SERVING COUNTIES
Bay, Calhoun, Clinton,
Eaton, Gratiot, Huron,
Ingham, Ionia, Jackson,
Kalamazoo, Livingston,
Montcalm, Saginaw,
Sanilac, Shiawassee,
Tuscola, and Washtenaw

Summary of Benefits

CY2025

Covenant Advantage (HMO-POS)
Covenant Advantage Plus (HMO-POS)
University of Michigan Health Advantage (HMO-POS)
University of Michigan Health Advantage Plus (HMO-POS)
University of Michigan Health Advantage Flex (PPO)

UNIVERSITY OF MICHIGAN HEALTH PLAN
UNIVERSITY OF MICHIGAN HEALTH

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Summary of Benefits

Jan. 1, 2025 – Dec. 31, 2025

This booklet provides a summary of what we cover and what you pay. It doesn't list every limitation, exclusion, or covered service. To get a complete list of services we cover, please refer to the Evidence of Coverage (EOC) which can be found on MyMedicarePortal.org. You can also request a printed copy of the EOC by contacting Customer Service at 844-529-3757 (TTY: 711).

To compare our plans with other Medicare Advantage health plans, ask the other plans for their Summary of Benefits booklets or use the Medicare Plan Finder on Medicare.gov.

To know more about the coverage and costs of Original Medicare, look in your current *Medicare & You* handbook. Find it online at Medicare.gov or get a copy by calling 800-MEDICARE (800-633-4227), 24 hours a day, seven days a week. TTY users should call 877-486-2048.

Sections in this booklet

Things to Know About University of Michigan Health Plan (UM Health Plan) Medicare Advantage Plans

- Covenant Advantage (HMO-POS) and Covenant Advantage Plus (HMO-POS)
- University of Michigan Health Advantage (HMO-POS) and University of Michigan Health Advantage Plus (HMO-POS)
- University of Michigan Health Advantage Flex (PPO)

Monthly Premium, Deductibles, and Limits on How Much You Pay for Covered Services

Covered Medical and Hospital Benefits

Part D Prescription Drug Coverage

Other Covered Benefits

This document is available in other formats such as braille and large print. This document may be available in a non-English language. For additional information, call 844-529-3757 (TTY: 711) to speak with a Customer Service representative.

Things to Know About University of Michigan Health Plan

Hours of operation

- From Oct. 1 through March 31, you can call us seven days a week from 8 a.m. to 8 p.m. E.T.
- From April 1 through Sept. 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. E.T.

Phone numbers and website

- If you have questions, call toll-free 844-529-3757 (TTY: 711).
- Our website: MyMedicarePortal.org

Who can join?

To join a UM Health Plan Medicare Advantage plan, you must be entitled to Medicare Part A, enrolled in Medicare Part B, a United States citizen or be lawfully present in the United States, and live in our service area. Our service area includes the following counties in Michigan: Bay, Calhoun, Clinton, Eaton, Gratiot, Huron, Ingham, Ionia, Jackson, Kalamazoo, Livingston, Montcalm, Saginaw, Sanilac, Shiawassee, Tuscola, and Washtenaw.

What is an HMO-POS?

An HMO-POS is a Medicare Advantage Plan that is a Health Maintenance Organization with a more flexible network allowing you to seek care outside of the traditional HMO network under certain situations or for certain treatment. With these plans, we don't require you to get a referral to see a specialist for care. You may pay some additional fees for using the POS (out-of-network) option.

What is a PPO?

PPO stands for preferred provider organization (PPO). With these plans, we don't require you to get a referral to see a specialist for care. You'll get the most value from your plan when using in-network providers, but you can see any provider who participates with Medicare. You don't have to choose a Primary Care Provider (PCP), although selecting one can help you coordinate care.

Which doctors, hospitals, and pharmacies can I use?
UM Health Plan has a network of doctors, hospitals, pharmacies, and other providers. Our plans allow you to see providers outside of the network (non-contracted providers). However, while we pay for certain covered services, the provider must be Medicare-participating. Except in an emergency or urgent situation, non-contracted providers may deny care. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can call us and we will send you a copy of the Provider Directory or visit MyMedicarePortal.org.

What do we cover?
Like all Medicare health plans, we cover everything that Original Medicare covers — and more.

- Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.
- Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

What drugs do we cover?
We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. Call us and we will send you a copy of our Prescription Drug Formulary (list of Part D prescription drugs) or visit MyMedicarePortal.org.

How will I determine my drug costs?
Our plans group each medication into one of five tiers. You will need to use the Prescription Drug Formulary to locate the tier your drug is in to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document, we discuss the benefit stages that occur: initial coverage and catastrophic coverage. Our plans do not have a deductible. If you have questions about the different benefit stages, please contact the plan for more information or access the Evidence of Coverage on our website.

Monthly Premium, Deductibles, and Limits on How Much You Pay for Covered Services

HMO-POS	HMO-POS Plus	PPO
Plan availability		
Covenant Advantage: Bay, Huron, Saginaw, Sanilac, Tuscola **UM Health Advantage:** Calhoun, Clinton, Eaton, Gratiot, Ingham, Ionia, Jackson, Kalamazoo, Livingston, Montcalm, Shiawassee, Washtenaw	**Covenant Advantage:** Bay, Huron, Saginaw, Sanilac, Tuscola **UM Health Advantage:** Calhoun, Clinton, Eaton, Gratiot, Ingham, Ionia, Jackson, Kalamazoo, Livingston, Montcalm, Shiawassee, Washtenaw	**UM Health Advantage Flex:** Bay, Calhoun, Clinton, Eaton, Gratiot, Huron, Ingham, Ionia, Jackson, Kalamazoo, Livingston, Montcalm, Saginaw, Sanilac, Shiawassee, Tuscola, Washtenaw
What you should know You must reside in one of these counties to enroll in our plan, however, care is not limited to the county you live in. Our plans provide access to a statewide network of care with providers at Michigan's top health systems.		
Monthly premium		
$0	$25	$0
What you should know You must continue to pay your Medicare Part B premium.		
Deductible		
$0	$0	$0
Maximum out-of-pocket		
Your yearly limit in this plan: $3,900 for covered hospital and medical services you receive from in-network providers. $5,000 for covered hospital and medical services you receive from out-of-network providers.	**Your yearly limit in this plan:** $3,900 for covered hospital and medical services you receive from in-network providers. $5,000 for covered hospital and medical services you receive from out-of-network providers.	**Your yearly limit in this plan:** $5,500 for covered hospital and medical services you receive from in-network and out-of-network providers.
What you should know The maximum out-of-pocket amount is the most you will pay for covered hospital and medical services in a calendar year. Once you reach this limit, the plan covers all costs for the remainder of the year. You will still need to pay any applicable monthly premiums and cost-sharing for your Part D prescription drugs.		

Covered Medical and Hospital Benefits

HMO-POS	HMO-POS Plus	PPO
Inpatient hospital coverage		
In-network Covenant Advantage: Days 1-7: $175 copay per day, per stay Days 8 and beyond: $0 copay per day, per stay UM Health Advantage: Days 1-7: $200 copay per day, per stay Days 8 and beyond: $0 copay per day, per stay	**In-network** Covenant Advantage: Days 1-7: $175 copay per day, per stay Days 8 and beyond: $0 copay per day, per stay UM Health Advantage: Days 1-7: $200 copay per day, per stay Days 8 and beyond: $0 copay per day, per stay	**In-network** UM Health Advantage Flex: Days 1-5: $350 copay per day, per stay Days 6 and beyond: $0 copay per day, per stay
Out-of-network 20% coinsurance	**Out-of-network** 20% coinsurance	**Out-of-network** 30% coinsurance
What you should know Our plans provide unlimited coverage for inpatient hospital stays. Prior authorization may be required.		
Outpatient hospital coverage		
In-network $150 copay	**In-network** $150 copay	**In-network** $200 copay
Out-of-network 20% coinsurance	**Out-of-network** 20% coinsurance	**Out-of-network** 30% coinsurance
What you should know Medicare-covered outpatient hospital services (based on the Medicare allowable amount). Prior authorization may be required.		
Ambulatory Surgical Center (ASC)		
In-network $100 copay	**In-network** $100 copay	**In-network** $150 copay
Out-of-network 20% coinsurance	**Out-of-network** 20% coinsurance	**Out-of-network** 30% coinsurance
What you should know For each Medicare-covered surgery. Prior authorization may be required.		
Doctor visits: Primary Care Provider (PCP)		
In-network $0 copay	**In-network** $0 copay	**In-network** $0 copay
Out-of-network Not covered	**Out-of-network** Not covered	**Out-of-network** $25 copay
What you should know Certain Medicare-covered services provided by a provider may require prior authorization. Additionally, keep in mind that not all preventive services are available through your primary care provider. For details, see the preventive care section.		

HMO-POS	HMO-POS Plus	PPO
Doctor visits: Specialist		
In-network $35 copay	**In-network** $30 copay	**In-network** $35 copay
Out-of-network 20% coinsurance	**Out-of-network** 20% coinsurance	**Out-of-network** $40 copay

Preventive care		
In-network $0 copay	**In-network** $0 copay	**In-network** $0 copay
Out-of-network 20% coinsurance	**Out-of-network** 20% coinsurance	**Out-of-network** $0 copay

What you should know

Our plan covers many preventive services, including:

- Abdominal aortic aneurysm screening
- Annual wellness visit
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)
- Cardiovascular disease testing
- Cervical and vaginal cancer screening
- Colorectal cancer screening
- Depression screening
- Diabetes screening
- Diabetes self-management training and diabetic services
- Health and wellness education programs
- HIV screening
- Immunizations (pneumonia, hepatitis B, influenza, and COVID 19)
- Medical nutrition therapy
- Medicare Diabetes Prevention Program (MDPP)
- Obesity screening and therapy to promote sustained weight loss
- Prostate cancer screening exams
- Screening and counseling to reduce alcohol misuse
- Screening for lung cancer with low dose computed tomography (LDCT)
- Screening for sexually transmitted infections (STIs) and counseling to prevent STIs
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
- Welcome to Medicare preventive visit (one time)

Any additional preventive services approved by Medicare during the contract year will be covered.

HMO-POS	HMO-POS Plus	PPO
Emergency care		
$140 copay	$140 copay	$125 copay
What you should know If you are admitted to the same hospital within 24 hours for the same condition, you pay $0 for the emergency room visit. See the "Inpatient Hospital Coverage" section of this booklet for other costs. This coverage is available worldwide.		
Urgently needed services		
$60 copay	$60 copay	$55 copay
What you should know Covered services for care needed when you have a non-emergency health issue that requires immediate attention. This coverage is available worldwide.		
Diagnostic services (labs, radiology, imaging)		
In-network **Lab services:** $0 copay **Diagnostic colonoscopies:** $0 copay **X-rays:** $35 copay **High tech radiology services (MRI, CT, and PET scans):** $100 copay **Diagnostic mammograms:** $0 copay **All other radiology services:** $20 copay **Diagnostic procedures and tests:** $10 copay **Therapeutic radiology services (such as radiation treatment for cancer):** $25 copay	**In-network** **Lab services:** $0 copay **Diagnostic colonoscopies:** $0 copay **X-rays:** $35 copay **High tech radiology services (MRI, CT, and PET scans):** $100 copay **Diagnostic mammograms:** $0 copay **All other radiology services:** $20 copay **Diagnostic procedures and tests:** $10 copay **Therapeutic radiology services (such as radiation treatment for cancer):** $25 copay	**In-network** **Lab services:** $0 copay **Diagnostic colonoscopies:** $0 copay **X-rays:** $35 copay **High tech radiology services (MRI, CT, and PET scans):** $100 copay **Diagnostic mammograms:** $0 copay **All other radiology services:** $20 copay **Diagnostic procedures and tests:** $0-$10 copay **Therapeutic radiology services (such as radiation treatment for cancer):** $35 copay
Out-of-network 20% coinsurance for Medicare-covered outpatient diagnostic tests and therapeutic services and supplies.	**Out-of-network** 20% coinsurance for Medicare-covered outpatient diagnostic tests and therapeutic services and supplies.	**Out-of-network** 30% coinsurance for Medicare-covered outpatient diagnostic tests and therapeutic services and supplies.
What you should know Prior authorization may be required for some services. A referral may be required for some out-of-network services. There is no copay for abdominal aortic aneurysm screening, diabetes screening, or prostate cancer screening when they are ordered as a preventive service.		

HMO-POS	HMO-POS Plus	PPO
Hearing services		
In-network **Exam to diagnose and treat hearing balance issues:** $25 copay **Routine hearing exam:** $25 copay **Hearing aid fitting or evaluation:** $0 copay every two calendar years	**In-network** **Exam to diagnose and treat hearing balance issues:** $25 copay **Routine hearing exam:** $25 copay **Hearing aid fitting or evaluation:** $0 copay every two calendar years	**In-network** **Exam to diagnose and treat hearing balance issues:** $25 copay **Routine hearing exam:** $25 copay **Hearing aid fitting or evaluation:** $0 copay every two calendar years
Out-of-network 20% coinsurance for Medicare-covered hearing exam.	**Out-of-network** 20% coinsurance for Medicare-covered hearing exam.	**Out-of-network** 30% coinsurance for Medicare-covered hearing exam.
Hearing aids $1,000 allowance toward hearing aids. Up to two hearing aids every two calendar years (both ears combined).	**Hearing aids** $1,500 allowance toward hearing aids. Up to two hearing aids every two calendar years (both ears combined).	**Hearing aids** $1,000 allowance toward hearing aids. Up to two hearing aids every two calendar years (both ears combined).
What you should know You can use your hearing aid benefit with both in- and out-of-network providers. If you choose an out-of-network provider, you'll pay them directly and then get reimbursed by us.		
Dental services		
Preventive services **In-network:** $0 copay **Intraoral complete series (full mouth X-rays, 1 every 3 calendar years):** $0 copay **Periodontal maintenance (following active therapy, 2 every calendar year). Note:** Applies toward annual cleaning frequency for the year. To qualify for 2 additional periodontal maintenance cleanings, a history of periodontal disease needs to be established.	**Preventive services** **In-network:** $0 copay **Intraoral complete series (full mouth X-rays, 1 every 3 calendar years):** $0 copay **Periodontal maintenance (following active therapy, 2 every calendar year). Note:** Applies toward annual cleaning frequency for the year. To qualify for 2 additional periodontal maintenance cleanings, a history of periodontal disease needs to be established.	**Preventive services** **In-network:** $0 copay **Intraoral complete series (full mouth X-rays, 1 every 3 calendar years):** 50% coinsurance **Periodontal maintenance (following active therapy, 4 every calendar year). Note:** Applies toward annual cleaning frequency for the year.
Medicare-covered dental services: $35 copay	**Medicare-covered dental services:** $30 copay	**Medicare-covered dental services:** $35 copay
Deductible: $100	**Deductible:** $75	**Deductible:** $100
Comprehensive services **Basic restorative:** 20% - 50% coinsurance after deductible **Oral surgery:** 20% - 50% coinsurance **Prosthetic maintenance:** 40% - 50% coinsurance	**Comprehensive services** **Basic restorative:** 20% - 50% coinsurance after deductible **Oral surgery:** 20% - 50% coinsurance **Prosthetic maintenance:** 40% - 50% coinsurance	**Comprehensive services** **Basic restorative:** 40% - 50% coinsurance after deductible **Oral surgery:** 40% - 50% coinsurance **Prosthetic maintenance:** 40% - 50% coinsurance
Annual dental allowance: $1,000	**Annual dental allowance:** $2,000	**Annual dental allowance:** $1,500

HMO-POS	HMO-POS Plus	PPO
Dental services, continued		
What you should know **Preventive services include:** • Comprehensive periodontal evaluation (1 every calendar year) • Comprehensive oral exam (2 every 12 months) • Periodic oral exam (2 per calendar year) • Limited oral evaluations (as needed for diagnosis of emergency condition) • Horizontal bitewing X-rays (1 every calendar year, up to 4 images) • Routine cleaning (2 every calendar year) • Fluoride treatments (2 every calendar year) A visit to an oral surgeon for Medicare-covered services may require prior authorization. Yearly deductible must be met before benefits for comprehensive dental services are available. **Comprehensive services (include but are not limited to):** • Basic restorative (fillings, inlays/onlays, crowns, retrograde filling, and protective restorations) • Oral surgery (simple/surgical extractions and other surgical procedures) • Prosthetic maintenance (services such as bridges, dentures, crowns, and tissue conditioning)		
Vision services		
Diabetic eye exams: $0 copay **Eyeglass frames or contacts after cataract surgery:** $0 copay **Eyeglass lenses after cataract surgery:** $0 copay	**Diabetic eye exams:** $0 copay **Eyeglass frames or contacts after cataract surgery:** $0 copay **Eyeglass lenses after cataract surgery:** $0 copay	**Diabetic eye exams:** $0 copay **Eyeglass frames or contacts after cataract surgery:** $0 copay **Eyeglass lenses after cataract surgery:** $0 copay
Medicare-covered services **In-network:** $35 copay **Out-of-network:** 20% coinsurance	**Medicare-covered services** **In-network:** $30 copay **Out-of-network:** 20% coinsurance	**Medicare-covered services** **In-network:** $35 copay **Out-of-network:** $40 copay
Routine vision services **Routine eye exam (one annually)** In-network: $0 copay Out-of-network: Up to $30 reimbursement **Retinal imaging:** $39 copay **Eyeglass lenses (one pair per calendar year):** $0 copay **Eyeglass frames (one pair per calendar year):** $0 copay **$200 eyewear allowance per calendar year**	**Routine vision services** **Routine eye exam (one annually)** In-network: $0 copay Out-of-network: Up to $30 reimbursement **Retinal imaging:** $39 copay **Eyeglass lenses (one pair per calendar year):** $0 copay **Eyeglass frames (one pair per calendar year):** $0 copay **$400 eyewear allowance per calendar year**	**Routine vision services** **Routine eye exam (one annually)** In and out-of-network: $0 copay **Retinal imaging:** $39 copay **Eyeglass lenses (one pair per calendar year):** $0 copay **Eyeglass frames (one pair per calendar year):** $0 copay **Combined in- and out-of-network: $200 eyewear allowance per calendar year**
Out-of-network Up to $120 eyewear reimbursement per calendar year	**Out-of-network** Up to $240 eyewear reimbursement per calendar year	

HMO-POS	HMO-POS Plus	PPO
What you should know Diabetic eye exams performed by an ophthalmologist or optometrist are covered by Medicare. You are eligible for one pair of Medicare-covered eyeglass frames (standard plastic single, bifocal, trifocal, or lenticular lenses) or one pair of Medicare-covered contact lenses (or 2 6-packs) after each cataract surgery. You are eligible for one pair of Medicare-covered eyeglass lenses after each cataract surgery. You are eligible for one pair of standard plastic single, bifocal, trifocal, or lenticular lenses or one pair of contact lenses (or 2 6-packs) per calendar year.		
Mental health services		
Inpatient stay **In-network:** Covenant Advantage Days 1-7: $175 copay per day, per stay: Days 8 and beyond: $0 copay per day, per stay UM Health Advantage: Days 1-7: $200 copay per day, per stay Days 8 and beyond: $0 copay per day, per stay **Out-of-network:** 20% coinsurance	**Inpatient stay** **In-network:** Covenant Advantage Days 1-7: $175 copay per day, per stay: Days 8 and beyond: $0 copay per day, per stay UM Health Advantage: Days 1-7: $200 copay per day, per stay Days 8 and beyond: $0 copay per day, per stay **Out-of-network:** 20% coinsurance	**Inpatient stay** **In-network:** UM Health Advantage Flex: Days 1-5: $350 copay per day, per stay Days 6 and beyond: $0 copay per day, per stay **Out-of-network:** 30% coinsurance
Outpatient visit **In-network:** **Outpatient individual visit:** $30 copay **Outpatient group visit:** $25 copay **Out-of-network:** 20% coinsurance	**Outpatient visit** **In-network:** **Outpatient individual visit:** $30 copay **Outpatient group visit:** $25 copay **Out-of-network:** 20% coinsurance	**Outpatient visit** **In-network:** **Outpatient individual visit:** $30 copay **Outpatient group visit:** $25 copay **Out-of-network:** 30% coinsurance
What you should know Our plans provide unlimited coverage for inpatient hospital stays. A referral or prior authorization may be required. If you receive authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, you'll pay the same cost-sharing as you would at an in-network hospital.		
Skilled nursing facility		
In-network Days 1-20: $0 copay per day, per stay Days 21-100: $150 copay per day, per stay	**In-network** Days 1-20: $0 copay per day, per stay Days 21-100: $150 copay per day, per stay	**In-network** Days 1-20: $0 copay per day, per stay Days 21-100: $150 copay per day, per stay
Out-of-network 20% coinsurance	**Out-of-network** 20% coinsurance	**Out-of-network** 30% coinsurance
What you should know Our plans cover up to 100 days per admission. No prior hospital stay is required. Admission to a new or different skilled nursing facility within the same benefit period may start a new stay for copay administration purposes. Prior authorization may be required.		

HMO-POS	HMO-POS Plus	PPO
Physical therapy		
In-network $25 copay	**In-network** $25 copay	**In-network** $25 copay
Out-of-network 20% coinsurance	**Out-of-network** 20% coinsurance	**Out-of-network** 30% coinsurance
What you should know A referral may be required.		
Ambulance		
$200 copay	$200 copay	$275 copay
What you should know This copay applies to each one-way trip. Prior authorization may be required for non-emergency ambulance transportation.		
Transportation		
In-network $0 copay	**In-network** $0 copay	**In-network** $0 copay
Out-of-network Not covered	**Out-of-network** Not covered	**Out-of-network** $0 copay
Limited to 20 one-way trips to plan-approved locations every year.	Limited to 30 one-way trips to plan-approved locations every year.	Limited to 20 one-way trips to plan-approved locations every year.
Medicare Part B Drugs		
Part B covered chemotherapy drugs In-network: 0%-20% coinsurance Out-of-network: 20% coinsurance	**Part B covered chemotherapy drugs** In-network: 0%-20% coinsurance Out-of-network: 20% coinsurance	**Part B covered chemotherapy drugs** In-network: 0%-20% coinsurance Out-of-network: 30% coinsurance
Other Part B drugs, including insulin administered via a durable medical equipment insulin pump In-network: 20% coinsurance Out-of-network: 20% coinsurance	**Other Part B drugs, including insulin administered via a durable medical equipment insulin pump** In-network: 20% coinsurance Out-of-network: 20% coinsurance	**Other Part B drugs, including insulin administered via a durable medical equipment insulin pump** In-network: 0%-20% coinsurance Out-of-network: 30% coinsurance
What you should know If a Part B prescription drug's price has increased at a rate faster than the rate of inflation, we'll reduce your coinsurance for that drug by a certain amount as directed by the Centers for Medicare & Medicaid Services (CMS). CMS will tell University of Michigan Health Plan what your coinsurance should be for that drug. Your coinsurance will never exceed 20% but could be lower based on information we receive from CMS. For Part B insulin (insulin administered through a durable medical equipment pump), you won't pay more than $35 for a one-month supply. Some Part B medications may be subject to prior authorization. Amounts you pay for Part B drugs count toward your maximum out-of-pocket.		

Part D Prescription Drug Coverage

HMO-POS	HMO-POS Plus	PPO
Deductible		
$0	$0	$0
Maximum out-of-pocket		
$2,000	$2,000	$2,000
What you should know Your Part D prescription drug copayments apply until you reach the maximum out-of-pocket limit. Once you meet this limit, you have no cost share ($0) for plan covered drugs.		
Insulin coverage		
30-day supply: $35 copay	**30-day supply:** $35 copay	**30-day supply:** $35 copay
What you should know You won't pay more than $35 for a one-month supply of any insulin product covered by our plan, regardless of the cost-sharing tier or your extra help status.		

Preferred Retail Pharmacy

HMO-POS			HMO-POS Plus			PPO		
30-day	**60-day**	**90-day**	**30-day**	**60-day**	**90-day**	**30-day**	**60-day**	**90-day**
Tier 1: Preferred generics								
$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2: Generics								
$10 copay	$20 copay	$30 copay	$10 copay	$20 copay	$30 copay	$10 copay	$20 copay	$30 copay
Tier 3: Preferred brand								
$45 copay	$90 copay	$135 copay	$45 copay	$90 copay	$135 copay	$47 copay	$94 copay	$141 copay
Tier 4: Non-preferred brand								
$95 copay	$190 copay	$285 copay	$95 copay	$190 copay	$285 copay	$100 copay	$200 copay	$300 copay
Tier 5: Specialty drugs								
33% coinsurance	N/A	N/A	33% coinsurance	N/A	N/A	33% coinsurance	N/A	N/A

Standard Retail Pharmacy

HMO-POS			HMO-POS Plus			PPO		
30-day	**60-day**	**90-day**	**30-day**	**60-day**	**90-day**	**30-day**	**60-day**	**90-day**
Tier 1: Preferred generics								
$5 copay	$10 copay	$15 copay	$5 copay	$10 copay	$15 copay	$5 copay	$10 copay	$15 copay
Tier 2: Generics								
$20 copay	$40 copay	$60 copay	$20 copay	$40 copay	$60 copay	$20 copay	$40 copay	$60 copay
Tier 3: Preferred brand								
$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$141 copay
Tier 4: Non-preferred brand								
$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay
Tier 5: Specialty drugs								
33% coinsurance	N/A	N/A	33% coinsurance	N/A	N/A	33% coinsurance	N/A	N/A

Mail Order (Express Scripts)

HMO-POS			HMO-POS Plus			PPO		
30-day	**60-day**	**90-day**	**30-day**	**60-day**	**90-day**	**30-day**	**60-day**	**90-day**
Tier 1: Preferred generics								
$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2: Generics								
$10 copay	$20 copay	$0 copay	$10 copay	$20 copay	$0 copay	$10 copay	$20 copay	$0 copay
Tier 3: Preferred brand								
$45 copay	$90 copay	$135 copay	$45 copay	$90 copay	$135 copay	$47 copay	$94 copay	$141 copay
Tier 4: Non-preferred brand								
$95 copay	$190 copay	$285 copay	$95 copay	$190 copay	$285 copay	$100 copay	$200 copay	$300 copay
Tier 5: Specialty drugs								
33% coinsurance	N/A	N/A	33% coinsurance	N/A	N/A	33% coinsurance	N/A	N/A

Out-of-network Pharmacy

HMO-POS	HMO-POS Plus	PPO
30-day	**30-day**	**30-day**
Tier 1: Preferred generics		
$5 copay	$5 copay	$5 copay
Tier 2: Generics		
$20 copay	$20 copay	$20 copay
Tier 3: Preferred brand		
$47 copay	$47 copay	$47 copay
Tier 4: Non-preferred brand		
$100 copay	$100 copay	$100 copay
Tier 5: Specialty drugs		
33% coinsurance	33% coinsurance	33% coinsurance

Other Covered Benefits

HMO-POS	HMO-POS Plus	PPO
Acupuncture		
In-network $35 copay	**In-network** $30 copay	**In-network** $35 copay
Out-of-network 20% coinsurance	**Out-of-network** 20% coinsurance	**Out-of-network** $40 copay
What you should know Medicare-covered acupuncture treatment (based on the Medicare allowable amount).		
Chiropractic care		
In-network $20 copay	**In-network** $20 copay	**In-network** $20 copay
Out-of-network 20% coinsurance	**Out-of-network** 20% coinsurance	**Out-of-network** 30% coinsurance
What you should know Medicare-covered chiropractic services (based on the Medicare allowable amount).		
Diabetes supplies and services		
Diabetes self-management training **In-network:** $0 copay **Out-of-network:** 20% coinsurance	**Diabetes self-management training** **In-network:** $0 copay **Out-of-network:** 20% coinsurance	**Diabetes self-management training** **In-network:** $0 copay **Out-of-network:** 30% coinsurance
Diabetes monitoring supplies (including blood glucose monitors, lancets, CGMs, and test strips*) **In-network:** 0% coinsurance **Out-of-network:** 20% coinsurance**	**Diabetes monitoring supplies (including blood glucose monitors, lancets, CGMs, and test strips*)** **In-network:** 0% coinsurance **Out-of-network:** 20% coinsurance**	**Diabetes monitoring supplies (including blood glucose monitors, lancets, CGMs, and test strips*)** **In-network:** 0% coinsurance **Out-of-network:** 30% coinsurance**
Therapeutic shoes or inserts **In and out-of-network:** 20% coinsurance	**Therapeutic shoes or inserts** **In and out-of-network:** 20% coinsurance	**Therapeutic shoes or inserts** **In-network:** 20% coinsurance **Out-of-network:** 30% coinsurance
What you should know *See Evidence of Coverage for a complete listing. **When glucose meters and test strips are obtained at a pharmacy, coverage is limited to specific Abbott/LifeScan products. Authorization is required for some items (e.g., diabetic custom-molded shoes and inserts, continuous glucose metes, insulin pumps).		

HMO-POS	HMO-POS Plus	PPO
Durable Medicare Equipment		
In and out-of-network: 20% coinsurance	**In and out-of-network:** 20% coinsurance	**In-network:** 20% coinsurance **Out-of-network:** 30% coinsurance
What you should know Wheelchairs, oxygen, etc. Prior authorization may be required.		
Home health care		
In-network $0 copay	**In-network** $0 copay	**In-network** $0 copay
Out-of-network 20% coinsurance	**Out-of-network** 20% coinsurance	**Out-of-network** 30% coinsurance
What you should know A referral may be required.		
Hospice		
$0 copay	$0 copay	$0 copay
What you should know When you enroll in a Medicare-certified hospice program, your services are covered and paid by Original Medicare. Please contact University of Michigan Health Plan for more details.		
Outpatient substance abuse		
In-network **Individual visit:** $30 copay **Group visit:** $25 copay	**In-network** **Individual visit:** $30 copay **Group visit:** $25 copay	**In-network** **Individual visit:** $30 copay **Group visit:** $25 copay
Out-of-network 20% coinsurance	**Out-of-network** 20% coinsurance	**Out-of-network** 30% coinsurance
What you should know Medicare-covered outpatient substance abuse services (based on the Medicare allowable amount). Prior authorization may be required.		
Over-the-counter (OTC) allowance		
$85 per quarter for OTC items	**Covenant Advantage:** $120 per quarter for OTC items **UM Health Plan:** $115 per quarter for OTC items	$105 per quarter for OTC items and medical copays combined
What you should know Combined quarterly allowance for approved health care products with flexible usage options: 1. Order online, by phone, or by mail through our OTC partner, Convey Health, with up to two orders allowed per quarter. 2. Use your Flex Spending Card at participating retailers nationwide. You cannot use your Flex Spending Card for prescription copays. Quarterly OTC allowances do not roll over from quarter to quarter.		

HMO-POS	HMO-POS Plus	PPO
Podiatry services		
In-network $35 copay	**In-network** $30 copay	**In-network** $35 copay
Out-of-network 20% coinsurance	**Out-of-network** 20% coinsurance	**Out-of-network** 30% coinsurance
What you should know Medicare-covered podiatry services (based on the Medicare allowable amount). A referral may be required.		
Prosthetic devices		
Prosthetic devices **In and out-of-network:** 20% coinsurance	**Prosthetic devices** **In and out-of-network:** 20% coinsurance	**Prosthetic devices** **In-network:** 20% coinsurance **Out-of-network:** 30% coinsurance
Related medical supplies **In and out-of-network:** 20% coinsurance	**Related medical supplies** **In and out-of-network:** 20% coinsurance	**Related medical supplies** **In-network:** 20% coinsurance **Out-of-network:** 30% coinsurance
What you should know Prior authorization may be required.		
Rehabilitation services		
Cardiac rehabilitation services **In-network:** $20 copay **Out-of-network:** 20% coinsurance	**Cardiac rehabilitation services** **In-network:** $20 copay **Out-of-network:** 20% coinsurance	**Cardiac rehabilitation services** **In-network:** $15 copay **Out-of-network:** 30% coinsurance
Occupational and physical therapy, and speech-language pathology services **In-network:** $25 copay **Out-of-network:** 20% coinsurance	**Occupational and physical therapy, and speech-language pathology services** **In-network:** $25 copay **Out-of-network:** 20% coinsurance	**Occupational and physical therapy, and speech-language pathology services** **In-network:** $25 copay **Out-of-network:** 30% coinsurance
What you should know Medicare-covered services. A referral may be required. A separate copayment for occupational therapy will apply if other outpatient therapy services are rendered on the same day.		

HMO-POS	HMO-POS Plus	PPO
SilverSneakers® (Wellness Program)		
$0	$0	$0
What you should know Your SilverSneakers® membership provides access to participating fitness centers nationwide and a library of on-demand virtual exercise classes and workshops – all at no additional cost to you.		

Telehealth		
Mental Health/Psychiatric/ Substance Abuse **In-network:** $30 copay **Out-of-network:** Not covered	**Mental Health/Psychiatric/ Substance Abuse** **In-network:** $30 copay **Out-of-network:** Not covered	**Mental Health/Psychiatric/ Substance Abuse** **In-network:** $30 copay **Out-of-network:** 30% coinsurance
PCP **In-network:** $0 copay **Out-of-network:** Not covered	**PCP** **In-network:** $0 copay **Out-of-network:** Not covered	**PCP** **In-network:** $0 copay **Out-of-network:** $25 copay
What you should know Prior authorization may be required.		

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Medicare advisor at 844-925-0182 (TTY:711).

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit UofMHealthMedicare.org or call 844-925-0182 (TTY:711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your primary care providers) to make sure your providers are in the network. If they are not listed, it means you will likely have to select a new PCP.
- ☐ Review the pharmacy directory in the Provider Directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to any monthly plan premium you may owe, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums, and/or copayments/co-insurance may change on Jan. 1, 2025.
- ☐ Our PPO plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services on our PPO plan, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

Effect of Coverage

- ☐ University of Michigan Health Plan has Medicare Advantage plans that have a contract with the Federal government.
- ☐ By joining University of Michigan Health Plan you understand that the plan will share your information with Medicare who may use it to track your enrollment, to make payments, or for other purposes allowed by Federal law that authorize the collection of this information (see the Privacy Act).
- ☐ Your enrollment in this plan will automatically end any enrollment in another Medicare health plan.
- ☐ Enrollment into this plan generally is for the entire year.
- ☐ You may leave this plan during the Annual Enrollment Period (AEP) that is Oct. 15 through Dec. 7 of every year (with the effective date being Jan. 1 of the following year) or under certain limited special circumstances by sending a request in writing to University of Michigan Health Plan.
- ☐ If you did not pick up Part D when you were first eligible, you may owe a late enrollment penalty and the plan will bill you for this.
- ☐ If this is the first time you are enrolling into a Medicare Advantage plan and terminated a Medigap plan to join, you are considered to be in your “trial period.” During this “trial period” you are allowed to make a one-time only election to disenroll from your first Medicare Advantage plan to return to Original Medicare at any time during the year and pick up your Medigap plan under Medigap guaranteed issue rights.

Notice of Availability of Language Assistance Services and Auxiliary Aids

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call the number on your Member ID card or speak to your provider.

ATENCIÓN: Si habla español, los servicios de asistencia con el idioma están disponibles para usted sin cargo. También se encuentran disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al número que figura en la tarjeta de identificación de miembro o hable con su proveedor.

تنبيه: إذا كنت تتحدث العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل بالرقم الموجود على بطاقة ID هوية العضو الخاصة بك أو تحدث مع مقدم الخدمة الخاص بك.

請注意：如果您說中文，您可以免費獲得語言協助服務。另免費提供適當的輔助工具和服務並以無障礙格式提供資訊。請致電您的會員 ID 卡上的電話號碼或聯絡您的提供者。

请注意：如果您说中文，您可以免费获得语言协助服务。另免费提供适当的辅助工具和服务并以无障碍格式提供信息。请致电您的会员 ID 卡上的电话号码或联系您的提供者。

ܙܘܗܪܐ: ܐܢ ܟܐ ܡܣܘܚܬ ܣܘܪܝܬ، ܐܝܬ ܠܘܟܘܢ ܬܫܡܫܝܬܐ ܕܗܝܪܢܘܬܐ ܠܫܢܢܝܬܐ. ܐܝܟܐ ܬܫܡܫܝܬܐ ܘܡܗܝܪܢܘܬܐ ܒܡܓܢ ܝܠܗܝ
ܘܬܚܝ ܕܠܬ ܬܫܡܫܝܬܐ ܠܝܗܝ ܒܡܘܪܝܐ ܠܡܫܡܥܬܐ. ܩܪܐ ܡܢܝܢ ܠܡܢܝܢܐ ܕܝܠܗ ܥܠ ܦܬܩܐ ܕ ID ܕܗܕܡܘܬܐ ܝܢ ܡܫܚܕ ܥܡ
ܡܩܪܒܢܘܬܐ.

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí sẽ có sẵn cho quý vị. Các hỗ trợ và dịch vụ phụ trợ phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận cũng được cung cấp miễn phí. Hãy gọi số trên thẻ ID Thành viên của quý vị hoặc nói chuyện với nhà cung cấp của quý vị.

KINI PARASYSH: Nëse flisni shqip, ofrohen shërbime falas të ndihmës gjuhësore. Ndihmat dhe shërbimet e përshtatshme ndihmëse për të ofruar informacion në formate të aksesueshme janë gjithashtu të disponueshme pa pagesë. Telefononi numrin në kartën tuaj të identitetit të Anëtarit ose flisni me ofruesin tuaj të shërbimit.

주의 사항: 한국어를 구사하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 액세스 가능한 형식으로 정보를 제공하기 위해 적절한 보조 도구 및 서비스도 무료로 제공됩니다. 가입자 ID 카드에 기재된 전화번호로 연락하시거나 귀하의 의료 제공자에게 문의하시길 바랍니다.

মনোযোগ: আপনি যদি ভাষা সন্নিবেশ করান কথা বলেন তবে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য উপলব্ধ। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সাহায্য এবং পরিষেবাগুলিও বিনামূল্যে পাওয়া যায়। আপনার সদস্য আইডি কার্ডের নম্বরে কল করুন বা আপনার প্রদানকারীর সাথে কথা বলুন।

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Odpowiednie materiały pomocnicze i usługi zapewniające informacje w dostosowanych formatach są również dostępne bezpłatnie. Należy zadzwonić pod numer podany na karcie członkowskiej lub porozmawiać z lekarzem prowadzącym.

HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie die Nummer auf Ihrer Versichertenkarte an oder sprechen Sie mit Ihrem Dienstleister.

ATTENZIONE: Se parli Italiano, sono a tua disposizione servizi gratuiti di assistenza linguistica. Sono inoltre disponibili gratuitamente ausili e servizi adeguati per fornire informazioni in formati accessibili. Chiama il numero sulla tua tessera ID membro o parla con il tuo fornitore.

注意：言語を挿入を話せる場合は、無料の言語支援サービスをご利用いただけます。アクセス可能な形式で情報を提供するための適切な補助手段やサービスも無料でご利用いただけます。会員 ID カードに記載されている番号に電話するか、プロバイダーにお問い合わせください。

ВНИМАНИЕ: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также можно получить бесплатно. Позвоните по номеру, указанному на вашей идентификационной карточке участника плана, или обратитесь к своему врачу.

PAŽNJA: Ako govorite srpski, dostupne su vam besplatne usluge jezičke pomoći. Odgovarajuća pomoćna sredstva i usluge za pružanje informacija u pristupačnim formatima takođe su dostupne besplatno. Pozovite broj sa vaše članske ID kartice ili razgovarajte sa vašim operaterom.

BIGYANG-PANSIN: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyo sa tulong sa wika. Ang mga naaangkop na pantulong na suporta at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay makukuha rin nang libre. Tawagan ang numero sa iyong card ng Member ID o makipag-usap sa iyong provider.

MyMedicarePortal.org

Toll-free: 844-529-3757 (TTY: 711)
8:00 a.m. to 8:00 p.m., seven days a week‡

PO Box 7119, Troy, MI 48007

‡ You may reach a messaging service on weekends from April 1 through Sept. 30 and holidays. Please leave a message and your call will be returned the next business day.

University of Michigan Health Plan has HMO-POS and PPO plans with a Medicare contract. Enrollment in University of Michigan Health Plan depends on contract renewal. All University of Michigan Health Plan plans include Part D drug coverage. To enroll, you must have both Medicare Parts A and B and reside in the following Michigan counties: Bay, Calhoun, Clinton, Eaton, Gratiot, Huron, Ingham, Ionia, Jackson, Kalamazoo, Livingston, Montcalm, Saginaw, Sanilac, Shiawassee, Tuscola, or Washtenaw.

You must continue to pay your Medicare Part B premium. Please note that enrollment is limited to specific times of the year.

Out-of-network/non-contracted providers are under no obligation to treat University of Michigan Health Plan members except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services. University of Michigan Health Plan plans allow members to see out-of-network providers (non-contracted providers).

University of Michigan Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 844-529-3757 (TTY: 711). ‡

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 844-529-3757 (رقم هاتف الصم والبكم: 711).