. No fiduciary shall have any liability for a breach of fiduciary responsibility by another fiduciary with respect to the Plan unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach, fails to take responsible remedial action to remedy such breach or, through its negligence in performing its own specific fiduciary responsibilities which give rise to its status as a fiduciary, it enables such other fiduciary to commit a breach of the latter's fiduciary responsibility.

No fiduciary is liable for a breach of fiduciary duty committed before it became a fiduciary and nothing in the Plan shall relieve any person from liability for his or her own misconduct or Fraud.

Network. A group of providers of health care services, who have participation agreements in effect with University of Michigan Health Service Company or its designee to participate in the Network. A health care provider may agree to provide only certain Covered Health Services. The participation status of health care providers changes from time to time.

Network Benefits. Benefits for Covered Health Services that are provided by Network health care providers. Emergency Department Services and Urgent Care Center visits are always covered at the Network Benefit level even when provided by Non-Network health care providers.

Non-Emergency Ambulance Transport. Services that are:

- Recommended by the attending Physician.
- Received from a licensed ambulance service between facilities when the following criteria are met:
  - The patient's condition must be such that any other form of transportation would not be medically recommended and

- Any of the following circumstances exists:
  - Transfer from an acute care facility to a patient's home or Skilled Nursing Facility; or
  - Transfer to and from a patient's home to an acute care facility to obtain Medically Necessary diagnostic or therapeutic services (such as MRI, CT scan, dialysis, etc.).
  - Transportation to or from one acute care facility to another acute care facility, Skilled Nursing Facility or free-standing dialysis center to obtain Medically Necessary diagnostic or therapeutic services (such as MRI, CT scan, intensive care services including neonatal ICU, acute interventional cardiology, radiation therapy, etc.), provided such services are:
    - Not available at the transferring facility where the patient is being treated; and
    - The patient cannot be safely transported in another way; and
    - The patient requires continued acute inpatient medical care.
  - Ground ambulance for a deceased patient in the following circumstances:
    - The patient was pronounced dead while in route or upon arrival at the Hospital or final destination; or
    - The patient was pronounced dead by a legally authorized individual (Physician or medical examiner) after the ambulance call was made, but prior to pick-up.

Non-Network. Describes those health care providers who do not participate in the Network.

Observation Care. A well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients require further treatment as Hospital inpatients or if they can be discharged from the Hospital. Observation status is commonly assigned to patients who present to the Emergency Department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge.

Outpatient Mental Health. Services include individual, conjoint, family or group psychotherapy and crisis intervention provided in a setting other than an inpatient facility.

Outpatient Substance Use Disorders Treatment. Outpatient visits (for example: individual, conjoint, family or group psychotherapy) for a member who is dependent on and/or abusing alcohol or drugs (or both). The visit may include counseling, Detox, medical testing, diagnostic evaluation, and referral for other services provided in a setting other than an inpatient facility.

Partial Hospitalization for Mental Health. A comprehensive, acute care program that consists of a minimum of six hours per day, five days a week, provided in an outpatient setting. Treatment may include but is not limited to counseling, medical testing, diagnostic evaluations, and/or referral to other services in a treatment plan. Partial Hospitalization services are often provided in lieu of inpatient psychiatric hospitalization.

Partial Hospitalization/Domiciliary Partial for Substance Use Disorders Treatment. A comprehensive, acute care program that consist of a minimum of six

hours per day, five days a week. Partial Hospitalization treatment may include, but is not necessarily limited to counseling, medical testing, diagnostic evaluation, and/or referral to other services in a treatment plan. Partial hospitalization services are provided on an outpatient basis; domiciliary services are unsupervised residential services.

PCP Referral. The process by which the Primary Care Physician directs you to a specialist physician prior to a specified service or treatment plan. The PCP coordinates the Referral and any required prior approval.

Physician. Any Doctor of Medicine, "M.D.," or Doctor of Osteopathy, "D.O.," who is properly licensed and qualified by law.

Any nurse practitioner, physician assistant, podiatrist, dentist, psychologist, optometrist, nurse midwife, or other health care provider who acts within the scope of his or her license are considered on the same basis as a Physician. The fact that a health care provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan. Michigan Care.

Plan Administrator. University of Michigan. As Plan Administrator, the company must supply you with this document and other information and file various reports and documents with government agencies. In its role of administering the Plan, the Plan Administrator also may make rulings, interpret the Plan, prescribe procedures, gather needed information, receive, and review financial information regarding the Plan, employ or appoint individuals to assist in any administrative function, and generally do all other things needed to administer the Plan.

The Plan Administrator has all powers and authority needed to enable it to carry out its duties under the Plan.

Failure by the Plan or Plan Administrator to insist upon compliance with any provisions of the plan at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by a person authorized by the Plan Administrator to sign the waiver.

Plan Sponsor. University of Michigan. References to “we,” “us,” and “our” throughout the Plan Document refer to the Plan Sponsor. Plan Sponsor is defined as (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustee, or other similar group of representatives of the parties who establish or maintain the plan. The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend, or modify the Plan and any or all benefits provided under the Plan, covering any active employee or current or future retiree or dependent in whole or in part at any time. Any such change or termination in benefits will be based solely on the decision of the Plan Sponsor and may apply to all eligible active and non-active employees and dependents as either separate groups or as one group, regardless of status.

Pregnancy. Includes all the following:

- Prenatal care.

- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Prescription Drug Product. A medication, product or device that has been approved by the FDA. It cannot be dispensed without a Prescription Order or Refill.
Preventive Health Services. Routine or screening Covered Health Services that are designated to keep you in good health and to prevent unnecessary Injury, Sickness or disability, including but not limited to the following as may be appropriate based on your age and/or gender:

- Evidence-based items or services with an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF), including breast cancer screening, mammography, and prevention;
- Immunizations for routine use in children, adolescents, and adults with a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care screenings for infants, children and adolescents provided in guidelines supported by the Health Resources and Services Administration (HRSA); and
- Evidence-informed preventive care and screening for women provided in guidelines supported by HRSA and not otherwise addressed by the USPSTF.
- Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention.

The complete list of recommendations and guidelines can be found at http://www.HealthCare.gov/center/regulations/prevention.html (the "List") and is continually updated to reflect both new recommendations and guidelines and revised or removed guidelines.
Primary Care Physician (PCP). A Network Physician that you choose to be responsible for providing or coordinating your care.
Reconstructive Surgery. Performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function but may also be done to approximate a normal appearance.
Recreational Therapy. Non-covered services for inpatient or outpatient recreational activities that may serve a therapeutic purpose.
Remote Patient Monitoring. Services utilizing digital technology to collect medical and other forms of health data from an individual in one location and electronically transmitting that information securely to a health care provider in a different location for assessment and recommendations.
Rescission. Means a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuation of coverage is *not* a Rescission if the cancellation or discontinuance of coverage has a prospective effect. Rescission is allowed if it is due to Fraud or intentional misrepresentation of a material fact, failure to timely pay required premiums or contributions toward the cost of coverage or failure to notify the Plan Administrator of a divorce, resulting in the ex-spouse no longer being eligible for coverage.

Respite Care. Temporary care as part of hospice care that is provided to you in a nursing home, hospice inpatient facility or Hospital so that your family member, friend, or care giver can rest or take some time off from care for you.
Residential Mental Health Treatment. Takes place in a licensed mental health facility, which has 24/7 supervision. A nurse or psychiatrist is on site 24/7 to assist with medical issues, administration of medication and crisis intervention as needed. The treatment team is multidisciplinary and led by board-certified psychiatrists. Residential Treatment is:

- Focused on improving functioning and not primarily for the purpose of maintenance of the long-term gains made in an earlier program;
- A structured environment that allows the individual to successfully reintegrate into the community. It cannot be considered a long-term substitute for lack of available supportive living environment(s) in the community or as long term means of protecting others in the member's usual living environment; and
- Not based on a preset number of days such as standardized program (i.e., "30-Day Treatment Program"), however, the benefit design will be the same as your medical inpatient benefit.

Residential Substance Use Disorders Treatment. Acute care services provided in a structured and secure full day (24 hour) setting to a member who is ambulatory and does not require medical hospitalization. Residential Services may include 24-hour professional supervision and may also include counseling, Detox, medical testing, diagnostic evaluation and referral or other services specified in a tratment plan. Residentaial Substance Use Disorders Treatment is sometimes also referred to as inpatient Substane Use Disorders Treatment or rehabilitation ("rehab").
Semi-Private Room. A room with two or more beds. The Plan covers a private room during an Inpatient Stay when one is Medically Necessary, or when a Semi-Private Room is not available.
Sensory Integration Therapy. A form of occupational therapy in which special exercises are used to strengthen the patient's sense of touch (tactile), sense of balance (vestibular), and sense of where the body and its parts are in space (proprioceptive).
Service Area. The geographic area made up of counties or parts of counties where the majority of Network health care providers are located. The service area for this plan is comprised of Washtenaw and Livingston counties and parts of Jackson, Wayne, Oakland, Lenawee and Monroe counties. The Service Area may change from time to time. Please visit the University of Michigan Benefits Office website at http://www.benefits.umich.edu for more information about the Plan's Service Area.
Sickness. Physical illness, disease or Pregnancy. The term Sickness as used in this Plan Document does not include mental illness or substance use disorders, regardless of the cause or origin of the mental illness or substance use disorder.
Skilled Care. Skilled nursing, skilled teaching, skilled rehabilitation, and home infusion services when all the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel to obtain the specified medical outcome, and provide for the safety of the patient; and

- It is ordered by a Physician; and
- It is not delivered to assist with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from a bed to a chair; and
- It requires clinical training to be delivered safely and effectively; and
- Examples include, but are not limited to, intravenous medication, administration, complex wound care, and rehabilitation services.
- It is not Custodial Care.

Determination of available Benefits is based on whether or not Skilled Care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service shall not be determined to be "skilled" simply because there is not an available caregiver.

Skilled Nursing Facility. A Hospital or nursing facility that is licensed and operated as required by law.

Spinal Manipulation. The detection or correction (by manual or mechanical means) of subluxations(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment, or subluxations of, or in, the vertebral column.

Subscriber. An Eligible Person who is properly enrolled under the Plan. The Subscriber is the person (who is not a Dependent) on whose behalf the Plan is established.

Unproven Services. Services that have not demonstrated beneficial effects on health outcomes and that are not based on trials that meet either of the following designs:

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments are based on the above designs.

Urgent Care Center. A facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required because of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Eligibility, Enrollment and Effective Date of Coverage.

Eligibility.

All Subscribers must meet eligibility requirements set by the University of Michigan. University of Michigan is responsible for determining eligibility. University of Michigan Health Service Company, as the Claims Administrator, updates its files with eligibility information provided by the University of Michigan. Please contact the University of Michigan Shared Services Center for eligibility information.
All Covered Persons must live in the Service Area unless stated otherwise in this chapter.

Additional Eligibility Guidelines.

The following guidelines apply to all Covered Persons:

- **Medicare**: If you are not an active employee and you or your Dependent(s) become Medicare eligible, you and/or your Dependent(s) will be enrolled in the Medicare Advantage product. You or your Dependent(s) must enroll in and maintain both Medicare Part A and Medicare Part B when eligible. Except as otherwise provided by applicable law, Benefits for individuals eligible for Medicare Advantage coverage are not duplicated.
- **Out-of-Service Area**: A Dependent choosing to register for Out-of-Service Area coverage must reside outside of the following counties for at least three consecutive months: Washtenaw or Livingston counties or parts of Jackson, Wayne, Oakland, Lenawee and Monroe counties. In addition, for coverage, Dependents are required to receive services within 50 miles of the Out-of-Service Area address you have registered with University of Michigan Health Service Company, the Claims Administrator. For additional information on registration procedures, please call Customer Service at 1-833-484-8450. Please visit the University of Michigan Benefits Office website at http://www.benefits.umich.edu for more information about the Plan's Service Area.

  The above guidelines do not change any other conditions of coverage described in the Plan Document. For example, health care services are Covered Health Services only if and to the extent, they are:

  - Medically Necessary, as determined by University of Michigan Health Service Company; and
  - Listed as covered under BENEFITS AND COVERAGE; and
  - Not limited or excluded under BENEFITS AND COVERAGE or GENERAL EXCLUSION AND LIMITATIONS.

  Certain services are Covered Health Services only if they are prior approved by University of Michigan Health Service Company. If prior approval is not obtained, no Benefits are paid and you may be responsible for all non-covered services. See the chapter, INFORMATION ABOUT YOUR BENEFITS.

The following Dependents are not eligible for Out-of-Service Area coverage:

- Dependents who are outside of the Service Area for vacation (except for Emergency or urgent conditions).
- Dependents who reside outside the Service Area to attend school for less than one semester, or less than three months.
- Dependents who are not students and reside outside the Service Area for less than three months.
- Individuals who misrepresent that they are residing outside the Service Area.
- Dependents who are not residing in the United States (or the portion of Canada within 50 miles of the Service Area).

- **Change of Status**: You agree to notify the Plan Administrator within 30 days of any change in eligibility status of you or any Dependents. When you are no longer eligible for coverage, you are responsible for payment for any services or Benefits unless the services are covered under another health benefit plan or insurance.
- **Inpatient Hospitalization**: If you were admitted to a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility prior to the effective date of the Plan you are covered for the Inpatient Stay on the effective date of coverage only if:
  - You have no continuing coverage under any other health benefits contract, program, or insurance;
  - University of Michigan Health Service Company approves the inpatient care as Medically Necessary; and
  - Your medical management is transferred to your Network Primary Care Physician before or on the effective date.

Other Party Liability.

The Plan does not provide Benefits or coordinate Benefits for services that:

- Are not prior approved by University of Michigan Health Service Company; or
- Are not Covered Health Services under the Plan.

It is your responsibility to provide complete and accurate information requested by us or University of Michigan Health Service Company. Failure to provide requested information, including information about over coverage, may result in denial of claims.

Non-Duplication.

- The Plan provides you with Benefits for health care services as described in this Plan Document.
- The Plan does not duplicate Benefits or pay more for Covered Health Services than the actual fees. This includes no duplicate Benefits paid for no-fault auto-related claims.
- Coverage described in this Plan Document will be reduced to the extent that the services are available or payable by other health plans or policies under

which you may be covered, whether or not you make a claim for the payment under such health plan or policy.

Workers' Compensation and Auto Policy Claims.

Benefits under the Plan exclude services and treatment for any work-related Injury to the extent that Benefits are paid or payable under any workers' compensation program or other similar program. Where services are provided by the Plan, the Plan is assigned the Covered Person's right to seek reimbursement from the other program or insurer.

Benefits under the Plan will not be reduced because of the existence of coverage under a Covered Person's non-coordinated no-fault automobile policy; the Plan will assume primary liability to provide Benefits available under the Plan in accordance with the Plan's terms and conditions.

Coordination of Benefits (COB).

We coordinate Benefits payable under the Plan per the National Association of Insurance Commissioners (NAIC) guidelines.

When you have coverage under a benefit document or policy that does not contain a coordination of benefits provision, that policy pays first as the Primary Plan. This means benefits under the other coverage are determined before the Benefits of this Plan.

After those benefits are determined, the University of Michigan's Benefits and the benefits of the other plan will be coordinated to provide up to 100% coverage whenever possible for services covered partly or totally under either plan. In no case will payments be more than the amounts to which providers or you as a Covered Person are entitled.

Right Of Recovery.

Whenever payments have been made by the Claims Administrator with respect to Eligible Expenses in an amount that is, at any time, in excess of the maximum amount of payment necessary to satisfy the intent of this provision, the Claims Administrator has the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments were made, any other insurance companies, including but not limited to Worker's Compensation carriers, and any other organizations.

If an overpayment is made in the opinion of the Plan Administrator, the Plan has the right to recover the overpayment. If a Covered Person is paid more than allowed by the Plan, the Covered Person must refund that overpayment. A request for refund is made in writing by the Plan. If an overpayment is made by the Plan on behalf of the Covered Person to a Hospital, Physician, or other covered health care provider, the Plan may request a refund of the overpayment from either the Covered Person or the covered health care provider. If the refund is not received from either the Covered Person or the covered health care provider, the overpayment is deducted from any future Plan Benefits available to the covered person or collected through legal process.

Subrogation and Reimbursement.

Subrogation is the assertion by the Claims Administrator of your right, or the rights of your Dependents or representatives, to make a legal claim against or to receive money or other valuable consideration from another person, insurance company or organization.

Reimbursement is the right of the Claims Administrator to make a claim against you, your Dependents, or representatives if you or they have received funds or other valuable consideration from another party responsible for Benefits paid by us.

Definitions: The following terms are used in this section and have the following meanings:

Claim for Damages. Means a lawsuit or demand against another person or organization for compensation for an Injury to a person when the injured party seeks recovery for the medical expenses.

Collateral Source Rule. A legal doctrine that requires the judge in a personal Injury lawsuit to reduce the amount of payment awarded to the plaintiff by the amount of Benefit the Plan has paid on behalf of the injured person.

Common Fund Doctrine. A legal doctrine that requires the Plan to reduce the amount received through subrogation by a pro rata share of the plaintiff's court costs and attorney fees.

First Priority Security Interest. Means the right to be paid before any other person from any money or other valuable consideration received by:

- Judgment or settlement of a legal action.
- Settlement not due to legal action.
- Undisputed payment.

Lien. Means a First Priority Security Interest in any money or other valuable consideration received by judgment, settlement or otherwise up to the amount of Benefits, costs, and legal fees the Plan paid as a result of plaintiff's injuries.

Made Whole Doctrine. A legal doctrine that requires a plaintiff in a lawsuit to be fully compensated for his or her damages before any subrogation Liens may be paid.

Other Equitable Distribution Principles. Means any legal or equitable doctrines, rules, laws, or statutes that may reduce or eliminate all or part of the Plan's claim of subrogation.

Plaintiff. Means a person who brings a lawsuit or claim for damages. The Plaintiff may be the injured party or a representative of the injured party.

Your Responsibilities.

In certain cases, the Plan may have paid for health care services for you or other Covered Persons, which should have been paid by another person, insurance company or organization. In these cases:

- You assign to the Claims Administrator your right to receive what the Plan paid for your medical expenses for the purpose of subrogation. You grant the Claims Administrator a Lien or Right of Recovery.
- Reimbursement on any money or other valuable consideration you receive through a judgment, settlement or otherwise regardless of 1) who holds the money or other valuable consideration or where it is held; 2) whether the money or other valuable consideration is designated as economic or non-economic damages; and 3) whether the recovery is partial or complete.
- You agree to inform the Claims Administrator when your medical expenses should have been paid by another party but were not due to some act or omission.

- You agree to inform the Claims Administrator when you hire an attorney to represent you, and to inform your attorney of the Claims Administrator's right and your obligations under the Plan.
- You must do whatever is reasonably necessary to help the Claims Administrator recover the money paid to treat the Injury that caused you to claim damages for personal Injury.
- You must not settle a personal Injury claim without first obtaining a written consent from the Claims Administrator if payment was made for the treatment you received for that Injury.
- You agree to cooperate with the Claims Administrator in efforts to recover money paid on your behalf.
- You acknowledge and agree that this Plan Document supersedes any Made Whole Doctrine, Collateral Source Rule, Common Fund Doctrine, or other Equitable Distribution Principles.

Member Rights and Responsibilities.

Confidentiality of Health Care Records.

Your health care records will be kept confidential by the Claims Administrator, its agents and the providers who treat you.
You agree to permit providers to release information to University of Michigan Health Service Company. This can include medical records and claims information related to services you may receive or have received.
University of Michigan Health Service Company agrees to keep this information confidential, and to ensure that they also maintain the confidentiality. This information will be used and disclosed only as authorized or required by law.
It is your responsibility to cooperate with the Claims Administrator by providing health history information and helping to obtain prior medical records at the request of University of Michigan Health Service Company.

Primary Care Physician.

You must select a Primary Care Physician (PCP) from the list of participating Network physicians who are available to accept you or your Dependents. If you do not choose a PCP upon enrollment, University of Michigan Health Service Company will choose a PCP for you.
You may change your or your family member's PCP by visiting Michigancare.com or by contacting Customer Service. For information on how to select a Primary Care Physician, and for a list of PCPs, contact Customer Service 1-833-484-8450.
For children under the age of 18, you may designate a Network pediatrician as the PCP. Alternatively, the parent or guardian may select a Network family practitioner or general practitioner as your minor child's PCP and may access a Network pediatrician for general pediatric services.
You do not need prior approval from University of Michigan Health Service Company or from any other person, including your PCP, in order to obtain routine obstetrical or gynecological care from a Network provider who specializes in obstetric and gynecologic care.

Additional Member Responsibilities.

You have the responsibility to:

- Read this Plan Document and Group Health Plan documents.
- Call Customer Service at 1-833-484-8450 for any questions.
- Comply with the plans and instructions for care that you have agreed on with your practitioners.
- Provide, to the extent possible, complete, and accurate information that the Claims Administrator and Network providers need in order to provide you with care.
- Make and keep appointments for non-emergent medical care. You must call the doctor's office if you need to cancel an appointment.
- Participate in the medical decisions regarding your health.
- Participate in understanding your health problems and developing mutually agreed upon treatment goals.
- Comply with the terms and conditions of the coverage provided by the Plan.
- Determine whether a provider is in the Network before obtaining services.

Forms, Identification Cards, Records and Claims.

Forms and Enrollment.

You must complete and submit any enrollment forms, or other forms that, as applicable, the Group Health Plan, or University of Michigan Health Service Company requests. You warrant that any information you submit is true, correct, and complete. The submission of false or misleading information to Group Health Plan, or University of Michigan Health Service Company in connection with coverage under the Plan is cause for Rescission of your coverage within 30 days written advance notice.

You have the right to appeal the decision to rescind your coverage by following the Appeal/Grievance procedure or by contacting Customer Service at 833-484-8450.

Identification Card.

You will receive an identification (ID) card. You must show your ID card every time you request health care services. If you do not show your ID card, health care providers don't know that you are covered under the Plan. They may bill you for the entire cost of the services you receive. You can ask for reimbursement as described in the chapter, HOW TO FILE A CLAIM.

Never let another person who is not a Covered Person under the Plan use your ID card. Immediately report the loss or theft of your ID card to UM Health Service Company. Be sure to destroy any old cards.

If you have not received your ID card or if your card is lost or stolen, please contact Customer Service immediately by calling 1-833-484-8450.

Authorization to Receive Information.

By accepting coverage described in this Plan Document, you agree that the Claims Administrator:

- May obtain any information from providers in connection with your coverage.
- May disclose any of your medical information to your PCP or other treating Physicians as permitted by law.
- May copy records related to your care.

Member Reimbursement.

Your coverage is designed to avoid the requirement that you pay a provider for Covered Health Services other than Copayments and/or Deductible when applicable. If, however, circumstances require you to pay a provider, the Plan will reimburse you for those Covered Health Services if you provide written proof of the payment within 12 months of the date of service (see chapter, HOW TO FILE A CLAIM).

Termination of Coverage.

Termination of Coverage.

Coverage described in this Plan Document will continue in effect for the period of time the Plan remains in effect. Coverage continues from year to year, subject to the rights of the University of Michigan as the Plan Sponsor and University of Michigan Health Service Company as the Claims Administrator to terminate the Plan as permitted by law.

Termination for Nonpayment.

- Nonpayment by University of Michigan:
  - If University of Michigan fails to reimburse University of Michigan Health Service Company according to the terms of the Administrative Services Agreement (ASA), University of Michigan Health Service Company may terminate the ASA.
  - If the ASA is terminated for nonpayment, any services received by you after the date of termination and paid by the Plan will be charged to you and to the University of Michigan as permitted by law.

Termination of a Member's Coverage.

- **Termination**. Coverage may also be terminated for any of the reasons listed below as determined by the University of Michigan. Such termination is subject to notice and appeal/grievance rights required by law:
  - You no longer meet eligibility requirement.
  - Coverage is cancelled for nonpayment.
  - You misuse your coverage, including illegal or improper use of your coverage such as:
    - Allowing an ineligible person to use your coverage.
    - Requesting payment for services you did not receive.
  - You fail to repay the Plan for payments we made for services that were not a Benefit under the Plan, subject to your rights under the grievance/appeal process.
  - You are repaying the Plan funds you received illegally.

- You are serving a criminal sentence for defrauding the Plan.
- The Plan terminates and no longer offers coverage.

- **Rescission**. If you commit Fraud that in any way affects your coverage or you make an intentional misrepresentation of a material fact to obtain, maintain or that otherwise affects your coverage, upon 30 days written advance notice your coverage may be rescinded. Once the Claims Administrator has notified you that your coverage is being rescinded, they may hold or reject claims during this 30-day period. Examples of reasons for Rescission may be:
  - Misuse of your ID card.
  - Intentional misuse of your coverage under the Plan.
  - Knowingly providing inaccurate information regarding eligibility.

Extension of Benefits.

Your rights to Benefits end the date your coverage terminates except that Benefits will be extended for a prior approved Inpatient Stay that began prior to the termination date. Coverage is limited to facility fees; professional claims are not payable after the termination date. Benefits will continue only for the condition being treated on the termination date, and only until any one of the following occurs:

- You are discharged.
- Your Benefits exhausted prior to the end of coverage.

NOTE: if coverage has been rescinded, this extension shall not apply.

Conversion and Continuation of Coverage.

COBRA Coverage.

If you no longer meet eligibility requirements, you may be able to continue coverage at your own expense under federal law known as COBRA (Consolidated Omnibus Budget Reconciliation Act). Most employers with 20 or more employees are required by federal law to offer this continuation coverage. The employer is the administrator of its COBRA plan. If you have questions, you should contact the University of Michigan Shared Services Center.
If your employer is required by COBRA to offer you the option of purchasing continuation coverage, you will need to be aware of the following conditions:

- You may apply and pay for group continuation coverage directly to your employer, but you must do so within the time limits allowed by law. You must also comply with other requirements of federal law.
- This coverage may continue for up to 18, 29 or 36 months, depending on the reason for your initial ineligibility.
  - You are considered a Plan member for all purposes, including termination for cause; however, events that would otherwise result in loss of eligibility are waived to the extent that the federal law specifically allows continuation.
  - Continuation coverage and all Benefits cease automatically under any of the following:

- The period allowed by law expires.
- The employer has terminated the Plan.
- You begin coverage under any other benefit program or health coverage plan (with some exceptions).
- After electing COBRA continuation coverage, you become eligible for Medicare.
- You do not pay for coverage fully and on time.

Individual Coverage.

If you choose not to enroll in COBRA, or if your COBRA coverage ends, you may be able to purchase an individual plan on or off the Marketplace. Contact UM Health Plan, an affiliate of University of Michigan Health Service Company, for information about individual plans on and off the Marketplace.

Other General Provisions.

Notice.

Any notice that the Plan Sponsor or the Claims Administrator is required to give to you will be:

- In writing.
- Delivered personally or sent by U.S. Mail.
- Addressed to your last address provided to either the University of Michigan or University of Michigan Health Service Company.

Change of Address.

You must notify the University of Michigan immediately if your address changes. You must live in the Service Area at least eight months out of each calendar year.

Privacy.

In administering your Plan Benefits, the Claims Administrator complies with all applicable privacy and access statutes, rules, and regulations.

Excluded Health Care Providers.

Consistent with the federal guidelines for payment of sanctioned health care providers, we do not pay claims for items or services furnished, ordered, or prescribed by any health care provider listed on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities. The basis for exclusion may include convictions for program-related Fraud and patient abuse, licensing board actions and default on Health Education Assistance Loans. You are responsible for the full payment of items or services furnished, ordered, or prescribed by any provider included on the OIG List of Excluded Individuals/Entities. This includes items or services such as prescriptions written by or medical equipment ordered by a provider included on this list. This list is available on the OIG web site at www.hhs.gov/oig.

Covered Health Services from a Network Health Care Provider.

Network health care providers are responsible for filing claims directly to University of Michigan Health Service Company. The Plan pays Network health care providers directly. You are responsible for meeting the Annual Deductible, if applicable, and for paying required Copayments or Coinsurance amounts to a Network health care provider at the time of service, or when you receive a bill from the health care provider. If a Network health care provider bills you for any other charges, contact Customer Service at 1-833-484-8450.

Covered Health Services from a Non-Network Health Care Provider.

When you receive Covered Health Services from a Non-Network health care provider (for Emergency Services or for prior approved services), you may have to file a claim. The claim must include all information required to pay the claim. University of Michigan Health Service Company does not require a claim form be submitted with a claim, but a completed claim form usually provides all the information needed to process your claim. Claim forms are available on michigancare.com.

Filing a Claim for Payment.

When you request payment of Benefits for Covered Health Services provided by Non-Network health care providers, you must provide University of Michigan Health Service Company with all the following information:

- The Subscriber's name and address.
- The patient's name, age, and relationship to the Subscriber.
- The member number stated on your ID card.
- An itemized bill from your health care provider that includes the following:
  - Patient diagnosis.
  - Date(s) of service.
  - Procedure code(s) and descriptions of service(s) rendered.
  - Charge for each service rendered.
  - Health care provider of service name, address, and provider identification number.
  - Indication if related to an accident.
  - Proof that you paid for the services (if appropriate).
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health care plan or program. If you are enrolled for other coverage, you must include the name of the other carrier(s).

Additional documentation may be requested of your health care provider before Benefits are considered for payment.

Filing Deadline for Claims.

It is your responsibility to present your ID card when receiving services from all health care providers or upon request.
If you pay for health care services, we recommend that requests for reimbursement be submitted within 90 days of the date of service. If University of Michigan Health Service Company does not receive a claim within one year of the date of service, we may not cover the health care services. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Post-Service Claim Requests.

Post service claim requests are submitted to University of Michigan Health Service Company after medical care has been received. If your post-service claim request is denied, you receive a written notice from the Plan within 30 days of receipt of the request, if all needed information was provided with the request. UM Health Service Company notifies you within this 30-day period if additional information is needed to process the request. They may issue a one-time extension of no longer than ten days and pend your request until all information is received.
Once notified of the extension you then have 45 days to provide this information. If all the needed information is received within the 45-day timeframe and the request is denied, UM Health Service Company notifies you of the denial within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your post-service claim request is denied.
A denial notice:

- Explains the reason for the denial.
- Refers to the part of the Plan Document or medical policy on which the denial is based.
- Describes any additional information needed.
- Explains why the information is required.
- Provides the claim appeal procedures, if applicable.

The chapter following this one on GRIEVANCES, APPEALS AND COMPLAINTS, contains information on your rights if you do not agree with Benefit determinations.

Pre-Service Requests.

Pre-service requests are submitted before service is received. They may require prior approval. If your pre-service request is submitted properly with all needed information, you receive written or electronic notice of the decision within 7 days of receipt of the request. If you file a pre-service request without all the information UM Health Service Company needs to review the request, they notify you of what is missing within five days after the pre-service request is received. If additional information is needed to process the pre-service request, they notify you of the information needed within 15 days after the request was received. They may issue a one-time extension of no longer than 15 days and pend your request until all information is received.
Once notified of the extension, you then have 45 days to provide this information. If all the needed information is received within the 45-day timeframe, University of Michigan Health Service Company notifies you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your pre-service request is denied.
A denial notice:

- Explains the reason for the denial.

- Refers to the part of the Plan Document or medical policy on which the denial is based.
- Describes any additional information needed.
- Explains why the information is required.
- Provides the claim appeal procedures, if applicable.

The chapter following this one on GRIEVANCES, APPEALS AND COMPLAINTS, contains information on your rights if you do not agree with our Benefit determinations.

Urgent Pre-Service Requests that Require Immediate Action.

Urgent pre-service requests require quicker service because:

- A delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function..

You receive notice of the Benefit determination in writing or electronically within 72 hours following receipt of the approval request, considering the seriousness of your condition.
Notice of denial may be oral with a written or electronic confirmation to follow within two days.
If you file an urgent pre-service request without all the information needed to review your request, UM Health Service Company notifies you of what is missing within 24 hours after the urgent pre-service request was received. If additional information is needed to process the request, they notify you of the information needed within 24 hours after the request is received. You then have 48 hours to provide the requested information.
You are notified of a determination no later than 48 hours after:

- UM Health Service Company receives the requested information; or
- The end of the 48-hour period within which you were to provide the additional information if the information is not received within that time.

A denial notice:

- Explains the reason for the denial.
- Refers to the part of the Plan Document or medical policy on which the denial is based.
- Describes any additional information needed.
- Explains why the information is required.
- Provides the claim appeal procedures, if applicable.

The chapter following this one on GRIEVANCES, APPEALS AND COMPLAINTS, contains information on your rights if you do not agree with our Benefit determinations.

Concurrent Care Claim Requests.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments it is considered a concurrent care claim request. If

you request on an urgent basis to extend the treatment, your request is decided by UM Health Service Company within 24 hours from receipt of your request only if your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours before the end of the approved treatment, the request is treated as an urgent pre-service request and decided according to the timeframes described previously under Urgent Pre-Service Requests.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request is considered a new claim request and decided according to post-service or pre-service timeframes, whichever applies.

The chapter following this one on GRIEVANCES, APPEALS AND COMPLAINTS, contains information on your rights if you do not agree with Benefit determinations.

Your Rights.

You have the right to request:

- A copy of the clinical review criteria used to determine Medical Necessity.
- A copy of the University of Michigan Health Service Company medical policy and/or nationally recognized guidelines.
- Any other information used in making the determination.

This request must be made in writing to University of Michigan Health Service Company who provides the information to you free of charge. Contact Customer Service at 1-833-484-8450 if you have questions about getting this information.

GRIEVANCES, APPEALS AND COMPLAINTS

University of Michigan Health Service Company, as the Claims Administrator of the Plan, welcomes your comments and suggestions in order to continue to improve service to you. If you have a problem, they want to solve it. They have a Grievance procedure with full and fair investigation to resolve your problem as rapidly and efficiently as possible. This procedure is required under MCL Section 500.2213 and the Affordable Care Act.
We and the Claims Administrator interpret and administer the terms of the Plan. Any adverse decisions regarding Benefits are subject to your right to appeal under applicable law.
Any Grievance you file because you received an Adverse Benefit Determination, must be filed within 180 days following notice of the Adverse Benefit Determination.

Terms Used in This Process.

Adverse Benefit Determination. Means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a member's eligibility to participate in a plan, and including with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.
Authorized Representative. Means:

- A person (can be a Physician) to whom a Covered Person has authorized in writing to act on his or her behalf at any stage in the Grievance process.
- A person authorized by law to provide substituted consent for a Covered Person; or
- A family member of the Covered Person or the Covered Person's treating health care professional if the Covered Person is unable to provide consent.

Complaint. A written or verbal expression of dissatisfaction about any matter other than an action subject to appeal such as a complaint about quality of care, quality of service or an administrative complaint.
Concurrent Care. An on-going course of treatment previously approved, for example, for a specific period of time or number of treatments.
Expedited/Urgent Grievance. A Grievance, for which a Physician has substantiated, verbally or in writing, that the timeframe for the normal Grievance procedure would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function.
Grievance/Appeal. A written expression of dissatisfaction by a Covered Person or Authorized Representative concerning an Adverse Benefit Determination of a Pre-Service, Post-Service, or Concurrent Care Claim. The terms "Appeal" and "Grievance" mean the same thing in the Plan.

Post-Service Claim. A claim that is filed for payment of Benefits after medical care has been received.
Pre-Service Request. A request that is filed before services are received. Prior approval may be required.
Urgent Pre-Service Request. A request that may require prior approval and is filed before receiving medical care. A delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or could cause severe pain that could not be adequately managed without the care or treatment that is requested.

What to Do First.

If you have a complaint about the quality of service or care that you receive, please contact Customer Service at the phone number below. They follow up on all complaints.
If you have a concern or question about a Benefit determination, particularly an Adverse Benefit Determination, you may informally contact Customer Service before requesting a formal Grievance. If the Customer Service specialist cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing.
You may submit a Grievance without first informally contacting Customer Service. Grievance forms are available on michigancare.com or by calling Customer Service at 1-833-484-8450.
Customer Service specialists are available to take your call during regular business hours, 8:30am to 5:30pm, Monday through Friday.

How to Request a Formal Grievance.

This process must be initiated in writing within 180 days following notice of the Adverse Benefit Determination. You may authorize, in writing, an Authorized Representative to act on your behalf at any stage of the Grievance process.
If the Grievance request relates to a claim for payment, your request should include:

- The patient's name and member number from the ID card;
- The date(s) of medical service(s);
- The health care provider's name;
- The reason you believe the claim should be paid; and
- Any documentation or other written information to support your request for claim payment.

Grievance Process – Step 1.

University of Michigan Health Service Company lets you know by letter within five calendar days from the date they receive your Grievance that the Grievance has been received. They inform you or your Authorized Representative of the review outcome by letter within 15 calendar days for Pre-Service Requests or 20 calendar days for Post-Service Claims. If your Grievance is related to clinical matters, the review is done in consultation with an expert health care professional who was not

involved in the prior determination. By requesting a Grievance, you consent to this referral and the sharing of pertinent medical claim information.
Upon request, and free of charge, you have the right to reasonable access to, and copies of, all documents, records, and other information relevant to your claim for Benefits. If UM Health Service Company receives additional information during the review, they provide you a copy of this information free of charge. You or your Authorized Representative has the right to present your Grievance and to provide written comments, documents, records, or other additional information relating to the claim.
All comments, documents, records and other information submitted are considered.

Grievance Process – Step 2.

If you are not satisfied with the decision on your issue in Step 1, you have the right to appear before a Board of Directors, a designated committee, or a managerial level conference to present your Grievance to University of Michigan Health Service Company. This is called a hearing.
You must start the hearing process within 60 days from the date of the letter with the review outcome in Step 1. You may come to the hearing in person or join UM Health Service Company by phone. If you request a Grievance hearing, a committee of qualified individuals, who were not involved in the decision being appealed, are appointed by the Plan to decide the Grievance. The committee may consult with, or seek the participation of, medical experts as part of the Grievance resolution process.
You must complete Step 1 of the Grievance Process before proceeding to Step 2.
You or your Authorized Representative is informed of the outcome of the hearing within ten calendar days.

Grievance Determinations.

Pre-Service Requests and Post-Service Claim Appeals.

Once the Grievance process starts, you are sent written or electronic notification of the determination within a total of 30 days from receipt of the Grievance request. Notification of the determination of Step 1 is sent within 15 calendar days for Pre-Service Requests or within 20 calendar days for Post-Service Claims, and notification of the determination of Step 2 is sent within ten calendar days.

Urgent Grievances/Appeals of Pre-Service Requests That Require Immediate Action.

Your appeal of a Pre-Service Request may require immediate action if a delay in treatment could:

- Significantly increase the risk to your health.
- Significantly decrease your ability to regain maximum function.
- Cause severe pain that could not be adequately managed without the care or treatment that is requested.

In these urgent situations:

- The appeal does not need to be submitted in writing.

- You or your Physician should call UM Health Service Company as soon as possible.

University of Michigan Health Service Company provides you with a written or electronic determination within 72 hours following receipt of your request for review of the determination. They consider the seriousness of your condition. If you wish to seek external review by an independent review organization for an urgent claim, you may ask for review while you go through the internal Grievance process (see the section, External Review Rights, below). If you do not request an independent review at the same time as the internal Grievance process and you later wish to seek external review, the review must be filed with the Department of Insurance and Financial Services (DIFS) within ten days of our final determination. For information about requesting review of an urgent situation by the Director of DIFS, see the section, External Review Rights, below.

External Review Rights.

If you are not satisfied with the final Grievance determination, you have rights to the following:

- You have the right to seek external review by an independent review organization pursuant to MCL 500.2213. You must submit your request for external review within 127 days from the date you receive our final determination. The Claims Administrator can provide you with a copy of the DIFS Health Care Request for External Review Form (FIS-0018). For additional information about external review, you can contact the Director of DIFS at the address shown below.

  Mail:

  OFFICE OF GENERAL COUNSEL - HEALTHCARE APPEALS SECTION
  DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
  PO BOX 30220
  LANSING MI 48909-7720

  Delivery Service:

  Office of General Counsel - Healthcare Appeals Section
  Department of Insurance and Financial Services
  530 W. Allegan St., 7th Floor
  Lansing, MI 48933-1521

  Telephone: 877-999-6442

  Fax: 517-284-8838

  www.michigan.gov/difs

- Any legal proceeding or action against University of Michigan Health Service Company, its successor, or their affiliates, agents and/or employees, must be brought within three years of the date you are notified of the final decision on your appeal of the Adverse Benefit Determination. If you do not initiate any such legal proceeding or other action within the three-year time period, you give up your rights to bring any such proceeding or action.

- The Plan complies with the Patient's Right to Independent Review Act (PRIRA). You can request external review through DIFS at Request External Review or go to https://difs.state.mi.us/complaints/externalReview.aspx.

INFORMATION ABOUT YOUR BENEFITS

Accessing Benefits.

Covered Health Services must be provided by Network health care providers, except for Emergency Services or Urgent Care Center visits.
Benefits are available only if all the following are true:

- Covered Health Services are received while the Plan is in effect.
- Covered Health Services are received before your coverage ends.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Plan.

The Plan pays Network Benefits for Covered Health Services that are:

- Provided by Network health care providers.
- Prior approved by UM Health Service Company, if required.
- Emergency Services such as ambulance charges and Emergency Department visits.
- Urgent Care Center visits.
- Covered Health Services received in a Non-Network Physician's office outside the Service Area to treat emergent/urgent conditions that require immediate attention.
- Non-Network Covered Health Services with prior approval (except for reimbursement of a routine eye exam).

Benefits for Covered Health Services are not subject to any limitation or Exclusion related to a pre-existing condition.

Medical Necessity.

A health care service or supply is a Covered Health Service under the Plan if determined to be Medically Necessary per University of Michigan Health Service Company medical policy and nationally recognized guidelines.
Even if you have already received treatment or services, or even if your health care provider has determined that a particular health care service or supply is medically appropriate, it does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Provider Network.

University of Michigan Health Service Company and/or its designees contracts with health care providers to form a Network. Network health care providers are independent practitioners. They are not employees of University of Michigan Health Service Company.
A directory of Network health care providers is available to you. You must choose your Network health care providers. Before going for services, make sure your health care provider is in the Network. A health care provider's status in the Network can change. You can check the health care provider's status by calling Customer Service at 1-833-484-8450 or by accessing michigancare.com.

If a health care provider leaves the Network or is otherwise not available to you, you must choose another Network provider to receive Network Benefits.

Medical Resource Management.

Your Network health care providers must get prior approval from the Medical Resource Management Department at University of Michigan Health Service Company for coverage of certain health care services. When your health care provider contacts the Plan, they can work together to give you information about additional services that are available to you.

Designated Facilities and Other Health Care Providers.

If you have a medical condition that UM Health Service Company believes needs special services, such as a transplant, they may direct you to a Designated Facility or other health care provider chosen by them. If you require Covered Health Services not available from a Network health care provider, they may direct you to a Non-Network facility or Physician.

Non-Network Covered Health Services Paid as Network Benefits.

University of Michigan Health Service Company's goal is to provide a comprehensive Network of health care providers that can meet all your health care needs. If the Plan decides that Covered Health Services are not available from a Network health care provider, you may be able to receive coverage when seeing a Non-Network health care provider. Please make sure that UM Health Service Company has approved the request. If you see a Non-Network health care provider without approval, except for Emergency Department or Urgent Care Center visits, Benefits are not paid. You may be responsible for all non-covered charges.

You may receive services from Non-Network health care providers at Network facilities, such as for pathology, anesthesiology, radiology and Emergency Department Physicians. The Plan covers these services provided by Non-Network health care providers at the Network Benefit level and in these situations, providers may not balance bill you for the difference between the amount they charge and the amount that the Plan pays.

Under the No Surprises Act, Non-Network providers at a Network facility cannot bill you more than the Network cost sharing amount for some services (like anesthesiology or radiology) received at a Network facility unless you consent by signing the notice and consent form waiving your protections.

The Non-Network providers providing services at a Network facility are required to provide a notice explaining the services may be more expensive and what your options are to avoid balance billing. You do not have to sign the notice or receive care from a Non-Network provider.

You have the right to request that services are performed by a Network provider. If you consent to receive nonemergency care from a Non-Network provider, the balance billing prohibition does not apply and you may be subject to balance billing. You may contact UM Health Service Company at 1-833-484-8450 Monday through Friday for assistance finding a Network provider.

If you have questions about a bill you have received, please call Customer Service at 1-833-484-8450. Michigan Department of Insurance and Financial Services may assist with any unresolved issues by calling 877-999-6442. Centers for Medicare and Medicaid Services may also assist with unresolved surprise bills from air ambulance providers by calling 800-985-3059.

Emergency Services.

Your health care provider does not have to get prior approval from University of Michigan Health Service Company before you receive care or treatment at an Emergency Department (ED), even if the Emergency Department is not in the Network.
We cover Emergency Department services required for stabilization and initiation of treatment. Network Benefit levels are always paid for Emergency Department services, even if the services are provided by a Non-Network health care provider.
However, if you are formally admitted as an inpatient to a Hospital after you receive Emergency Department services, University of Michigan Health Service Company must be notified within one business day or on the same day of admission or as soon as reasonably possible if there are extenuating circumstances.
If you are formally admitted as an inpatient to a Hospital within 24 hours of receiving Emergency treatment for the same condition, you do not pay the Emergency Department visit Copayment.
The Emergency Department Copayment is not waived for outpatient Observation Care received directly following a visit to the Emergency Department.

Prior Approval.

Certain Covered Health Services require prior approval from University of Michigan Health Service Company for coverage of these services or products. Health care providers must get the approval on your behalf before they provide these services to you. We recommend you make sure the approval has been received.
Prior approval is not required before you see a Network health care provider of obstetrics or gynecology for routine care.
When Covered Health Services require prior approval, they must meet criteria for coverage. University of Michigan Health Service Company maintains Benefit Coverage, Drug Determination Policies and Payment Reimbursement Policies that are available on michigancare.com.
Always make sure that the services you plan to receive are Covered Health Services, even if not specifically listed below as requiring prior approval. For example, in one instance a procedure may be covered but, in another situation, the same procedure is not covered. By calling Customer Service before you receive treatment, you can check to see if the service is:

- A Cosmetic Procedure. An example of a procedure that may or may not be considered Cosmetic is rhinoplasty. It is covered when certain clinical indicators are present but is considered cosmetic in other circumstances.
- An Experimental, Investigational or Unproven Service.
- A service that is not covered under the Plan.

Prior approval is not a guarantee of Benefits. Coverage depends on the services that are actually received, your eligibility status, and any Benefit limitations or Exclusions.
If your health care provider does not get prior approval as required, Benefits may be reduced or may not be paid at all.
The list below of Covered Health Services that require prior approval is subject to change and may not include every service, supply, drug, or procedure. Please

access michigancare.com or call Customer Service for the most current information.

Covered Health Services that Require Approval.

1. Autism Spectrum Disorders treatment.
2. Behavioral Health Services – non-routine services such as:
   - All Inpatient Stays (see under Hospital – inpatient below).
   - Residential Treatment Programs.
   - Intermediate Care (day treatment and Partial Hospitalization).
   - Certain outpatient services: Intensive Outpatient therapy (IOP), electroconvulsive therapy (ECT), and transcranial magnetic stimulation (TMS).
3. Conventional eyeglass lenses and/or corrective contact lenses (if condition cannot be corrected with eyeglasses) for the conditions of keratonconus, aniseikonia monocular aphakia, anisometropia, post cataract surgery or post corneal transplantation surgery.
4. Dental services – accidental – your health care provider does not have to get approval at the time of the initial Emergency treatment but prior to follow up care (for additional information, please see Oral Surgery in the Benefits and Coverage chapter).
5. Drugs and medications – select group that are subject to meeting criteria for coverage (for example, certain injectables administered by a health care provider).
6. Durable Medical Equipment and medical supplies – certain items only.
7. Fertility preservation services.
8. Gender-affirming surgery and procedures.
9. Genetic testing; including genetic testing of embryos.
10. Home health care.
11. Home infusion services.
12. Hospice room and board.
13. Hospital – inpatient (including extended maternity stays, Emergency admission for behavioral health and non-behavioral health conditions and long-term acute inpatient care).

    Your health care provider does not have to get approval before you receive care or treatment at an Emergency Department or Urgent Care Center.

    Your health care provider must get prior approval as follows:

    - For elective admissions: five business days before admission.
    - For non-elective admissions: within one business day or the same day of admission.
    - For Emergency admissions, within one business day or the same day of admission or as soon as reasonably possible if there are extenuating circumstances.

- Maternity admissions – no prior approval is required unless Inpatient Stay is longer than:
  - 48 hours for the mother and newborn child following a normal vaginal delivery.
  - 96 hours for the mother and newborn child following a cesarean section delivery.
  - If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than the federally established minimum time frames above. If delivery occurs outside of a Hospital, the above time periods begin on inpatient admission to the Hospital.

14. Preventive Health Services, certain services only – BRCA mutation testing.
15. Procedures – inpatient or outpatient, as listed here: hyperbaric oxygen therapy, spinal cord stimulation, sacral nerve stimulation, facet joint injections and facet neurotomy, temporomandibular joint syndrome/dysfunction surgery, orthognathic surgery, femoro-acetabular impingement hip surgery, varicose vein treatment, biofeedback training, tissue-engineered skin substitutes, blepharoplasty and repair of brow ptosis, and total cervical disc arthroplasty.
16. Prosthetic and orthotic devices (if cost is over $1,000).
17. Proton beam therapy.
18. Reconstructive Surgery and procedures, including but not limited to abdominoplasty, breast reduction, and rhinoplasty.
19. Rehabilitation services – outpatient physical, occupational and speech therapy.
20. Skilled Nursing Facility and Inpatient Rehabilitation Facility.
21. Transplant services.
22. Weight reduction procedures.

Approval Requirements for Non-Network Health Care Providers.

If you have been referred to a Non-Network health care provider we may pay for Covered Health Services if University of Michigan Health Service Company determines that there is not a health care provider in the Network that can perform a necessary Covered Health Service. Your health care provider must get prior approval so that claims are covered. Otherwise, Benefits are not paid and you may be responsible for all costs associated with those services.

Utilization Review.

Prior approval is one part of the utilization review process, which also includes concurrent review of ongoing course of treatment, urgent/expedited review, and post-service review. For complete information on the process and timelines for review of claims and requests, see the chapter, HOW TO FILE A CLAIM.

When Medicare or Other Coverage is Primary.

If you have other health care coverage that pays before the Plan pays, the prior approval requirements described above still apply to you.

Information About Your Cost Share.

The Plan does not contain an annual or lifetime limit on the dollar amount of Essential Health Benefits.
Your outpatient Prescription Drug coverage is administered through a pharmacy benefit manager not affiliated with University of Michigan Health Service Company. There is a separate Annual Out-of-Pocket Maximum for outpatient Prescription Drugs.

Your Annual Deductible.

The Plan does not have an Annual Deductible.

Your Annual Out-of-Pocket Maximum.

The most that you pay, out of your pocket, in a calendar year for your share of the cost of Covered Health Services. Included in this maximum are your Coinsurance amounts and your Copayments, except for outpatient Prescription Drug Copayments. Charges above Eligible Expenses do not go toward satisfaction of the Annual Out-of-Pocket Maximum.

> $3,000 per Covered Person per calendar year, not to exceed $6,000 for all Covered Persons in a family.

If one Covered Person meets the single Annual Out-of-Pocket Maximum but not the family Annual Out-of-Pocket Maximum, that member does not pay any more cost sharing for the rest of the calendar year. Cost sharing for the remaining family members must still be paid until the family Annual Out-of-Pocket Maximum has been met.

List of Covered Health Services.

1. Professional (Physician) Services (Other Than Mental Health and Substance Use Disorders).

Referrals are required for coverage of visits to and by specialists when services are rendered on an outpatient basis including home visits, except for Dependent children receiving pediatric services from a Network pediatrician. A Referral is not a guarantee of Benefits. Coverage depends on the services that are actually received, your eligibility status, and any Benefit limitations or Exclusions.

Physician's Office Services – Sickness or Injury.

- Your cost share:
  - Primary Care Physician (PCP) office: $25 per visit.
  - Specialist office: $30 per visit.
  - Convenience care facility/retail clinic: $25 per visit.
  - Associated Covered Health Services received during an office visit do not require a separate cost share.

- Coverage for:
  - Services received in a PCP's or specialist's office that may be freestanding, located in a clinic or located in a Hospital.
  - Associated services such as radiology, pathology, other diagnostic services, and osteopathic manipulation.
  - Consultations.
  - Medical education services to manage chronic diseases such as diabetes or asthma.
- Covered Health Services received at a Non-Network Physician's office outside the Service Area to treat emergent or urgent conditions are covered.

Maternity Care.

- Your cost share:
  - Covered in full.
- Coverage for prenatal care, postnatal care, and delivery charges.

Home Visits.

- Your cost share:
  - Covered in full.
- Coverage for care provided by a Physician in the home or temporary residence.

Inpatient and Outpatient Professional Services.

- Your cost share:
  - Covered in full.
- Coverage for Physician services provided during an Inpatient Stay in a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility and at an outpatient facility such as a clinic or ambulatory surgical center.
- Office visits in an outpatient facility setting are subject to applicable Copayments. See Physician's Office Services – Sickness or Injury.

Allergy Care.

- Your cost share:
  - $30 Copayment per visit.
  - Injections – covered in full.
- Coverage includes:
  - Survey, including history, physical exam, and diagnostic laboratory studies.
  - Intradermal, scratch and puncture tests.
  - Patch and photo tests.
  - Double-blind food challenge test and bronchial challenge test.
  - Allergy immunotherapy shots.

- Therapeutic injections of anti-allergen, antihistamine, bronchodilator or antispasmodic agents.

- The Plan does not cover:
  - Fungal or bacterial skin tests.
  - Self-administered and/or over-the-counter drugs.
  - Psychological testing, evaluation, or therapy for allergies.
  - Environmental studies, evaluation, or control.

Continuity of Care for Professional Services.

Current Members:

If you have regularly been seeing a Physician who is no longer in the Network, we may continue to cover the services you receive from that Physician while you are covered under the Plan. To receive continued care from a Non-Network Physician, the treating Physician must agree to continue to see you and your situation must be one of the following:

- You are currently involved in an ongoing course of treatment (you may be able to continue for up to 90 days).
- You are in your second or third trimester of pregnancy (you may be able to continue until the end of the postpartum care directly related to the Pregnancy).
- You are diagnosed with a terminal illness and are actively being treated for the illness (you may continue receiving treatment for the illness for the remainder of your life).
- You are currently being treated for a health condition that your treating Physician or health care provider can prove that by stopping treatment with this Physician or health care provider would cause the condition to get worse or reduce the expected results of the treatment.

If you believe that you may qualify for continued care with a Physician who no longer participates in the Network, please contact Customer Service by calling 1-833-484-8450.

New Members:

If you are a new member and want to continue an active course of treatment from your existing Non-Network health care provider, you may request continuing coverage of the services you receive based on the criteria above.

2. Inpatient Hospital Services.

- Your cost share:
  - Covered in full.

- Coverage for:
  - Facility charges (room and board).
  - General nursing services and special diets.
  - Anesthesia, laboratory, radiology, and pathology services.
  - Chemotherapy, inhalation therapy and dialysis.

- Physical, speech and occupational therapy.
- Other services and supplies necessary for treatment.
- Maternity care, including newborn examination, routine newborn care during the Inpatient Stay and services to treat a newborn's Injury, Sickness, or Congenital Anomaly.

3. Outpatient Services.

- Your cost share:
  - Your cost share for covered outpatient services depends on the service received and where you receive the service. For your cost share, the services are covered in full unless described in another section of the Plan as referenced below.
- Coverage for:
  - Medically Necessary services when performed in an outpatient Hospital setting, Physician's office, free standing center, or dialysis center for the diagnosis or treatment of a disease, Injury, or other medical condition.
  - Surgical procedures, such as colonoscopy, esophagogastroduodenoscopy (EGD), and cardiac catheterization.
  - Anesthesia, laboratory, radiology, and pathology services.
  - Chemotherapy, inhalation therapy, radiation therapy and dialysis.
  - Physical, speech and occupational therapy - see Outpatient Therapy Services.
  - Injections and infusions - see Professional Physician Services (Other Than Mental Health and Substance Use Disorder) and Home Infusion Therapy Services.
  - Certain vaccinations related to travel: Cholera, Japanese Encephalitis, Typhoid, and Yellow Fever vaccines.
  - Professional Services - see Professional Physician Services (Other Than Mental Health and Substance Use Disorder).
  - Durable Medical Equipment and supplies - see Durable Medical Equipment and Diabetic Supplies.
  - Diabetic equipment and supplies - see Durable Medical Equipment and Diabetic Supplies.
  - Orthotic and prosthetic equipment and supplies - see Orthotics and Prosthetics.
  - Laboratory and pathology tests.
  - Radiology such as X-rays, ultrasounds, and mammography.
  - High tech radiology, such as CT scans, MRIs, and MRAs; and nuclear medicine, such as PET scans, radioactive isotope studies and use of radium.
  - Therapeutic treatment services such as:
    - Dialysis.
    - Intravenous chemotherapy or other intravenous infusion therapy.
    - Radiation therapy.

- Medical education services to manage chronic disease states such as diabetes or asthma.
- Facility charges, medical supplies and equipment.
- Observation Care.
- Professional fees.
- Nutritional counseling (non-preventive), must be provided by a qualified health care professional and conditions for which nutritional counseling is a Covered Health Service include, but are not limited to:
  - Weight management.
  - Diabetes mellitus.
  - Coronary artery disease.
  - Congestive heart failure.
  - Severe obstructive airway disease.
  - Gout.
  - Renal Failure.
  - Phenylketonuria.
  - Hyperlipidemia.

- Pain management services such as:
  - Evaluation and treatment of chronic pain that persists without relief from standard methods of treatment.
  - Insertion of spinal cord stimulators.
  - Facet joint injections and facet neurotomy.

- The Plan does not cover:
  - Radiation therapy provided by Non-Network providers.
  - Megavitamin and nutrition-based therapy.
  - Food, nutritional supplements, protein, or caloric boosting supplements (for example, Boost, Ensure, Glucerna, Osmolite, or PediaSure).
  - Herbal preparations or supplements.
  - Medications listed in University of Michigan Health Service Company's Site of Care Policy that are administered at an outpatient facility that can instead be safety administered in an outpatient professional setting (for example, in a Physician's office) or through home infusion therapy services. The Site of Care Policy is available on michigancare.com.

4. Emergency and Urgent Care.

- Your cost share:
  - Emergency Department (ED) – $100 Copayment per visit.
  - Urgent Care Center – $25 Copayment per visit.
  - Convenience Care facility/retail clinic – $25 Copayment per visit.

- Definitions:
  - Accidental Injury. A traumatic Injury, which, if not immediately diagnosed and treated, could be expected to result in permanent damage to your health.
  - Emergency Department Services. Services to treat emergency conditions as described above.
  - Medical Emergency. The sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to your health. In the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
  - Stabilization. The point at which it is reasonably probable that no material deterioration of a condition is likely to result from or occur during your transfer.
  - Urgent Care Services. Services that appear to be required in order to prevent serious deterioration to your health resulting from an unexpected illness or injury that could be expected to seriously worsen if not treated within 24 hours. Examples include flu, strep throat, or other infections; foreign material in the eye, sprain or pain following a fall; and a cut, sore or burn that does not heal.
  - Convenience Care Facilities. Usually retail-based clinics that are staffed by nurse practitioners and physician assistants that provide care outside the Emergency Department, Urgent Care Center or Physician's office for basic medical services and common, non-life-threatening conditions, such as for allergies, athlete's foot, cold and flu symptoms, poison ivy and sunburn.
- Coverage for:
  - Covered Health Services required up to the point of Stabilization when they are needed for immediate treatment of a Medical Emergency.
  - Professional fees and associated services.
  - Non-Network services received from Emergency Departments and Urgent Care Centers.
- The ED visit Copayment is waived if admitted for an Inpatient Stay within 24 hours for the same condition. However, if Observation Care directly follows an Emergency Department visit, the ED visit Copayment is not waived.

5. Ambulance Services – Ground, Air or Water.

- Your cost share:
  - Covered in full.
- Coverage for:
  - Emergency or Non-Emergency Ambulance Transport.
  - Licensed ambulance providers.
  - Transport to the nearest Hospital where Emergency Services can be performed.
  - Transfer of the patient to another treatment location such as another Hospital, a Skilled Nursing Facility, a medical clinic, or the patient's home.

- Air or water ambulance transport if:
  - The patient has a potentially life-threatening condition and transport by ground ambulance poses a threat to your survival or seriously endangers your health.
  - No other means of transportation are available.
  - The provider is not a commercial airline.
  - The patient is taken to the nearest facility capable of treating the patient's condition.

- Covered Health Services for ground ambulance services received from Non-Network health care providers are covered at the Network Benefit level. However, a Non-Network ground Ambulance provider is not covered under the No-Surprises Act and may bill you for any portion of their charges not covered by the Plan, including the difference between their billed charges and the Eligible Expense. If you have questions about a bill you have received, please call Customer Service.
- The Plan does not cover:
  - Medical services provided by Emergency transport providers that are government supported such as fire departments or rescue squads or where fees are in the form of a voluntary donation.
  - Ambulance transport (ground, water, or air) that University of Michigan Health Service Company determines is not to the closest Hospital within a reasonable distance and equipped to treat the condition, including transport to a preferred Hospital or for the convenience of being closer to your home or someone to provide continuing care to you.
  - Non-Network ground Ambulance charges not covered by the Plan, including the difference between their billed charges and the Eligible Expense.

6. Preventive Health Services.

- Your cost share:
  - Covered in full.
- The Plan complies with the Affordable Care Act. The Preventive Health Services Benefit is subject to change.
- A complete list of recommendations and guidelines can be found at http://www.HealthCare.gov/center/regulations/prevention.html and is continually updated to reflect both new recommendations and guidelines and revised or removed guidelines.

Covered Preventive Health Services for Adults.

- Routine physical exams as recommended by your Primary Care Physician – limited to one exam per calendar year.
- Routine eye exams – limited to one exam per calendar year. Covered in full with a Network provider. If you obtain a routine eye exam from a Non-Network provider, the Plan reimburses you up to $40. Submit an itemized bill showing you paid for the service to:

UNIVERSITY OF MICHIGAN HEALTH SERVICE COMPANY

CUSTOMER SERVICE
PO BOX 30377
LANSING MI 48909-7877

- Screenings such as:
  - Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked.
  - Alcohol misuse screening.
  - Blood pressure screening for all adults.
  - Cholesterol screening for adults of certain ages or at higher risk.
  - Colorectal cancer screening for adults age 45 through 74. Includes up to 2 prescriptions in 365 days for a select group of Prescription Drug Products for bowel prep.
  - Depression screening for adults.
  - Type 2 diabetes screening for adults of certain ages or at higher risk .
  - Hepatitis B screening for people at higher risk.
  - Hepatitis C screening for adults age 18 to 79 years.
  - HIV screening for all adults at higher risk
  - Lung cancer screening for adults 50 to 80 at higher risk.
  - Obesity screening for all adults.
  - Tobacco use screening for all adults.
  - Syphilis screening for all adults at higher risk.
  - Tuberculosis screening for certain adults at higher risk.
- Counseling such as:
  - Aspirin use for men and women of certain ages.
  - Alcohol misuse counseling.
  - Diet counseling for adults at higher risk for chronic disease.
  - Sexually transmitted infection (STI) prevention counseling for adults at higher risk.
  - Obesity counseling for all adults.
  - Nutritional counseling (considered to be Preventive Health Services).
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
  - Hepatitis A.
  - Hepatitis B.
  - Herpes Zoster.
  - Human Papillomavirus.

- Influenza.
- Measles, Mumps, Rubella.
- Meningococcal.
- Pneumococcal.
- Tetanus, Diphtheria, Pertussis.
- Varicella.

Covered Preventive Health Services for Women, Including Pregnant Women.

- Routine physical exams – limited to one exam per calendar year.
- Well-woman visits – limited to one exam per calendar year.
- Routine eye exams – limited to one exam per calendar year. Covered in full with a Network provider. If you obtain a routine eye exam from a Non-Network provider, the Plan reimburses you up to $40. Submit an itemized bill showing you paid for the service to:

  UNIVERSITY OF MICHIGAN HEALTH SERVICE COMPANY

  CUSTOMER SERVICE
  PO BOX 30377
  LANSING MI 48909-7877
- HPV DNA testing for women 30 years and older.
- Screenings such as:
  - Gestational diabetes for pregnant women.
  - HIV screening.
  - Interpersonal and domestic violence screening.
  - Anemia screening on a routine basis for pregnant women.
  - Bacteriuria urinary tract or other infection screening for pregnant women
  - Breast cancer mammography screenings.
  - Cervical cancer screening for sexually active women.
  - Chlamydia infection screening.
  - Gonorrhea screening for pregnant women and all women at higher risk.
  - Hepatitis B screening for pregnant women at their first prenatal visit.
  - Osteoporosis screening for women over age 60 depending on risk factors.
  - Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
  - Tobacco use screening for all women, and expanded counseling for pregnant tobacco users.
  - Syphilis screening for all pregnant women or other women at increased risk.
- Counseling such as:
  - Sexually-transmitted infection counseling.

- HIV counseling.
- Contraceptive counseling.
- Breastfeeding support and counseling.
- Interpersonal and domestic violence counseling.
- BRCA Genetic Counseling for women at higher risk.
- Breast cancer chemoprevention counseling for women at higher risk.
- Nutritional counseling (considered to be Preventive Health Services).
- Urinary incontinence screening.

- Other services such as:
  - Breast feeding interventions to support and promote breast feeding, including breast pumps reimbursed up to $150 from Network providers and lactation counseling received in a Physician's office.
  - Select FDA-approved contraceptive methods on the ACA Preventive Prescription Drug List such as office-administered devices and appliances (intrauterine devices [IUDs]); implantable and injected drugs (Depo-Provera); and diaphragms including measurement, fittings, removal, administration, and management of side effects.

Covered Preventive Health Services for Children.

- Routine physical exams including well baby and well child visits.
- Routine eye exams – limited to one exam per calendar year. Covered in full with a Network provider. If you obtain a routine eye exam from a Non-Network provider, the Plan reimburses you up to $40. Submit an itemized bill showing you paid for the service to:

  UNIVERSITY OF MICHIGAN HEALTH SERVICE COMPANY

  CUSTOMER SERVICE
  PO BOX 30377
  LANSING MI 48909-7877

- Screenings such as:
  - Autism screening for children at 18 and 24 months.
  - Blood screening for newborns.
  - Cervical dysplasia screening for sexually active females.
  - Congenital hypothyroidism screening for newborns.
  - Depression screening for adolescents beginning routinely at age 12.
  - Developmental screening for children under age three, and surveillance throughout childhood.
  - Dyslipidemia screening for children at higher risk of lipid disorders.
  - Hearing screening for all newborns.
  - Hematocrit or hemoglobin screening for children.
  - Hemoglobinopathies or sickle cell screening for newborns.

  - Hepatitis B screening for adolescents at higher risk.
  - HIV screening for adolescents at higher risk.
  - Hypothyroidism screening for newborns.
  - Lead screening for children at risk of exposure.
  - Obesity screening.
  - Phenylketonuria (PKU) screening for this genetic disorder in newborns.
  - Vision screening for all children.
- Assessments such as:
  - Alcohol and drug use assessments for adolescents.
  - Behavioral assessments for children of all ages.
  - Height, weight, and body mass index measurements for children.
  - Medical history for all children throughout development.
  - Oral health risk assessment for young children.
- Counseling such as:
  - Use of fluoride chemoprevention supplements for children without fluoride in their water source.
  - Use of iron supplements for children ages six to 12 months at risk for anemia.
  - Obesity counseling.
  - Sexually transmitted infection (STI) prevention counseling for adolescents at higher risk.
  - Nutritional counseling (considered to be Preventive Health Services).
- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
  - Diphtheria, Tetanus, Pertussis.
  - Haemophilus influenzae type b.
  - Hepatitis A.
  - Hepatitis B.
  - Human Papillomavirus.
  - Inactivated Poliovirus.
  - Influenza.
  - Measles, Mumps, Rubella.
  - Meningococcal.
  - Pneumococcal.
  - Rotavirus.
  - Varicella.
- Other services such as:

- Tuberculin testing for children at higher risk of tuberculosis.
- Gonorrhea preventive medication for the eyes of all newborns.

7. Reproductive Care and Family Planning Services.

Infertility.

- Your cost share:
  - Physician's office - $30 per visit.
  - Other services – covered in full (does not include in-vitro fertilization or fertility preservation – see below).
- Coverage for diagnostic evaluation, assessment, and counseling for infertility when Medically Necessary.

In-Vitro Fertilization (IVF).

- Your cost share:
  - Physician's office - $30 per visit.
  - In-vitro fertilization (IVF) – 20% Coinsurance for all procedures, professional services, and related services such as drugs administered in the Physician's office.
- Coverage for:
  - Single embryo transfer for women through age 35.
  - Single or double embryo transfer for women age 35 through 42 years 364 days; IVF service not covered for women aged 43 and over.
  - Females diagnosed with infertility when determined to meet the criteria defined by the University of Michigan and University of Michigan Health Service Company. Infertility is defined as follows:
    - For male/female couples who are unable to conceive after engaging in regular unprotected intercourse for a defined period of time or the inability to sustain a Pregnancy;
      - For females under the age of 35, the time frame is 12 months of unprotected intercourse.
      - For females over age 35, the time frame is six months.
    - For females without documented infertility who do not have the exposure to sperm, coverage requires a minimum of 12 donor sperm intrauterine insemination (IUI) cycles for females under age 35; and six donor sperm cycles for females age 35 and older that do not result in live birth. The IUI cycles must be supervised by a Physician or an appropriate licensed practitioner. IUI and services related to donor sperm are not covered Benefits but are required to meet criteria for coverage of IVF.
  - Embryo freezing and storage up to one year for each cycle for members in active infertility treatment.
  - Genetic testing of embryos for at risk individuals when approved by the Plan.
  - Infertility drugs when administered by a health care provider.

NOTE: History of failed IVF attempts or embryo quality may alter the number of embryos transferred according to evidence-based guidelines.

- Fertility preservation services:
  - When a Medically Necessary surgical or medical treatment may directly or indirectly result in damage to or destruction of eggs or sperm of a Covered Person.
  - For enrollees up to age 26 when a genetic condition results in early menopause or impaired sperm production and causes infertility in subsequent years.
  - Covered Health Services for fertility preservation for women up to age 43 include: egg retrieval, cryopreservation and storage for one year; or egg retrieval, fertilization, embryo cryopreservation and storage for one year.
  - Covered Health Services for fertility preservation for men include semen cryopreservation and storage for one year and testicular aspiration to retrieve sperm when Medically Necessary.

Limitations and Exclusions.

- Covered Health Services for treatment of infertility via IVF or fertility preservation are limited to a lifetime maximum Benefit of $20,000 per contract while covered under any University of Michigan health plan. Note: diagnostic work-up, ultrasounds, counseling and labs already covered are excluded from the lifetime maximum.
- The Plan does not cover:
  - IVF services that are not provided through the Michigan Medicine Center for Reproductive Medicine.
  - IVF services for women aged 43 and over.
  - Intrauterine insemination (IUI).
  - Infertility medications obtained from a pharmacy.
  - Egg harvesting or other infertility treatment performed during an operation not related to an infertility diagnosis.
  - Coverage for a member who is not medically infertile.
  - Donor eggs and donor sperm.
  - All services related to surrogate parenting arrangements, including but not limited to IVF services and maternity and obstetrical care for non-member surrogate parents.
  - Any treatment, procedure or prescription medication designed to create a Pregnancy, except for in-vitro fertilization as described above.
  - Any form of preservation or long-term storage of reproductive materials, except as noted above.

Voluntary Sterilization.

- Your cost share:
  - Males - Physician’s office visit - $30 Copayment per visit.

- Females –covered in full for tubal ligation.

- The Plan does not cover reversal of sterilization.

Termination of Pregnancy.

- Your cost share:
  - Covered in full ($30 Copayment may apply).
- Coverage for first trimester elective termination of Pregnancy and therapeutic termination in the second or third trimester in accordance with locally accepted medical practice.

Genetic Testing.

- Your cost share:
  - Genetic Counseling and BRCA testing (for women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 and BRCA2 genes) – covered in full.
  - Genetic Counseling for other conditions: $30 Copayment per office visit.
  - Genetic Tests for other conditions: Covered in full.
- Coverage for:
  - Physician office visits.
  - Genetic Counseling.
  - Medically Necessary Genetic Tests.

8. Skilled Nursing Facility (SNF) and Inpatient Rehabilitation Facility (IPR) Services.

- Your cost share:
  - Covered in full.
- Coverage for:
  - Facility charges.
  - Medical supplies and other non-Physician services received during the Inpatient Stay.
  - Skilled Care as defined by the Plan.

Limitations and Exclusions.

- Benefits for SNF and IPR services are limited to a combined 120 days per calendar year.
- The Plan does not cover:
  - Custodial Care.
  - Care for dementia or developmental disability.

9. Home Health Care.

- Your cost share:
  - Covered in full.

- Coverage for:
  - Necessary medical supplies while under the care of a Home Health Care Provider.
  - Skilled Care that is provided by or supervised by a registered nurse in your home.
  - Intermittent physical, speech or occupational therapy (outpatient therapy limited as described in Outpatient Therapy Services do not apply).
  - Hospice care.
- The Plan does not cover:
  - Housekeeping services.
  - Custodial Care.
  - Private duty nursing.

10. Hospice Care.

- Your cost share:
  - Covered in full.
- Coverage for:
  - Medically necessary room and board services from and in-network hospice program
  - Does not take the place of inpatient hospice or respite care.
  - Medically stable up unable to stay in their home due to:
  - Lack of caregiver.
  - Caregiver inability.
  - Needs cannot be met in the home.
  - Services received in a licensed hospice facility, or in the home or Skilled Nursing Facility by a licensed hospice agency.
  - Terminally ill members with a life expectancy of six months or less.
  - Comfort and support services for the terminally ill member.
  - Physical, psychological, social, and spiritual care for the terminally ill person and the person's family.
  - Short-term grief counseling and Respite Care for immediate family members.
  - Professional fees, medical supplies, and equipment.

Limitations and Exclusions.

- Respite Care is limited to five days per calendar year.
- Hospice room and board limited to 45 days.
- The Plan does not cover:
  - Food, food supplements and home-delivered meals.
  - Custodial Care.

- Care for dementia or developmental disability.

11. Home Infusion Therapy Services.

- Your cost share:
  - Covered in full.
- Must be ordered by a Physician:
  - To treat an acute condition; or
  - To manage an incurable or chronic condition; and
  - Provided by or supervised by a registered nurse on an intermittent basis in your home.
- Coverage for:
  - Durable Medical Equipment.
  - Nutritional therapy such as enteral feeding administered via tube and parenteral nutrition administered intravenously.
  - Medical supplies, solutions, prescribed formulas, nutrients, equipment, and accessories needed for home infusion therapy services.
- When appropriate, Covered Person and/or caregiver will learn to administer home infusion therapy medications.
- Home health care services provided along with home infusion therapy are described above under Home Health Care.
- The Plan does not cover:
  - Megavitamin and nutrition-based therapy.
  - Food, formula, and nutritional supplements, except for prescribed formula specifically administered via tube feeding and nutrients necessary for IV feeding. Non-covered items include:
    - Infant formula.
    - Donor breast milk.
    - Protein or caloric boosting supplements (for example, Boost, Ensure, Glucerna, Osmolite, or PediaSure).
    - Over-the-counter supplements or formulas.
    - Herbal preparations or supplements.

12. Mental Health Care.

- Your cost share:
  - Outpatient counseling/therapy including individual, conjoint, family or group psychotherapy and crisis intervention and Intensive Outpatient - $25 Copayment per visit.
  - Inpatient Stay, Residential Services and Partial Hospitalization – covered in full.
  - Diagnostic testing, injections, therapeutic treatment, and medical services – covered in full.

- Treatment in a facility must be provided by a licensed Physician or other licensed behavioral health professional and the facility must be accredited by COA, AOA, CARF, or The Joint Commission.
- The Plan complies with the federal Mental Health Parity and Addictions Equity Act.
- Coverage for:
  - Solution-focused treatment (both individual and group sessions) and crisis interventions.
  - Treatments that are expected to result in measurable, substantial, and functional improvement.
  - The least restrictive and most cost-effective treatment necessary for restoring reasonable function.
- The Plan does not cover:
  - Treatment for mental, neurological, and other disorders when such conditions are solely medical in nature and that may be covered under other Benefit categories of the Plan.
  - Treatment for conduct and impulse control disorders, and paraphilias.
  - Treatment provided to comply with court-ordered involuntary commitments, police detentions and other similar arrangements.
  - Services provided outside of an inpatient, intermediate or outpatient setting.
  - Mental health services for the following:
    - Psychoanalysis and open-ended psychotherapy.
    - Religious oriented counseling provided by a religious counselor who is not participating in the network.
    - Gambling addiction issues.
    - Treatment of or programs for sex offenders or perpetrators of sexual or physical violence.
    - Sleep disorders.
    - Delirium, dementia, and amnesic and other cognitive disorders (unless noted otherwise).
    - Psychotherapy for elimination disorders.
    - Couples counseling.
    - Transitional living centers, wrap-around care services, halfway or three-quarter-way houses, non-licensed programs, therapeutic boarding schools, milieu therapies, private room or apartments.
    - Sex therapy.
    - Non-medical services including enrichment programs such as: dance therapy, art therapy, equine therapy, ropes courses, music therapy, yoga and other movement therapies, guided imagery, consciousness raising, socialization therapy, social outings and education/preparatory courses or classes.

13. Autism Spectrum Disorders Treatment.

- Your cost share:
  - Applied Behavioral Analysis (ABA) and behavioral health services - $25 Copayment per visit.
  - Outpatient Habilitative Services - $25 Copayment per visit.
- Coverage for:
  - Diagnosis and treatment of certain Autism Spectrum Disorders.
  - Behavioral health treatment, such as Applied Behavioral Analysis (ABA).
  - Outpatient psychiatric and psychological visits for assessments, evaluations, and tests, including the Autism Diagnostic Observation Schedule.
  - Outpatient Habilitative Services, such as physical, occupational and speech therapy.
  - Nutritional counseling.
  - Genetic testing, if recommended in the Autism Treatment Plan.
  - Services and treatment that is comprehensive and focused on managing and improving the symptoms directly related to the member's Autism Spectrum Disorder.
- The Plan does not cover:
  - Sensory Integration Therapy.
  - Chelation therapy for the treatment of autism.
  - Treatment of conditions such as Rett's Disorder or childhood disintegrative disorder.

14. Substance Use Disorders Services and Chemical Dependency.

- Your cost share:
  - Outpatient counseling/therapy including individual, conjoint, family or group psychotherapy and crisis intervention - $25 Copayment per visit.
  - Inpatient Stay for Detoxification, Residential Services and Partial Hospitalization – covered in full.
  - Diagnostic evaluation, medical testing, injections, therapeutic treatment, and medical services – covered in full.
- Treatment in a facility must be provided by a licensed Physician or other licensed behavioral health professional and the facility must be accredited by COA, AOA, CARF, or The Joint Commission.
- The Plan complies with the federal Mental Health Parity and Addictions Equity Act.
- Coverage for:
  - Solution-focused treatment (both individual and group sessions) and crisis interventions.

- Treatments that are expected to result in measurable, substantial, and functional improvement.
- The least restrictive and most cost-effective treatment necessary for restoring reasonable function.

- The Plan does not cover:
  - Treatment provided to comply with court-ordered involuntary commitments, police detentions and other similar arrangements.
  - Services to hold or confine a person under chemical influence when no medical services are required.
  - Services provided outside of an inpatient, intermediate or outpatient setting.

15. Outpatient Rehabilitation Services.

- Your cost share:
  - Physical, occupational and speech therapy – $25 Copayment per session.
  - Cardiac and pulmonary rehabilitation therapy – covered in full.
- Coverage for:
  - Short-term outpatient rehabilitation services for conditions that can be expected to improve significantly within Benefit limitations.
  - Physical therapy.
  - Occupational therapy.
  - Speech therapy, including post-cochlear implant aural therapy (must meet criteria).
  - Pulmonary rehabilitation therapy.
  - Phase II cardiac rehabilitation therapy, which is the next extension of cardiac rehabilitation beginning a few days after discharge from the hospital. Phase II is a supervised and monitored outpatient program.
  - Biofeedback for treatment of medical diagnoses when Medically Necessary as determined by UM Health Service Company Benefit Coverage Policy.

Limitations and Exclusions.

- Benefits for any combination of physical therapy, occupational therapy, and speech therapy are limited to combined total of 60 visits per condition per calendar year.
- Benefits for Phase II cardiac rehabilitation therapy are limited to 36 visits per calendar year.
- Benefits for pulmonary rehabilitation therapy are limited to 12 visits per calendar year.
- Rehabilitation/habilitation therapy for treatment of Autism Spectrum Disorders is not included in the limits shown above.
- Rehabilitation therapy as part of home health care does not count toward the limits stated above.
- The Plan does not cover:

- Speech therapy for chronic conditions or congenital speech abnormalities; learning disabilities; deviant swallow or tongue thrust, or mild and moderate developmental speech or language disorders.
- Therapy to maintain current functional level and prevent further deterioration.
- Cognitive therapy and retraining (neurological training and retraining).
- Inpatient or outpatient Recreational Therapy.
- Patient education and home programs.
- Audio therapy.
- Vocational rehabilitation.
- Eye exercise therapy or vision therapy.
- Craniosacral therapy.
- Prolotherapy.
- Sensory Integration Therapy.

16. Durable Medical Equipment (DME) and Diabetic Supplies.

- Your cost share:
  - Covered in full.
- Coverage for:
  - DME that is ordered or provided by a Physician.
  - Diabetic supplies and equipment including:
    - Blood glucose monitors.
    - Test strips for glucose monitors, lancets, and spring powered lancet devices, visual reading and urine test strips.
    - Syringes and needles.
    - Insulin pumps and medical supplies required for use of an insulin pump.
    - Diabetic shoes.
  - Some disposable equipment if, for example, it is necessary for proper functioning or application of covered DME. Call Customer Service for the current list.
  - Diabetic, ostomy, and urological supplies are available in up to a 90-day supply when the member has a chronic condition and receiving a 90-day supply is medically appropriate.
  - Gradient compression stockings to a limit of four pair per calendar year.
  - DME that meets the minimum specifications that are necessary for your needs. If you want equipment above the minimum specifications, you must pay any difference in cost.
  - A single purchase (including repair or replacement) of a type of DME once every three calendar years.
  - Repair or replacement only when Medically Necessary:
    - Due to change in your medical condition.

- Due to change in body size due to growth.
- To improve physical function.
- Due to normal wear and tear.
- Due to malfunction.

Limitations and Exclusions.

- The Plan does not cover:
  - DME that can be used for physical appearance.
  - DME used as safety, comfort, or convenience items.
  - DME used to affect performance in sports-related activities.
  - Disposable and non-disposable related items unless necessary for proper functioning or application of DME.
  - Duplicate DME items.
  - Penile implants for the treatment of impotence having a psychological origin.
  - All bath aids, such as shower chairs and safety rails.
  - Toilet seat risers.
  - Grabbers.
  - Stair lifts.
  - Ramps.
  - Diapers.
  - Home modifications.
  - Wheelchair lifts.
  - Lift chairs.
  - Standing systems, stationary and mobile.
  - Automobile modifications and adaptive devices, such as hand grips, hand controls and special foot pedals.
  - Mobility carts and power-operated vehicles, for example, scooters, motorized carts, and electric scooters.
  - Car seats and safety seats.
  - Strollers.
  - Polar packs.
  - Temper-pedic and all other mattresses or mattress overlays.
  - Air conditioners. Air purifiers and filters or air cleaning devices. Dehumidifiers and humidifiers.
  - Batteries and battery chargers, unless for approved power-operated wheelchairs.
  - Hot tubs and whirlpools. Tanning beds, lamps, and services. Light bulbs and short and long wave UV light units to be used in the home.
  - Powered exoskeleton devices.

17. Orthotics and Prosthetics.

- Your cost share:
  - Covered in full.
- Definitions:
  - Orthotics. Artificial devices that support the body and assist in its function (e.g., a knee brace, back brace, etc.).
  - Prosthetics. Artificial devices that serve as a replacement of a part of the body lost by injury (traumatic) or missing from birth (congenital).
- Coverage for:
  - External Prosthetic Devices. Devices such as an artificial leg or an artificial arm.
  - Internal Implantable Prosthetic Devices. Devices surgically attached or implanted during a surgery such as a permanent pacemaker, artificial hip or knee, artificial heart valves, or implanted lens immediately following surgery for replacement of an organic lens of the eye (e.g., cataract surgery).
  - Conventional eyeglass lenses and/or corrective contact lenses (if condition cannot be corrected with eyeglasses) for the following conditions:
    - Keratonconus and aniseikonia (a prescription difference of two or more diopters between the two eyes).
      - Initial eyeglass lenses or corrective contact lenses.
    - Monocular aphakia (congenital or surgical absence of the lens, usually after cataract extraction.
      - Initial eyeglass lenses or corrective contact lenses.
    - Anisometropia (a condition in which the two eyes have an unequal refractive power) or antimetropia (hyperopia of one eye, with myopia in the other), that results in aniseikonia:
      - Corrective contact lenses in combination with eyeglasses or alone.
        - Post cataract surgery.
        - Post corneal transplantation surgery.
  - Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. This includes mastectomy bras (up to four per calendar year) and lymphedema sleeves for the arm.
  - Ankle-foot orthoses (AFO) and knee-ankle-foot orthoses (KAFO) for extremities.
  - Shoes designed for attachment to medically appropriate leg braces.
  - Therapeutic shoes and inserts for diabetic patients.
  - Prescription custom fabricated foot insert, molded to patient, longitudinal/metatarsal support.

Limitations and Exclusions.

- Prosthetic and orthotic devices must meet the minimum specifications for your basic functional needs. If you want a prosthetic or orthotic device above the minimum specifications, you must pay any difference in cost.

- Replacement lenses for infants and children with monocular aphakia are limited as follows:
  - If cataract removal surgery is performed on one eye, one contact lens initially following surgery, and an additional replacement lens each year until the child's fifth birthday is covered.
  - If cataract removal surgery is performed on both eyes, two lenses are covered initially, and two replacement lenses annually until the child reaches his/her fifth birthday.
- Replacement lenses when diagnosis is keratoconus or aniseikonia are covered when:
  - Due to change in prescripton.
  - Due to the expiration of the lifetime expectancy of the lens.
  - There is a prescription from the member’s ophthalmologist confirming the continued medical need for the lens.
- Hard and soft lenses may be approved in certain circumstances when both types of lenses are worn concurrently when diagnosis is keratoconus or aniseikonia.
- Replacement lenses are covered due to growth and development.
- The Plan does not cover:
  - Nonrigid devices and supplies such as garter belts, arch supports, and corsets.
  - Spare prosthetic or orthotic devices.
  - Routine maintenance of the prosthetic or orthotic device.
  - Hair prostheses such as wigs, hair pieces, hair implants, etc.
  - All devices to assist in communication and speech, except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
  - Mouth prosthetics, mouth orthotics, mouth splints, and mouth appliances.
  - Items used specifically for physical appearance or as safety items or to affect performance in sports-related activities.
  - Shoe lifts.
  - Oral appliances for snoring.
  - Over the counter arch supports or supportive devices for the feet.
  - Orthopedic or corrective shoes (except when either one or both are an integral part of a leg brace).

18. Organ and Tissue Transplants.

- Your cost share:
  - Covered in full.
- University of Michigan Health Service Company has specific guidelines regarding Benefits for transplant services listed below.

- Transplantation programs include three phases: pre-transplant services, the transplant period and post-transplant services.
- Coverage for:
  - Transplants done at a Designated Facility (except for corneal transplants, which can be performed at any Network facility).
  - Donor expenses for a donor who is not a Covered Person under the Plan if not covered by the donor's plan. If both the donor and the recipient are covered under the Plan, all Covered Health Services are covered under the recipient.
  - Computer organ bank searches and any subsequent testing necessary after a potential donor is identified unless covered by another benefit plan or policy.
  - Facility charges, inpatient, or outpatient.
  - Medical supplies and other non-Physician services received during the Inpatient Stay.
  - Surgery.
  - Long-term acute inpatient services.
  - Professional fees including consultations.
  - Office visits and associated charges.
  - Transplants that include:
    - Hematopoietic stem cell transplants.
    - Heart transplants.
    - Heart/lung transplants.
    - Lung transplants.
    - Kidney transplants.
    - Kidney/pancreas transplants.
    - Liver transplants.
    - Liver/small bowel transplants.
    - Pancreas transplants.
    - Small bowel transplants.
- The Plan does not cover:
  - Removal of an organ or tissue from you for purposes of a transplant to another person unless recipient's plan does not cover.
  - Health care services for transplants involving animal organs.
  - Transplant services that are not performed at a Designated Facility, except for corneal transplants.
  - Community-wide searches for a donor.

19. Reconstructive Surgery.

- Your cost share:
  - Covered in full.

- Services can be received in a Hospital on an inpatient or outpatient basis, other outpatient settings such as Alternate Facilities and in a Physician's office.
- Coverage for:
  - Surgery or other procedures when associated with an Injury, Sickness or Congenital Anomaly.
  - Breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry.
  - Other services required by the Women's Health and Cancer Rights Act of 1998, including treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service.
  - Medically Necessary plastic surgery such as blepharoplasty of upper lids, surgical treatment of male gynecomastia, reduction mammoplasty, panniculectomy, and sleep apnea treatments (for example, rhinoplasty or septorhinoplasty).
  - Repair of extensive scars or disfigurement resulting from Medically Necessary surgery, disease, accidental Injury, burns and/or severe inflammation.
  - Inpatient or outpatient facility charges.
  - Professional fees.
- The Plan does not cover:
  - Cosmetic Procedures.
  - Removal or replacement of an existing breast implant if it was initially performed as a Cosmetic Procedure, unless due to complications and determined by University of Michigan Health Service Company to be Medically Necessary.

20. Oral Surgery.

- Your cost share:
  - Oral surgeon's or dentist's office – $30 Copayment per visit.
  - Other outpatient settings – covered in full.
  - Inpatient Stay – covered in full.
- Coverage for:
  - Treatment of fracture or suspected fractures of the jaw and facial bones and dislocation of the jaw.
  - Removal of tumors and cysts of the jaws, cheeks, lips, tongue, and roof or floor of the mouth.
  - Removal of benign or malignant bony growths of the jaw and hard palate.
  - External incision and drainage of cellulitis.
  - Incision of sensory sinuses, salivary glands, or ducts.
  - Removal of sound, natural teeth to prepare for other covered medical procedures.

- Rebuilding or repair of soft tissues of the mouth or lip to correct problems caused by Congenital Anomaly or accidental Injury. This includes treatment for cleft lip or cleft palate.
- Medical and surgical services for accidental Injuries (includes services received from Non-Network providers).
  - Treatment necessary for immediate repair of trauma to the jaw, natural teeth, cheeks, lips, tongue and roof and floor of the mouth.
  - "Immediate" means treatment within 72 hours of the Injury.
  - Any follow-up treatment performed after the first 72 hours post-Injury is not covered.
- Treatment for cancer.
- Treatment for conditions affecting the mouth other than the teeth.
- Dental-related general anesthesia and associated facility fees if:
  - Local anesthesia would not be effective because of acute infection, anatomic variation, or allergy; or
  - Patient has a concurrent hazardous medical condition; or
  - Patient has suffered extensive oral-facial and/or dental trauma.

- The Plan does not cover:
  - Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums including:
    - Extraction, restoration and replacement of teeth (including extraction of impacted wisdom teeth).
    - Services to improve dental clinical outcomes.
  - Tooth implants and related services, bone grafts and other implant-related procedures and related services, even when required because of an Injury.
  - Orthodontic services, including braces.
  - Dental X-rays, all hospitalization charges, facility charges, and anesthesia charges related to dental care. The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - The direct treatment of acute traumatic Injury, cancer or cleft palate.
  - Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.
  - Services for the treatment of an overbite or underbite. Maxillary and mandibular osteotomies, unless determined by University of Michigan Health Service Company to be Covered Health Services.

21. Temporomandibular Joint (TMJ) Syndrome Treatment.

- Your cost share:

- $30 Copayment per office visit.
- Outpatient physical therapy – $25 Copayment per session.
- Other outpatient settings – covered in full.
- Inpatient Stay – covered in full.

- TMJ syndrome means muscle tension and spasms related to the temporomandibular joint, facial, and cervical muscles, causing pain, loss of function and neurological dysfunction.
- Coverage for:
  - Health care professional fees for Covered Health Services to treat TMJ resulting from a medical cause or Injury.
  - Facility charges.
  - Surgery directly to the temporomandibular joint.
  - Related anesthesia services.
  - Arthrocentesis performed for the treatment of TMJ dysfunction.
  - Diagnostic X-ray, including contrast studies.
- The Plan does not cover:
  - Routine dental services, orthodontic services, prostheses, or appliances related to TMJ syndrome treatment.
  - Dental implants and related services, including repair and maintenance of implants and surrounding tissue.

22. Orthognathic Surgery.

- Your cost share:
  - $30 Copayment per visit.
  - Other outpatient services – covered in full.
  - Inpatient Stay – covered in full.
- Coverage for:
  - Surgery done on an inpatient Hospital basis to correct a skeletal malformation involving the lower or the upper jaw. A bone cut is usually made in the affected jaw and the bones are repositioned and realigned. Surgery must be provided along with a course of orthodontic treatment to correct bodily dysfunction, or deformities or malposition of the jaw.
  - Postoperative care.
  - Physician office visits.
  - Outpatient diagnostic services such as cephalometric study and X-rays.
- The Plan does not cover dental or orthodontic treatment including braces, prosthesis, and appliances for or related to treatment for orthognathic conditions.

23. Weight Reduction Procedures.

- Your cost share:
  - All services associated with weight reduction procedures, including facility fees and professional services – 50% Coinsurance up to $1,000 Copayment.
- Coverage for:
  - Facility charges.
  - Medical supplies and other non-Physician services.
  - Surgery, which must be received in a Hospital on an inpatient basis.
  - Professional fees.
- The Plan does not cover bariatric surgery more than once per lifetime unless done to correct or reverse complications from a previous bariatric surgery or for another condition determined to be Medically Necessary by University of Michigan Health Service Company.

24. Gender-Affirming Treatment.

- Your cost share:
  - Covered in full (limitations apply).
- Coverage for:
  - Surgical reconstructive procedures of the genitals, also known as sex reassignment surgery (referred to as “bottom surgery”). This includes hysterectomy, oophorectomy, and orchiectomy.
  - Breast reduction and chest reconstruction for reassignment (referred to as “top surgery”).
  - Electrolysis or laser hair removal for reassignment at the surgical site for male to female transition surgery or from a donor site for female to male transition surgery.
  - Mental health services consistent with an approved gender reassignment treatment plan.
  - Facial feminization procedures such as forehead contouring/reconstruction, mandible contouring/reconstruction, rhinoplasty, genioplasty, blepharoplasty, lip lift via alar base excision, chondrolaryngoplasty (Adam’s apple reduction), and facial/neck hair removal.
  - Facial masculinization procedures such as forehead contouring/reconstruction, mandible contouring/reconstruction, rhinoplasty, genioplasty, and blepharoplasty.
  - Fertility preservation if medical or surgical interventions related to their transition could result in infertility (see Reproductive Care and Family Planning Services).
  - Speech-language therapy for gender dysphoria.

Limitations and Exclusions.

- Covered Persons must meet all the following for bottom and top surgery:
  - Have persistent, well-documented Gender Dysphoria manifested by clinically significant distress and by significant functional impairment. This assessment has

been made via a detailed psychological assessment and documented by two mental health professionals (either psychiatrist, PhD-prepared clinical psychologist or master's level clinician who are licensed to practice independently in their state). Note: Only one assessment is required for top surgery.

  - Are 18 years of age or older.
  - Have the capacity to make a fully informed decision and to consent for treatment.
  - If significant medical or mental health concerns are present, they must be controlled.
  - Twelve continuous months of hormone therapy as appropriate to the patient's gender role (unless there is a contraindication to hormonal therapy); Hormonal therapy is not required prior to mastectomy in biological female-to-male patients.
  - The aim of hormone therapy prior to surgery is primarily to introduce a period of reversible estrogen or testosterone suppression before the patient undergoes irreversible surgical intervention.
  - Twelve continuous months of living in a gender role that is congruent with their gender identity. Living in a gender role congruent with gender identity for 12 continuous months is not required prior to top surgery.

- Covered Persons must meet all the following criteria for facial feminization and masculinization surgeries, chondrolaryngoplasty, and facial hair removal:
  - The member has persistent, well-documented gender dysphoria manifested by clinically significant distress and by significant functional impairment. This assessment has been made via a detailed psychological assessment and documented by a mental health professional (either psychiatrist, PhD prepared clinical psychologist or master's level clinician who is licensed to practice independently in their state).
  - Are 18 years of age or older.
  - Have the capacity to make a fully informed decision and to consent for treatment.
  - If significant medical or mental health concerns are present, they must be controlled.
  - Facial feminization/masculinization surgeries and chondrolaryngoplasty additionally require that members meet both of the following criteria:
    - Twelve continuous months of hormone therapy (estrogen/testosterone), unless there is a medical contraindication to hormonal therapy.
    - Twelve continuous months of living in a gender role congruent with gender identity.
- The Plan does not cover services such as (please refer to the Benefit Coverage Policy on the Plan's website):
  - Abdominoplasty.
  - Brow lift.
  - Calf implants.
  - Collagen injections.

- Fat grafting.
- Gluteal and hip augmentation.
- Hair transplantation/hairline repositioning.
- Insertion of penile prosthesis (non-inflatable/inflatable).
- Insertion of testicular expanders.
- Laryngoplasty.
- Lip enhancement (Filler, vermillion augmentation).
- Liposuction/lipofilling.
- Mastopexy.
- Otoplasty.
- Pectoral implants.
- Penile prosthesis.
- Removal of redundant skin.
- Replacement of tissue expander with permanent prosthesis testicular insertion.
- Rhytidectomy (face lift).
- Scrotoplasty.
- Services for the reversal of gender-affirming procedures.
- Skin resurfacing (e.g., dermabrasion, chemical peels).
- Vocal cord/voice modification procedures.

25. Hearing Services.

- Your cost share:
  - Covered up to the allowed amount for one standard monaural or two standard binaural hearing aids. Network providers commit to offering standard hearing aids that can be dispensed without any additional cost share on the part of the Covered Person.
  - Members who select hearing aids that are above the allowed amount have to pay the difference in price between the allowed amount and the provider's price.
- Coverage every 36 months for:
  - One hearing evaluation test to determine if a hearing problem exists.
  - Audiometric examination and hearing aid evaluation test to determine hearing acuity and the specific type or brand of hearing aid needed.
  - Services for the fitting of a hearing aid and follow-up services to evaluate performance of the hearing aid and its conformance to the prescription.
  - Monaural or binaural in-the-ear, behind-the-ear, or on-the-body hearing aid types.
  - One conformity test.
  - Custom ear molds for children under the age of 18 according to the following schedule:

    - Under three year of age: four time every 12 months (per hearing aid).
    - Age three up to age 13: twice every 12 months (per hearing aid).
    - Age 13 up to age 18: once every 12 months (per hearing aid).
- The Plan does not cover:
  - Charges above the allowed amount. You must pay the difference between the allowed amount and the provider's price.
  - Repair or replacement of hearing aids or hearing aid parts unless the member would have been eligible for a hearing aid under the frequency limits of this coverage at the time of repair or replacement.
  - Replacement batteries.
  - Medical or surgical treatment or drugs and medications relating to hearing problems.

26. Prescription Drugs.

- Your cost share:
  - Covered in full.
- Coverage for:
  - Injectable and infusible Prescription Drug Products, which require administration by a health care professional in a medical office, home, outpatient facility or during an Inpatient Stay.
  - Cancer drug therapy when:
    - The drug is ordered by a Physician for treatment of cancer.
    - The drug is approved by the U.S. Food and Drug Administration (FDA) for use in cancer therapy.
    - The current medical literature indicates that the drug therapy is effective, and recognized cancer organizations generally support the treatment.
    - The drug is classified as:
      - A drug used to treat cancer; or
      - An anti-emetic drug used to combat the toxic effects of chemotherapy drugs; or
      - A drug used to enhance chemotherapy drugs.
- The Plan does not cover:
  - Outpatient Prescription Drug Products (information on this Benefit is available at UM Prescription Drug Plan at https://hr.umich.edu/benefits-wellness/health-well-being/prescription-drug-plan).
  - Drugs not approved by the FDA and/or considered to be Experimental or Investigational.
  - Drugs that are intended to be self-administered.
  - Over-the-counter drugs and medicatons.

- Medications listed in University of Michigan Health Service Company's Site of Care Policy administered at an outpatient facility that can instead be safety administered in an outpatient professional setting (for example, in a Physician's office) or through home infusion services. The Site of Care Policy is available on michigancare.com.
- Medications that are not Medically Necessary may cause significant patient harm; or are not appropriate for the patient's documented medical condition.

27. Clinical Trials.

- Your cost share:
  - $25 Copayment per PCP visit.
  - $30 Copayment per specialist visit.
  - Other Covered Health Services – covered in full.
- You must be a qualified person participating in an approved clinical trial, which means:
  - The referring provider participated in the trials and has concluded that your participation in it would be appropriate because you meet the trial's protocol; or
  - You provided medical and scientific information establishing that your participation in the trial would be appropriate because you meet the trial's protocol.
- Clinical trials of experimental drugs or treatments proceed through four phases:
  - Phase I: Researchers test a new drug or treatment in a small group of people (20-80) for the first time to evaluate its safety, to determine a safe dosage range and to identify side effects. Phase I trials do not determine efficacy and may involve significant risks as these trials represent the initial use in human patients.
  - Phase II: The study drug or treatment is given to a larger group of people (100-300) to see if it is effective and further evaluate its safety.
  - Phase III: If a treatment has shown to be effective in Phase II, it is subjected to additional scrutiny in Phase III. In this phase, the sample size of the study population is increased to between 1,000 and 3,000 people. The goals in Phase III are to confirm the effectiveness noted in Phase II, monitor for side effects, compare the study treatment against current treatment protocols, and collect data that will facilitate safe use of the therapy or treatment under review.
  - Phase IV: These studies are done after the drug or treatment has been marketed or the new treatment has become a standard component of patient care. These studies continue testing the study drug or treatment to collect information about their effect in various populations and any side effects associated with long-term use. Phase IV studies are required by the FDA when there are any remaining unanswered questions about a drug, device, or treatment.
- Coverage for:
  - Covered Health Services related to treating your condition, excluding the Experimental item, device, drug, or service associated with the clinical trial.
  - Services incurred during Phase I, Phase II, Phase III, or Phase IV clinical trials.

- Clinical trials that are conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening diseases or conditions and includes any of the following:
  - A federally funded trial, as described in the ACA;
  - A trial conducted under an Investigational new drug application reviewed by the FDA;
  - A drug trial that is exempt from having an Investigational new drug application; or
  - A study or investigation conducted by a federal department that meets the requirements of Section 2709 of the ACA.

  NOTE: Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Experimental treatment and services when all the following are met:
  - University of Michigan Health Service Company considers the Experimental treatment to be conventional treatment when used to treat another condition (i.e., a condition other than what you are currently being treated for).
  - The treatment is covered under the Plan when it is provided as conventional treatment.
  - The services related to the Experimental treatment are covered under the Plan when they are related to conventional treatment.
  - The Experimental treatment and related services are provided during an approved clinical trial.

- The Plan does not cover:
  - The Experimental or Investigational item, device, drug, or service itself, except as explained above.
  - Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the trial participant.
  - Administrative costs related to Experimental treatment or for research management.
  - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
  - Coverage for Services not otherwise covered under this Certificate of Coverage.
  - Drugs or devices provided to you during an oncology clinical trial that have not been approved by the FDA, regardless of whether the approval is for treatment of the condition, and to the extent they are not normally provided or paid for by the sponsor of the trial or the manufacturer, distributor or provider of the drug or device.
  - Complications resulting from an Experimental procedure.

28. Telemedicine Services.

- Your cost share:

- $25 Copayment per PCP visit, on demand visit, or behavioral health visit.
- $30 Copayment per specialist visit or consult.
- Other Covered Health Services – covered in full.

- Services can be received in a Hospital on an outpatient basis, other outpatient settings such as Alternate Facilities, in a Physician's office and in the home.
- Telemedicine is the use of an electronic medium to link patients with health care professionals in different locations. Telemedicine services include the following types of services:
  - Telehealth or video visits between the patient and a health care provider where the patient uses their own electronic device to connect with a provider for a live video interaction;
  - E-visits where the patient and provider connect via a portal for asynchronous, or store and forward online messaging;
  - Remote Patient Monitoring Services where a patient receives certain devices in the home that are periodically monitored by their health care provider in order to manage an ongoing condition (Copayment applies for initial set-up and then a monthly Copayment applies); or
  - Electronic consultations or e-consults between health care professionals where a PCP connects via a portal with a specialist to receive input on a specific clinical matter involving the patient (specialist Copayment applies).
- The health care professionals must be able to examine the patient via a secure, interactive audio and/or video telecommunications system, or through the use of store and forward online messaging.
- If the patient is directly participating, the patient must be able to interact with the offsite professional at the time the services are provided.
- Not all Covered Health Services are covered telemedically such as, but not limited to, new patient examinations, Preventive Health Services, surgery, substance use disorders treatment, reporting of normal test results, provision of educational materials, and handling of administrative issues (such as registration, scheduling of appointments, or updating billing information).
- The Plan does not cover any devices or equipment to assist in Telemedicine services, such as laptops, mobile devices, and other tools to connect providers with patients.

29. Weight Management Services.

- Your cost share:
  - $25 Copayment per PCP visit.
  - $30 Copayment per specialist visit.
  - Other Covered Health Services: Covered in full.
- Coverage for:
  - Physician office visits.
  - Outpatient behavioral health therapy visits.

- Nutritional counseling.
- Outpatient laboratory and pathology services.

- The Plan does not cover weight management programs.

30. Spinal Manipulation Services.

- Your cost share:
  - $25 Copayment per visit.
- Coverage for:
  - Chiropractic or osteopathic manipulation treatment when provided by a Network Spinal Treatment provider (Chiropractor or Doctor of Osteopathy, "D.O.") in the provider's office.
  - Services and supplies for analysis and adjustment of spinal subluxations(s) and spinal misalignment(s).
  - Diagnosis and treatment by manipulation of the skeletal structure.
  - Muscle stimulation by any means (except treatment of fractures and dislocations of the extremities).
  - Development of a rehabilitative exercise plan related to spinal subluxations(s) or spinal misalignment(s).
  - X-rays of the spine.

Limitations and Exclusions.

- Benefits for chiropractic and osteopathic spinal manipulation services are limited to a combined maximum of 24 visits per calendar year.
- The Plan does not cover:
  - Treatment of fractures and dislocations of the extremities.
  - Spinal Treatment services that exceed the visit limits specified above.
  - Any service not related to the spine.
  - Supplements, drugs, medical equipment, or supplies dispensed by or prescribed by a Spinal Manipulation provider.
  - Laboratory services.
  - Consultations.
  - Rehabilitative exercise not related to spinal subluxations or spinal misalignments.
  - Fracture care.
  - Nutritional advice.

31. Travel Reimbursement.

- Travel and lodging are covered for reasonable and necessary travel expenses for Covered Health Services that cannot be legally rendered in the state in which you reside and for which you must travel at least 100 miles to receive such care.
- Reimbursement for:

- Roundtrip economy class travel (air, train, bus, taxi, ride sharing services, car rental) is reimbursed for travel between your home and the location where services are received.
- Mileage reimbursement is based on current IRS medical mileage reimbursement standards for medical travel. Tolls and parking are also reimbursable expenses.
- Airfare is limited to commercially scheduled coach class tickets.
- Lodging is limited to $50 per person per night (up to $100 if a companion travels or up to $150 if two adult companions travel with a Covered Person under 18).
- Companion travel for the above expenses if the companion's presence is needed for you to receive health care services (limited to one companion for a Covered Person aged 18 and older; two companions for Covered Person under age 18).
- Itemized receipts confirming proof of traveling more than 100 miles distance from the approved procedure facility are required, including (but are not limited to) all hotel, airline, and parking receipts.
- Approved reimbursement requests are paid to the subscriber.

- The following criteria must be met for you to be reimbursed:
  - The service must be an eligible procedure covered under the Michigan Care benefit plan.
  - The service must be permitted under applicable law where the service is performed.
  - The service must be performed by a Network provider.
  - All required prior authorizations for the service must be obtained.
  - You must be unable to obtain the service within 100 miles of the Michigan Care service area.
  - You obtain approval from Michigan Care for the covered travel.

32. Travel Vaccines

- Certain vaccinations required for travel are covered as a Network Benefit when obtained by a Michigan Care approved Non-Network Provider.

Limitations and Exclusions.

- Covered travel vaccinations are limited to the following:
  - Cholera Vaccine
  - Japanese Encephalitis Vaccine
  - Typhoid Vaccine
  - Yellow Fever Vaccine
- Exclusions
  - Vaccinations or immunizations required solely for purposes of career, education, sports, camp, travel, employment, insurance, marriage or adoption unless otherwise stated.

- Services rendered by any Non-Network Provider not approved by Michigan Care.

GENERAL EXCLUSIONS AND LIMITATIONS

Many non-covered services are listed in the chapter, BENEFITS AND COVERAGE, under Benefit categories. The services listed in this chapter are in addition to those stated earlier.

1. Facility admission charges prior to your effective date unless you have no continuing coverage under any other health benefits contract, program or insurance or you had no previous coverage.
2. Health care services, medical supplies and medications that do not meet the definition of a Covered Health Service.
3. Health care services, medical supplies and medications that require prior approval when prior approval has not been obtained.
4. Health care services, medical supplies, and medications for which medical criteria have not been met.
5. Experimental, Investigational and Unproven Services are excluded. The fact that an Experimental, Investigational, or Unproven Service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition does not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
6. Complementary and Alternative Medicine (CAM) testing and treatment as defined by the National Center for Complementary and Alternative Medicine. Examples include but are not limited to:
   - Acupressure.
   - Acupuncture.
   - Aromatherapy.
   - Environmental testing and analysis.
   - Hair testing and analysis.
   - Herbal or vitamin therapies.
   - Hypnosis.
   - Massage therapist services.
   - Music therapy.
   - Reflexology.
   - Rolfing.
   - Saliva testing and analysis.
7. Cosmetic Procedures and services including but not limited to:
   - Pharmacological regimens, nutritional procedures, or treatments.
   - Scar or tattoo removal or revision procedures.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.

- Treatment to improve the appearance of the skin.
- Treatment for spider veins, unless Medically Necessary.
- Hair removal by any means, unless stated as covered.
- Plastic surgery, unless stated as covered.
- Collagen implants.
- Diastasis recti repair.

8. Beauty/barber services.
9. Guest services.
10. Medical supplies, equipment and similar incidental health care services and supplies for personal comfort, or for the convenience of either the Covered Person or his or her Physician.
11. Physical conditioning programs.
12. Any hair replacement product or process.
13. Services performed by a health care provider who is a family member by birth or marriage, including spouse, brother, sister, parent, or child. This includes any service the health care provider may perform on himself or herself.
14. Services performed by a health care provider with your same legal residence.
15. Health care services provided at a diagnostic facility without a written order by a Physician or other qualified health care provider. Services that are self-directed to a freestanding or Hospital-based diagnostic facility. Services ordered by a Physician or other health care provider who is an employee or representative of a diagnostic facility, when that Physician or other health care provider:
    - Has not been actively involved in your medical care prior to ordering the service, or
    - Is not actively involved in your medical care after the service is received.

    This Exclusion does not apply to mammography screening.
16. Foreign language and sign language interpreters.
17. Academic services including school tuition for or services that are school-based for children or adolescents provided under the Individuals With Educational Disabilities Act (IDEA).
18. Health care services if other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation or similar legislation. This applies whether or not you choose to file a claim.

    This Exclusion does not apply to no-fault automobile insurance.

    If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits are not paid for any Injury, Sickness or mental illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

19. Health care services for treatment of military service-related disabilities, when you are enrolled for coverage through the Veterans Administration (VA).
20. Health care services while on active military duty.
21. Health care services provided in a foreign country, unless required as Emergency Services.
22. Purchase and fitting of eyeglasses, or refractive contact lenses; unless otherwise stated in the Benefits and Coverage chapter.
23. Surgery intended to allow you to see better without glasses or other vision correction such as radial keratotomy or laser-assisted in situ keratomileusis (LASIK).
24. Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments when:
    - Required solely for purposes of career, education, sports, camp, travel (except for certain vaccinations), employment, insurance, marriage, or adoption.
    - Covered travel vaccinations are limited to the following:
        - Cholera vaccine
        - Japanese Encephalitis vaccine
        - Yellow Fever vaccine
        - Typhoid vaccine
    - Related to judicial or administrative proceedings or orders.
    - Conducted for purposes of medical research, except for qualified clinical trials.
    - Required to obtain or maintain a license of any type.
25. Health care services received because of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
26. Health care services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made if you did not have coverage under the Plan.
27. Health care services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
28. Benefits when a health care provider waives Copayments, Coinsurance amounts and/or the Annual Deductible for a health care service.
29. Medical services and supplies, which are provided while member is in the custody of any law enforcement authorities or while incarcerated in a facility such as a youth home. Charges involving a member's medical condition, which arise out of the commission of a felony by such a member, if convicted, unless resulting from an underlying medical condition or act of domestic violence.
30. Respite care, except as part of hospice care services.
31. Rest cures.
32. Work hardening.
33. Autopsy.
34. Psychosurgery.

35. Medical and surgical treatment of excessive sweating (hyperhidrosis), unless determined by University of Michigan Health Service Company to be Covered Health Services.
36. Medical and surgical treatment for snoring or daytime sleepiness, except when part of treatment for documented obstructive sleep apnea.
37. Gym memberships. Aquatic exercise programs or classes. Personal trainers. Exercise equipment, including pools, even if prescribed by a Physician.
38. Covered Health Services when a Covered Person has refused to comply with or has terminated the scheduled service or treatment against the advice of a Physician or University of Michigan Health Service Company.
39. Legal/court fees, copy/fax fees, late fees, shipping charges, long distance telephone charges, and fees for copying X-rays.
40. Charges for missed appointments.
41. Items or services furnished, ordered, or prescribed by any health care provider that involves Fraud.
42. Habilitative Services, except for Covered Health Services related to treatment of Autism Spectrum Disorders.
43. Court-related services including but not limited to, pretrial and court testimony, court-ordered treatment, or the preparation of court-related reports.
44. Services and supplies provided by or at free-standing birthing centers, home births, and lay-midwives.
45. Unless otherwise stated in this Plan Document, travel, lodging, and/or meals necessary while receiving health care services is excluded, regardless of location, even though prescribed by a Physician or necessary because of where treatment is received.

ATTACHMENT I

Plan Document Elements

Name of Plan:

Michigan Care

Name, Address and Phone Number of Plan Sponsor and Named Fiduciary:

University of Michigan
3003 S. State Street
Suite G405 Wolverine Tower
Ann Arbor, MI 48109
The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

Effective Date of Plan:

January 1, 2021
Restated: January 1, 2022, January 1, 2023, January 1, 2024, January 1, 2025

Type of Plan:

Group health care coverage plan.

Claims Administrator:

The company, which provides certain administrative services for the Plan.
University of Michigan Health Service Company
PO Box 30377
Lansing, MI 48909-7877
The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan:

The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a preferred provider network; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Third-Party Administrator ("TPA").

Governing Law:

This Agreement shall be governed by and construed under the laws of the State of Michigan to the extent not preempted by Federal law.

Right to Change, Amend, Interpret, Modify, Withdraw or Add Benefits, or Terminate This Plan:

Although the Plan Sponsor currently intends to continue the Benefits provided by this Plan, the Plan Sponsor reserves the right, at any time and for any reason or no

reason at all, to change, amend, interpret, modify, withdraw, or add Benefits or terminate this Plan or this plan document, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants and their beneficiaries. Any change or amendment to or termination of the Plan, its benefits or its terms and condition, in whole or in part, shall be made solely in a written amendment (in the case of a change or amendment) or in a written resolution (in the case of termination), whether prospective or retroactive, to the Plan. The amendment or resolution is effective only when approved by the body or person to whom such authority is formally granted by the terms of the Plan. No person or entity has any authority to make any oral changes or amendments to the Plan.

ATTACHMENT II

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).
If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).