UNIVERSITY OF MICHIGAN
007005187 - PPO
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.** 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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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

Members	Eligibility Criteria
Dependents	• Subscriber's legal spouse, same or opposite gender domestic partner eligible for coverage under the subscriber's contract • **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, coinsurance and dollar maximums)

Benefits	In-network	Out-of-network
Deductible	None	None
Flat-dollar copays	• $25 copay for office visits and office consultations with a **primary care physician** • $30 copay for office visits and office consultations with a **specialist** • $25 copay for online visits with a **primary care physician** • $30 copay for online visits with a **specialist** • $25 copay for chiropractic and osteopathic manipulative therapy • $25 copay for outpatient physical, speech and occupational therapy • $100 copay for emergency room visits • $25 copay for urgent care visits	• $100 copay for emergency room visits
Coinsurance amounts (percent copays)	• 50% of approved amount for private duty nursing care • 20% for treatment of infertility	• 50% of approved amount for private duty nursing care • 50% of approved amount for mental health care and substance use disorder treatment • 50% of approved amount for most other covered services
Annual out-of-pocket maximums - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	$3,000 for one member, $6,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** In-Network coinsurance amounts do not apply toward the out-of-network coinsurance maximum.	$5,000 for one member, $10,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-Network cost-sharing amounts do not count toward the In-network maximum.
Lifetime dollar maximum	• $30,000 maximum for certain gender affirming services • $20,000 for Infertility treatment	

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Preventive care services

Benefits	In-network	Out-of-network
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 **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	50% (no deductible)
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Contraceptive injections	100% (no deductible or copay/coinsurance)	50% (no deductible)
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
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)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	50% (no deductible) **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	

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Benefits	In-network	Out-of-network
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	50% (no deductible)
	One per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	• $25 copay for each office visit with a **primary care physician** • $30 copay for each office visit with a **specialist**	50% after out-of-network deductible
Online visits - by physician must be medically necessary **Note:** Online visits by a vendor are not covered.	• $25 copay per online visit with a **primary care physician** • $30 copay for online visits with a **specialist**	50% (no deductible)
Outpatient and home medical care visits - must be medically necessary	• $25 copay per visit with a **primary care physician** • $30 copay per visit with a **specialist**	50% (no deductible)
Office consultations - must be medically necessary	• $25 copay for each office consultation with a **primary care physician** • $30 copay for each office consultation with a **specialist**	50% after out-of-network deductible
Urgent care visits - must be medically necessary	$25 copay per urgent care visit	50% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	$100 copay per visit (copay waived if admitted or for an accidental injury)	$100 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	100% (no deductible or copay/coinsurance)	50% (no deductible)
Diagnostic tests and x-rays	100% (no deductible or copay/coinsurance)	50% (no deductible)
Therapeutic radiology	100% (no deductible or copay/coinsurance)	50% (no deductible)

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Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	50% (no deductible)
Postnatal care visit	100% (no deductible or copay/coinsurance)	50% (no deductible)
Delivery and nursery care	100% (no deductible or copay/coinsurance)	50% (no deductible)

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	100% (no deductible or copay/coinsurance) Unlimited days	50% (no deductible)
Inpatient consultations	100% (no deductible or copay/coinsurance)	50% (no deductible)
Chemotherapy	100% (no deductible or copay/coinsurance)	50% (no deductible)

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a **participating** skilled nursing facility	100% (no deductible or copay/coinsurance) Limited to a maximum of 120 days per member per calendar year	100% (no deductible or copay/coinsurance)
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)	100% (no deductible or copay/coinsurance)
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
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)	100% (no deductible or copay/coinsurance)
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization - consult with your doctor	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

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Benefits	In-network	Out-of-network
• Online visits **Note:** Online visits by a vendor are not covered.	$25 copay per **online visit**	50% (no deductible)
Outpatient substance use disorder treatment - in approved facilities **only**	100% (no deductible or copay/coinsurance)	50% (no deductible) (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization **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.	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	$25 copay per visit	50% (no deductible)
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	100% (no deductible or copay/coinsurance)	50% (no deductible)

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 100% (no deductible or copay/ coinsurance) for diabetes medical supplies • 100% (no deductible or copay/ coinsurance) for diabetes self-management training • 100% (no deductible or copay/ coinsurance) for Diabetes Prevention Program, subject to additional criteria	50% (no deductible)
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	50% (no deductible)
Chiropractic spinal manipulation and osteopathic manipulative therapy	$25 copay per visit	50% (no deductible)
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy - provided for rehabilitation	$25 copay per visit (including services billed with an autism diagnosis)	50% (no deductible) **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year	

Benefits	In-network	Out-of-network
Durable medical equipment **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.	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Prosthetic and orthotic appliances	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Private duty nursing care	50% (no deductible)	50% (no deductible)
Treatment of infertility - IVF and fertility preservation services **Note:** Covered treatment procedures are payable only when rendered by the UMHS Center for Reproductive Medicine. **Note:** Additional restrictions apply	80% (no deductible), limited to $20,000 lifetime maximum	Not covered
Routine eye examination - one per member, per calendar year	100% (no deductible or copay/coinsurance)	Annual maximum of $40 per service payable at 50% (no deductible)
Nutritional counseling when performed to treat the following conditions: anorexia nervosa, bulimia nervosa and eating disorder not otherwise specified	100% (no deductible or copay/coinsurance)	50% (no deductible)
Prescription drugs	Not covered	Not covered

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.