Blue Care Network of Michigan

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

Benefits-at-a-Glance for University of Michigan Domestic POS Student Health Plan
August 24, 2024

This is intended as an easy-to-read summary. **It is not a contract**. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan.

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 BCN 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*.

Member's Responsibility: Deductible, Copays, Coinsurance and Dollar Maximums

Note: The **Deductible** will apply to certain services as defined below.

	In-network	Out-of-network
Deductible	$100 per individual/$200 per family per benefit year	$100 per individual/$200 per family per benefit year
	If you use in-network and out-of-network services, separate deductible amounts apply. The deductible for in-network and out-of-network is not combined to satisfy the deductible limit.	
Fixed Dollar Copays	$20 for PCP office visits	Not Applicable
	$20 for specialist visits	Coinsurance applies
	$75 for emergency room visits	$75 for emergency room visits
	$20 for urgent care visits	$20 for urgent care visits
Coinsurance	10% and 20% for select services as noted below	10% and 20% for select services as noted below
Medical Annual Coinsurance Maximum (ACM)	None	None
Annual out-of-pocket maximums (OOPM)	$3,500 per member/$7,000 per family per benefit year	$3,500 per member/$7,000 per family per benefit year
	If you use in-network and out-of-network services, separate OOPM amounts apply. The OOPM for in-network and out-of-network is not combined to satisfy the OOPM limit.	

Preventive Services – as defined by the Affordable Care Act and included in your Benefit Document

	In-network	Out-of-network
Health Maintenance Exam	Covered – 100%	Covered – 20% coinsurance of the approved amount after deductible
Annual Gynecological Exam	Covered – 100%	Covered – 20% coinsurance of the approved amount after deductible
Pap Smear Screening	Covered – 100%	Covered – 20% coinsurance of the approved amount after deductible
Well-Baby and Child Care	Covered – 100%	Covered – 20% coinsurance of the approved amount after deductible
Immunizations – pediatric and adult	Covered – 100%	Covered – 20% coinsurance of the approved amount after deductible
Prostate Specific Antigen (PSA) Screening	Covered – 100%	Covered – 20% coinsurance of the approved amount after deductible
Routine Colonoscopy	Covered – 100%	Covered – 20% coinsurance of the approved amount after deductible
Mammography Screening	Covered – 100%	Covered – 20% coinsurance of the approved amount after deductible
Voluntary Female Sterilization	Covered – 100%	Covered – 20% coinsurance of the approved amount after deductible
Breast Pumps (DME guidelines apply.)	Covered – 100%	Not applicable
Maternity Pre-Natal Care	Covered – 100%	Covered – 20% coinsurance of the approved amount after deductible

Physician Office Services

PCP Office Visits – Note: Applicable cost sharing applies when other services are received in the office.	Covered – $20 copay	Not Applicable
Online Visits	Covered – $20 copay	Covered – 20% coinsurance of the approved amount after deductible
Consulting Specialist Care – Note: Applicable cost sharing applies when other services are received in the office	Covered – $20 copay after deductible	Covered – 20% coinsurance of the approved amount after deductible

Emergency Medical Care

Hospital Emergency Room	Covered – $75 copay; waived if admitted	Covered – $75 copay; waived if admitted
Urgent Care Center	Covered – $20 copay after deductible	Covered – $20 copay after deductible
Ambulance Services	Covered – 100% after deductible	Covered – 100% after deductible

Diagnostic Services

	In-network	Out-of-network
Laboratory and Pathology Tests	Lab and path is covered in full for both in-network and out-of-network	
Diagnostic Tests and X-rays	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible
High Technology Imaging (MRI, MRA, CAT, PET)	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible
Radiation Therapy – inpatient	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible

Maternity Services Provided by a Physician

Postnatal Care. See Preventive Services section for routine Prenatal Care	Covered – $20 copay	Covered – 20% coinsurance of the approved amount after deductible
Delivery and Nursery Care	Covered – 10% coinsurance after deductible for professional services; see Hospital Care for facility charges. Well newborn nursery care covered 100%.	Covered – 20% coinsurance of the approved amount after deductible for professional services; see Hospital Care for facility charges

Hospital Care

Inpatient hospital – facility	Covered – $150 copay after deductible per admission; unlimited days	Covered – 20% coinsurance of the approved amount after deductible; unlimited days
Inpatient hospital – professional	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible
Outpatient Surgery – facility and professional	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible

Alternatives to Hospital Care

Skilled Nursing Care – facility; unlimited days	Covered – $150 copay after deductible per admission	Covered – 20% coinsurance of the approved amount after deductible
Hospice Care – inpatient facility; unlimited days	Covered – $150 copay after deductible per admission	Covered – 20% coinsurance of the approved amount after deductible
Home Health Care	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible

Surgical Services

	In-network	Out-of-network
Surgery – includes all related surgical services and anesthesia.	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible
Elective Abortion	Covered – 10% coinsurance	Covered – 10% coinsurance
Human Organ Transplants	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible
Reduction mammoplasty	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible
Male Mastectomy	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible
Temporomandibular Joint Syndrome	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible
Orthognathic Surgery	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible

Behavioral Health

Inpatient Mental Health Care - facility	Covered – $150 copay after deductible per admission	Covered – 20% coinsurance of the approved amount after deductible
Inpatient Substance Use Disorder - facility	Covered – $150 copay after deductible per admission	Covered – 20% coinsurance of the approved amount after deductible
Inpatient MH and SUD - professional	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible
Outpatient Mental Health Care – includes online visits	Covered – $20 copay	Covered – 20% coinsurance of the approved amount after deductible
Outpatient Substance Use Disorder	Covered – $20 copay	Covered – 20% coinsurance of the approved amount after deductible

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	Covered – $20 copay	Covered – 20% coinsurance of the approved amount after deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	Covered – $20 copay after deductible	Covered – 20% coinsurance of the approved amount after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit	See your outpatient mental health benefit and medical office visit benefit

Other Services	In-network	Out-of-network
Allergy Testing and Therapy	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible
Allergy Injections	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible
Chiropractic Spinal Manipulation	Covered – $20 copay after deductible; unlimited visits	Covered – 20% coinsurance of the approved amount after deductible; unlimited visits
Outpatient Physical, Speech and Occupational Therapy including habilitative services	Covered – $20 copay after deductible unlimited visits	Covered – 20% coinsurance of the approved amount after deductible; unlimited visits
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 10% coinsurance after deductible on all associated costs	Covered – 20% coinsurance of the approved amount after deductible on all associated costs
Durable Medical Equipment (DME)	Covered – 10% coinsurance after deductible through BCN Vendor	
Prosthetic and Orthotic Appliances (P&O)	Covered – 10% coinsurance after deductible through BCN Vendor	
Diabetic Supplies	Covered – 10% coinsurance after deductible through BCN Vendor	
Routine Adult Vision Exam	Covered – $20 copay	Covered – 20% coinsurance
	Limited to: 2 vision exams per Member per Benefit Year and one office visit for the fitting of prescription contact lenses per Member per Benefit Year	
Hearing aid	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible
	Limited to one hearing aid per ear every 6-24 month consecutive period per benefit year	
Transplant Services – eligible travel and lodging for initial transplant surgery – member must submit receipts for reimbursement	• $10,000 limit • Max payable $50 per night for lodging for recipient • Max payable $50 per night for lodging per companion	
Injuries due to intercollegiate sports	Not covered	
Intramural and club sports	Covered – applicable cost share applies based on the service and location of the service	

Prescription Drugs

	In-network	Out-of-network
Prescription Drugs – 30-day supply	**Custom Select Drug List:** Preferred Generics – $6 copay Non-Preferred Generics – $25 copay Preferred Brand – $50 copay Non-Preferred Brand – $80 copay Preferred Specialty - 20% coinsurance (max $200) Non-Preferred Specialty - 20% coinsurance (max $300)	**Custom Select Drug List:** Preferred Generics – $6 copay Non-Preferred Generics – $25 copay Preferred Brand – $50 copay Non-Preferred Brand – $80 copay
	Drugs for the treatment of Sexual Dysfunction, Cough & Cold and prenatal vitamins – Covered at the applicable tiered copay	
	• Preventive Drugs including female contraceptives are covered in full for Generic and Single Source Brand names on the Custom Select Drug List. Multi-Source Brands are not covered. • Drugs for Weight loss, Compounds and Select High Abuse Drugs are not covered. • Specialty drugs are covered only when obtained from a pharmacy in the BCN Exclusive Pharmacy Network for Specialty Drugs	
90-day Retail Prescription Drugs	**Custom Select Drug List:** Preferred Generics – $12 copay Non-Preferred Generics – $50 copay Preferred Brand – $100 copay Non-Preferred Brand – $160 copay	Not covered
Mail Order Prescription Drugs	Not covered	Not covered

Pediatric vision

Eye Exam – Limited to once per calendar year through the last day of the year in which an individual turns age 19. Prescription Glasses – Frames (chosen from a select collection) and lenses are covered once in a calendar year through the last day of the year in which an individual turns age 19	Covered-100%	Covered- 100% of the approved amount

Pediatric dental (Age 18 and younger)

Pediatric dental – Administered by Blue Cross Blue Shield of Michigan. For benefit questions call the dental customer service number on the back of your card.	**Blue Dental PPO dentists**	**Blue Par Select and nonparticipating dentists**
	To find a PPO dentist near you, please visit mibluedentist.com or call 1-888-826-8152	
Dental deductible	$25 per member/$75 per contract deductible per calendar year	$25 per member/$75 per contract deductible per calendar year
Dental out-of-pocket maximum -- applies to deductible and coinsurance amounts for covered dental services provided by Blue Dental PPO dentists. It does not apply to charges that exceed our approved PPO fee, services provided by non-PPO dentists or non-covered services.	$375 per member/ $750 per contract per calendar year	Not applicable
Class I – Diagnostic and preventive services like oral exams, cleanings, fluoride, bitewing X-rays and sealants	Covered – 100% of the approved amount	Covered – 100% of the approved amount
Class II – Basic services like fillings, full-mouth X-rays, non-surgical endodontic and periodontic treatments and extractions of non-impacted teeth	Covered – 80% of the approved amount after dental deductible	Covered – 80% of the approved amount after dental deductible
Class III – Major services like crowns, surgical endodontic and periodontic treatments, oral surgery and dentures	Covered – 50% of approved amount after dental deductible	Covered – 50% of the approved amount after dental deductible
Orthodontic Services	Covered – 50% of approved amount	Covered – 50% of approved amount
	Lifetime maximum limit of $1,000	

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UNIVERSITY OF MICHIGAN DOMESTIC STUDENT HEALTH PLAN Effective Date: 08/24/2022

Adult Dental Coverage (Age 19 and Older)

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.

Coverage determination: Claims are subject to dental necessity verification and availability of dental benefits when they are processed, as well as the terms and conditions of the applicable BCBSM certificates and riders.

Network access information
With Blue Dental PPO, members can choose any licensed dentist anywhere. However, they'll have the greatest coverage and savings when they choose a dentist who is a member of the Blue Dental PPO network.

Blue Dental PPO network-Blue Dental members have unmatched access to PPO (in-network) dentists through the Blue Dental PPO network, which offers more than 535,000 dentist locations* nationwide. PPO dentists agree to accept our approved amount as full payment for covered services, and members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826- 8152.**

*A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices is two dentist locations.

Blue Par Select℠ arrangement-Most non-PPO (out-of-network) dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services, and members pay only applicable coinsurance and deductible amounts. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com.**

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Eligibility information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • Dependent children: related to you by birth, marriage, legal adoption or legal guardianship; eligible for dental coverage through the end of the calendar year in which they turn age 26, provided all eligibility requirements are met.

Member's responsibility (deductible, coinsurance and dollar maximums)

Benefits	In-network	Out-of-network
Deductible • Applies to Class I Class II and Class III services	None	None
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services	None (covered at 100%)	100%
• Class II services	90%	90%
• Class III services	90%	90%

Class I services

Benefits	In-network	Out-of-network
Oral exams **Note:** Prior to receiving services, your dentist should contact Blue Cross Blue Shield of Michigan at the number on the back of your ID card to verify which exams are covered.	100% of approved amount	100% of approved amount
	Note: Twice per benefit year	
Dental prophylaxis (teeth cleaning)	100% of approved amount	100% of approved amount
	Note: Twice per benefit year	

Class II services

Benefits	In-network	Out-of-network
Fillings - permanent (adult) teeth	90% of approved amount	90% of approved amount
	Note: Once per tooth and surface every 48 months	
Filings – primary (child) teeth	90% of approved amount	90% of approved amount
	Note: Once per tooth and surface every 24 months	
Panoramic or full-mouth x-rays associated with removal of wisdom teeth	90% of approved amount	90% of approved amount
	Note: Once every 60 months	
Palliative (emergency) treatment	90% of approved amount	90% of approved amount
General anesthesia or IV sedation for the removal of wisdom teeth	90% of approved amount	90% of approved amount

Class III services

Benefits	In-network	Out-of-network
Extractions and surgical removal of wisdom teeth	90% of approved amount	90% of approved amount