



Blue Cross  
Blue Shield  
of Michigan

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

## UNIVERSITY OF MICHIGAN 007005187 - CMM Effective Date: 01/01/2021

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](http://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.

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## Eligibility Information

Member	Eligibility Criteria
Dependents	<ul style="list-style-type: none"> <li>Subscriber's legal spouse, same or opposite gender domestic partner eligible for coverage under the subscriber's contract</li> <li><b>Dependent children:</b> 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.</li> </ul>

## 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, \$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)	<ul style="list-style-type: none"> <li>50% of approved amount for private duty nursing</li> <li>20% of approved amount for most other covered services</li> </ul>
<b>Note:</b> Coinsurance amounts apply once the deductible has been met.	
<b>Annual out-of-pocket maximums</b> -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, \$6,000 for a family (when two or more members are covered under your contract) each calendar year
Lifetime dollar maximum	<ul style="list-style-type: none"> <li>\$30,000 maximum for certain gender affirming services</li> <li>\$20,000 for Infertility treatment</li> </ul>

## 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  <b>Note:</b> 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  <b>Note:</b> 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)

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Benefits	Coverage
Well-baby and child care visits <ul style="list-style-type: none"> <li>8 visits, birth through 12 months</li> <li>6 visits, 13 months through 23 months</li> <li>6 visits, 24 months through 35 months</li> <li>2 visits, 36 months through 47 months</li> <li>Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</li> </ul>	100% (no deductible or copay/coinsurance)
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  <b>Note:</b> 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  <b>Note:</b> 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	80% after deductible
<b>Note:</b> Online visits by a vendor are not covered.	
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

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## 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

## Hospital care

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

## Alternatives to hospital care

Benefits	Coverage
Skilled nursing care-must be in a <b>participating</b> skilled nursing facility	80% after deductible, limited to 120 days per member per calendar year
Hospice care	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 <b>participating</b> hospice program <b>only</b> ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)
Home health care: <ul style="list-style-type: none"> <li>• must be medically necessary</li> <li>• must be provided by a <b>participating</b> home health care agency</li> </ul>	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: <ul style="list-style-type: none"> <li>• must be medically necessary</li> <li>• must be given by a <b>participating</b> Home Infusion Therapy (HIT) provider or in a <b>participating</b> freestanding Ambulatory Infusion Center (AIC)</li> <li>• may use drugs that require preauthorization-consult with your doctor</li> </ul>	80% after deductible
Nursing home care with hospice support	80% after deductible

## Surgical services

Benefits	Coverage
Surgery-includes related surgical services and medically necessary facility services by a <b>participating</b> ambulatory surgery facility	80% after deductible
Presurgical consultations	<ul style="list-style-type: none"> <li>• 100% (no deductible or copay/coinsurance) when obtained from a participating provider,</li> <li>• 80% after deductible when obtained from a nonparticipating provider</li> </ul>

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Benefits	Coverage
Voluntary sterilization for males	80% after deductible
<b>Note:</b> For voluntary sterilizations for females, see " <b>Preventive care services.</b> "	
Voluntary abortions	80% after deductible
Radial keratotomy surgery and related anesthesia - professional charges only	Not covered
Gender reassignment and gender affirming procedures	80% after deductible
<b>Note:</b> 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.	

## Human organ transplants

Benefits	Coverage
Specified human organ transplants-must be in a <b>designated</b> 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
<b>Inpatient</b> mental health care and <b>inpatient</b> substance use disorder treatment	80% after deductible, unlimited days
Residential psychiatric treatment facility: <ul style="list-style-type: none"> <li>covered mental health services <b>must</b> be performed in a residential psychiatric treatment facility</li> <li>treatment <b>must</b> be preauthorized</li> <li>subject to medical criteria</li> </ul>	80% after deductible
Outpatient mental health care	80% after deductible
Online visits	80% after deductible
<b>Note:</b> Online visits by a vendor are not covered.	
Outpatient substance use disorder treatment-in approved facilities <b>only</b>	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	80% after deductible
<b>Note:</b> 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.	

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Benefits	Coverage
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)	<ul style="list-style-type: none"> <li>100% (no deductible or copay/coinsurance) for diabetes medical supplies</li> <li>100% (no deductible or copay/coinsurance) for diabetes self-management training</li> <li>100% (no deductible or copay/coinsurance) for Diabetes Prevention Program, subject to additional criteria</li> </ul>
<p><b>Note:</b> 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.</p> <p><b>Note:</b> When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.</p>	
Allergy testing and therapy	80% after deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	80% after deductible, limited to a <b>combined</b> 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	80% after deductible
<p><b>Note:</b> 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.</p>	
Prosthetic and orthotic appliances	80% after deductible
Private duty nursing	50% after deductible
Treatment of infertility - IVF and fertility preservation services	80% after deductible, limited to \$20,000 lifetime maximum
<p><b>Note:</b> Covered treatment procedures are payable only when rendered by the UMHS Center for Reproductive Medicine.</p> <p><b>Note:</b> Additional restrictions apply</p>	
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

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## Hearing Care Coverage

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### 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.

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