Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

# UNIVERSITY OF MICHIGAN
# CMM Traditional
# 0070051870000 - 07D5G
# Effective Date: 07/01/2019

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

**Preauthorization for Select Services** - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency

**Note:** A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo**. Select **Approving covered services.**

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

**Preauthorization for Specialty Pharmaceuticals** - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility**.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

**ADM HCR-RXOC;ADM PLANYR JAN;ASCMOD 9365 MED;CMM ASC;CMM-AMB-CC ASC;CMM-CC ASC;CMM-CR 20% ASC;CMM-D $500 ASC;CMM-OPM 3K/6K A;CMM-VSTM ASC;DC 26-ME ASC;DP-SOG ASC;EBMT ASC;HC (A) ASC**



Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

## Eligibility Information

| Member | Eligibility Criteria |
|---|---|
| **Dependents** | • Subscriber's legal spouse, same or opposite gender domestic partner eligible for coverage under the subscriber's contract<br>• **Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship, including eligible children of your same or opposite gender domestic partner; eligible for coverage through the last day of the month the dependent turns age 26. |

## Member's responsibility (deductibles, copays and dollar maximums)

**Note:** If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

| Benefits | Coverage |
|---|---|
| **Deductibles** | $500 for one member,<br>$1,000 for a family (when two or more members are covered under your contract) each calendar year |
| **Flat-dollar copays** | None |
| **Coinsurance amounts (percent copays)**<br><br>**Note:** Coinsurance amounts apply once the deductible has been met. | • 50% of approved amount for private duty nursing<br>• 20% of approved amount for most other covered services |
| **Annual out-of-pocket maximums** -applies to percent copays for all covered services - including mental health and substance use disorder services - but does not apply to fixed dollar copays and private duty nursing percent copays, if applicable | $3,000 for one member,<br>$6,000 for a family (when two or more members are covered under your contract) each calendar year |
| **Lifetime dollar maximum** | • $30,000 maximum for certain gender affirming services<br>• $20,000 for Infertility treatment |

## Preventive care services

| Benefits | Coverage |
|---|---|
| Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures | 100% (no deductible or copay/coinsurance), one per member per calendar year<br><br>**Note:** Additional well-women visits may be allowed based on medical necessity. |
| Gynecological exam | 100% (no deductible or copay/coinsurance), one per member per calendar year<br><br>**Note:** Additional well-women visits may be allowed based on medical necessity. |
| Pap smear screening-laboratory and pathology services | 100% (no deductible or copay/coinsurance), one per member per calendar year |
| Voluntary sterilization for females | 100% (no deductible or copay/coinsurance) |
| Prescription contraceptive devices-includes insertion and removal of an intrauterine device by a licensed physician | 100% (no deductible or copay/coinsurance) |
| Contraceptive injections | 100% (no deductible or copay/coinsurance) |
| Well-baby and child care visits<br>• 8 visits, birth through 12 months<br>• 6 visits, 13 months through 23 months<br>• 6 visits, 24 months through 35 months<br>• 2 visits, 36 months through 47 months<br>• Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit | 100% (no deductible or copay/coinsurance) |

**ADM HCR-RXOC;ADM PLANYR JAN;ASCMOD 9365 MED;CMM ASC;CMM-AMB-CC ASC;CMM-CC ASC;CMM-CR 20% ASC;CMM-D $500 ASC;CMM-OPM 3K/6K A;CMM-VSTM ASC;DC 26-ME ASC;DP-SOG ASC;EBMT ASC;HC (A) ASC**

| Benefits | Coverage |
|---|---|
| Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act | 100% (no deductible or copay/coinsurance) |
| Fecal occult blood screening | 100% (no deductible or copay/coinsurance), one per member per calendar year |
| Flexible sigmoidoscopy exam | 100% (no deductible or copay/coinsurance), one per member per calendar year |
| Prostate specific antigen (PSA) screening | 100% (no deductible or copay/coinsurance), one per member per calendar year |
| Routine mammogram and related reading | 100% (no deductible or copay/coinsurance), one per member per calendar year<br><br>**Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable. |
| Colonoscopy-routine or medically necessary | 100% (no deductible or copay/coinsurance) for the first billed colonoscopy, one per member per calendar year<br><br>**Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable. |

## Physician office services

| Benefits | Coverage |
|---|---|
| Office visits | 80% after deductible |
| Online visits - by physician must be medically necessary<br><br>**Note:** Online visits by a vendor are not covered. | 80% after deductible |
| Outpatient and home medical care visits | 80% after deductible |
| Office consultations | 80% after deductible |

## Emergency medical care

| Benefits | Coverage |
|---|---|
| Hospital emergency room | 80% after deductible |
| Ambulance services-must be medically necessary | 80% after deductible |

## Diagnostic services

| Benefits | Coverage |
|---|---|
| Laboratory and pathology services | 80% after deductible |
| Diagnostic tests and x-rays | 80% after deductible |
| Therapeutic radiology | 80% after deductible |

## Maternity services provided by a physician or certified nurse midwife

| Benefits | Coverage |
|---|---|
| Prenatal care visits | 100% (no deductible or copay/coinsurance) |
| Postnatal care | 80% after deductible |
| Delivery and nursery care | 80% after deductible |

**ADM HCR-RXOC;ADM PLANYR JAN;ASCMOD 9365 MED;CMM ASC;CMM-AMB-CC ASC;CMM-CC ASC;CMM-CR 20% ASC;CMM-D $500 ASC;CMM-OPM 3K/6K A;CMM-VSTM ASC;DC 26-ME ASC;DP-SOG ASC;EBMT ASC;HC (A) ASC**

## Hospital care

| Benefits | Coverage |
|---|---|
| Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies<br><br>**Note:** Nonemergency services must be rendered in a **participating** hospital. | 80% after deductible, unlimited days |
| Inpatient consultations | 80% after deductible |
| Chemotherapy | 80% after deductible |

## Alternatives to hospital care

| Benefits | Coverage |
|---|---|
| Skilled nursing care - must be in a **participating** skilled nursing facility, limited to 120 days per member per calendar year | 80% after deductible |
| Hospice care - including nursing home care with hospice support | 100% (no deductible or copay/coinsurance), up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods-provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management) |
| Home health care:<br>• must be medically necessary<br>• must be provided by a **participating** home health care agency | 80% after deductible |
| Home health aide - when provided by the University of Michigan medical students for members who are C5 level quadriplegic | 100% (no deductible or copay/coinsurance) |
| Infusion therapy:<br>• must be medically necessary<br>• must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC)<br>• may use drugs that require preauthorization-consult with your doctor | 80% after deductible |

## Surgical services

| Benefits | Coverage |
|---|---|
| Surgery-includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility | 80% after deductible |
| Presurgical consultations | • 100% (no deductible or copay/coinsurance) when obtained from a participating provider,<br>• 80% after deductible when obtained from a nonparticipating provider |
| Voluntary sterilization for males<br><br>**Note:** For voluntary sterilizations for females, see **"Preventive care services."** | 80% after deductible |
| Voluntary abortions | 80% after deductible |
| Radial keratotomy surgery and related anesthesia - professional charges only | Not covered |
| Gender reassignment and gender affirming procedures<br><br>**Note:** Certain gender affirming services are payable by participating providers, limited to a lifetime maximum of $30,000 per member over the age of 18 subject to prior authorization. Please see plan modification for further information. | 80% after deductible |

## Human organ transplants

| Benefits | Coverage |
|---|---|
| Specified human organ transplants-must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) | 100% (no deductible or copay/coinsurance) |
| Bone marrow transplants-must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) | 80% after deductible |
| Experimental bone marrow transplants-must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) | 80% after deductible |
| Kidney, cornea and skin transplants | 80% after deductible |

## Behavioral Health Services (Mental Health and Substance Use Disorder)

| Benefits | Coverage |
|---|---|
| **Inpatient** mental health care and **inpatient** substance use disorder treatment | 80% after deductible, unlimited days |
| Residential psychiatric treatment facility:<br>• covered mental health services **must** be performed in a residential psychiatric treatment facility<br>• treatment **must** be preauthorized<br>• subject to medical criteria | 80% after deductible |
| Outpatient mental health care | 80% after deductible |
| Online visits<br><br>**Note:** Online visits by a vendor are not covered. | 80% after deductible |
| Outpatient substance use disorder treatment-in approved facilities **only** | 80% after deductible |

## Autism spectrum disorders, diagnoses and treatment

| Benefits | Coverage |
|---|---|
| Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization<br><br>**Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment. | 80% after deductible |
| Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder | 80% after deductible |
| Other covered services, including mental health services, for autism spectrum disorder | 80% after deductible |

## Other covered services

| Benefits | Coverage |
|---|---|
| Outpatient Diabetes Management Program (ODMP)<br><br>**Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no cost-sharing when rendered by a participating provider.<br><br>**Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs. | • 100% after deductible for diabetes medical supplies<br>• 100% (no deductible or copay/coinsurance) for diabetes self-management training |

**ADM HCR-RXOC;ADM PLANYR JAN;ASCMOD 9365 MED;CMM ASC;CMM-AMB-CC ASC;CMM-CC ASC;CMM-CR 20% ASC;CMM-D $500 ASC;CMM-OPM 3K/6K A;CMM-VSTM ASC;DC 26-ME ASC;DP-SOG ASC;EBMT ASC;HC (A) ASC**

| Benefits | Coverage |
|---|---|
| Allergy testing and therapy | 80% after deductible |
| Chiropractic spinal manipulation and osteopathic manipulative therapy | 80% after deductible, limited to a **combined** 38-visit maximum per member per calendar year |
| Outpatient physical, speech and occupational therapy- provided for rehabilitation | 80% after deductible, unlimited treatment |
| Durable medical equipment<br><br>**Note:** DME items required under the preventive benefit provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of preventive DME items that PPACA requires to be covered at 100%, call BCBSM. | 80% after deductible |
| Prosthetic and orthotic appliances | 80% after deductible |
| Private duty nursing | 50% after deductible |
| Treatment of infertility - IVF and fertility preservation services<br><br>**Note:** Covered treatment procedures are payable only when rendered by the UMHS Center for Reproductive Medicine.<br><br>**Note:** Additional restrictions apply | 80% after deductible, limited to $20,000 lifetime maximum |
| Cardiac rehabilitation - certain restrictions apply | 80% after deductible |
| Routine eye examination | 100% (no deductible), one exam per member per calendar year |
| Nutritional counseling when performed to treat the following conditions: anorexia nervosa, bulimia nervosa and eating disorder not otherwise specified | 80% after deductible |
| Prescription drugs | Not covered |

# Hearing Care Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

## Member's responsibility (deductible and copay)

| Benefits | Participating provider | Nonparticipating provider |
|---|---|---|
| Deductible | None | Not applicable |
| Copay | None | Not applicable |

## Covered services

You **must** receive the following services from **a hearing participating provider**. Hearing care services are **not** covered when performed by nonparticipating providers unless the services are performed outside of Michigan **and** the local Blue Cross and Blue Shield plan does **not** contract with providers for hearing care services. In this case, BCBSM will pay the approved amount for hearing aids and related covered services obtained from a nonparticipating provider. You may be responsible for charges that exceed our approved amount.

If you select a digitally controlled programmable hearing device, you may be responsible for charges that exceed the cost of a covered hearing aid.

| Benefits | Participating provider | Nonparticipating provider |
|---|---|---|
| Audiometric exam - one every 36 months | 100% of approved amount | Not covered |
| Hearing aid evaluation- one every 36 months | 100% of approved amount | Not covered |
| Ordering and fitting the hearing aid (a monaural or binaural hearing aid) - one every 36 months | 100% of approved amount | Not covered |
| Hearing aid conformity test- one every 36 months | 100% of approved amount | Not covered |

**Note:** You **must** obtain a medical evaluation (sometimes called a medical clearance exam) of the ear performed by a physician-specialist before you receive your hearing aid. If a physician-specialist is not accessible, your primary care doctor may perform the medical evaluation. **This evaluation is not covered under your hearing care coverage, so you must pay for this exam unless your medical coverage includes coverage for office visits.**
A physician-specialist is a licensed doctor of medicine or osteopathy who is also board certified or in the process of being board certified as an otolaryngologist. A physician-specialist determines whether a patient has a hearing loss and whether such loss can be offset by a hearing aid.