Michigan Care PHP Service Company Benefit Summary DAS08001

The purpose of this document is to provide as an easy-to-read summary of the plan. It provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the Plan Document. If there is a discrepancy between this summary and any applicable plan documents, the plan document will control. University of Michigan reserves the right to change, amend, interpret, modify, withdraw or add benefits

Deductible	This Plan has no deductible.
Out-of-Pocket Maximum- Medical only	$3,000 per individual / $6,000 per family

	Member Responsibility	
Benefit	**Network Providers**	**Non-network Providers**
PCP office visit	$25 per visit	Not Covered
Specialist office visit	$30 per visit	Not Covered
Preventive health services	No charge	Not Covered
Urgent care/retail clinic visit	$25 per visit	$25 per visit
Emergency department visit	$100 per visit- waived if admitted	$100 per visit- waived if admitted
Autism Spectrum Disorders -ABA services -Outpatient habilitation services for treatment of autism	$25 per visit for ABA and outpatient habilitation services	Not Covered
Allergy care -Office visit -Injections	-$30 per office visit -No charge- injections	Not Covered
Ambulance	No charge	No charge
Bariatric surgery	50% up to $1,000	Not Covered
Behavioral health services for mental illness and substance use disorders -Inpatient -Outpatient therapy visits and testing -Other outpatient services -Intermediate treatment -Residential treatment programs	-No charge- inpatient -$25 per visit- outpatient therapy and testing -No charge- other outpatient svcs -No charge- intermediate treatment -No charge- residential treatment	Not Covered
Durable medical equipment and diabetic supplies Limitations apply	No charge	Not Covered
Hearing services Limited to once every 36 months	No charge for standard hearing aid up to allowed amount	Not Covered
Home health care services	No charge	Not Covered
Home infusion services	No charge	Not Covered
Hospice services Respite care is limited to 5 days per calendar year	No charge	Not Covered

	Member Responsibility	
Benefit	**Network Providers**	**Non-network Providers**
Infertility/fertility preservation services -diagnosis and treatment of underlying causes -Office visit -IVF/fertility preservation Limits apply	- underlying causes covered as any other medical service - $30 copay for office visit - 20% coinsurance for IVF/fertility preservation - $20,000 lifetime plan maximum for IVF and fertility preservation	Not Covered
Inpatient or outpatient hospital facility	No charge	Not Covered
Physician prenatal, delivery and postnatal charges	No charge	Not Covered
Preventive health services Includes but is not limited to routine physical, well-bay and well-child care, immunizations, routine colonoscopy, mammography screening, routine eye exam and female sterilization	No charge	Not Covered
Outpatient diagnostic lab and pathology	No charge	Not Covered
Outpatient diagnostic x-ray and testing	No charge	Not Covered
Outpatient high tech radiology and nuclear medicine	No charge	Not Covered
Outpatient rehabilitation services: Combined limit for PT/OT/ST of 60 visits per condition per calendar year Limit for cardiac rehabilitation of 36 visits/ calendar year. Limit for pulmonary rehabilitation 12 visits/ calendar year	$25 per visit for physical, occupational and speech therapy No charge for cardiac and pulmonary rehabilitation	Not Covered
Professional fees for medical or surgical services – inpatient or outpatient	No charge	Not Covered
Prosthetic and orthotic devices Limits apply	No charge	Not Covered
Skilled nursing facility/inpatient rehabilitation facility Combined limit of 120 days per calendar year	No charge	Not Covered
Spinal manipulation services by chiropractor or D.O. Combined limit of 24 visits per calendar year	$25 per visit	Not Covered
Surgery – inpatient or outpatient	No charge	Not Covered
Transplant services	No charge	Not Covered