Blue Cross Blue Shield of Michigan

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

UNIVERSITY OF MICHIGAN
CONSUMER-DIRECTED HEALTH PLAN (CDHP)
Effective Date: 01/01/2026
Benefits-at-a-glance

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.

Prior authorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, receive prior authorization 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.

Prior authorization 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 prior authorization of the drugs. If prior authorization 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	• 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)

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

Benefits	In-network	Out-of-network
Deductibles **Note:** Your deductible **combines** deductible amounts paid under your Simply Blue HSA medical coverage **and** your prescription drug coverage under another insurer. **Note:** The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract.	$1,700 for a one-person contract or $3,400 for a family contract (two or more members) each calendar year **(no 4th quarter carry-over)**	$1,700 for a one-person contract $3,400 for a family contract (two or more members) each calendar year **(no 4th quarter carry-over)**
	Deductibles are based on amounts defined annually by the federal government for Simply Blue HSA-related health plans. Deductibles may increase annually. Please call your customer service center for an annual update.	
Flat-dollar copays	None	None
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 10% or 20% of approved amount for most other covered services	• 50% of approved amount for most other covered services
Annual out-of-pocket maximums - applies to deductibles and coinsurance amounts for all covered services **Note:** Your annual out-of-pocket maximum include amounts you paid for covered services under your BCBSM certificate and your prescription drug coverage under another insurer.	$5,500 for a one-person contract $10,600 for a family contract (two or more members) each calendar year	$11,000 for a one-person contract $21,200 for a family contract (two or more members) each calendar year
Lifetime dollar maximum	$20,000 for infertility treatment	

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

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Benefits	In-network	Out-of-network
Gynecological exam	100% (no deductible or copay/coinsurance), two 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 of female reproductive organs	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Well-baby and Well-child 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.	50% after out-of-network 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	

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.	50% after out-of-network deductible
	One routine colonoscopy per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	90% after in-network deductible	50% after out-of-network deductible
Online visits - by physician or **BCBSM** selected vendor must be medically necessary **Note:** Online visits by a non-BCBSM selected vendor are not covered. Not all services delivered virtually are considered an online visit, but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	90% after in-network deductible	50% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	90% after in-network deductible	50% after out-of-network deductible
Office consultations - must be medically necessary	90% after in-network deductible	50% after out-of-network deductible
Urgent care visits - must be medically necessary	90% after in-network deductible	50% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	90% after in-network deductible	90% after in-network deductible
Ambulance services - must be medically necessary	90% after in-network deductible	90% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	90% after in-network deductible	50% after out-of-network deductible
Diagnostic tests and x-rays	90% after in-network deductible	50% after out-of-network deductible
Therapeutic radiology	90% after in-network deductible	50% after out-of-network 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% after out-of-network deductible
Postnatal care	100% (no deductible or copay/coinsurance)	50% after out-of-network deductible
Delivery and nursery care **Note:** For facility services See "Hospital Care"	90% after in-network deductible	50% after out-of-network 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.	90% after in-network deductible Unlimited days	50% after out-of-network deductible
Inpatient consultations	90% after in-network deductible	50% after out-of-network deductible
Chemotherapy	90% after in-network deductible	50% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a **participating** skilled nursing facility	90% after in-network deductible Limited to a maximum of 120 days per member, per calendar year	90% after in-network deductible
Hospice care	90% after in-network deductible 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). There is a fifth level of 45-days per lifetime that requires prior authorization. The 5th level is covered for nursing home care.	90% after in-network deductible
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	90% after in-network deductible	90% after in-network deductible
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 prior authorization - consult with your doctor	90% after in-network deductible	90% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	90% after in-network deductible	50% after out-of-network deductible
Presurgical consultations	90% after in-network deductible	50% after out-of-network deductible
Voluntary sterilization of male reproductive organs **Note:** For voluntary sterilization of female reproductive organs, see **"Preventive care services."**	100% after in-network deductible	50% after out-of-network deductible
Elective Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	90% after in-network deductible	50% after out-of-network deductible
Gender reassignment and gender affirming procedures **Note:** Certain gender affirming services are payable by participating providers. Please see plan modification for further information.	90% after in-network deductible	Not covered

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	90% after in-network deductible	90% after in-network deductible - in designated facilities **only**
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	90% after in-network deductible	50% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	90% after in-network deductible	50% after out-of-network deductible
Kidney, cornea and skin transplants	90% after in-network deductible	50% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder treatment	90% after in-network deductible	50% after out-of-network deductible
Note: Facility services are covered in participating facilities only.	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential treatment facility • treatment requires prior authorization • subject to medical criteria	90% after in-network deductible	50% after out-of-network deductible
Outpatient mental health care: • Facility and clinic **Note:** Facility services are covered in participating facilities only.	90% after in-network deductible	90% after in-network deductible
• Online visits **Note:** Online visits by a non-BCBSM selected vendor are not covered.	90% after in-network deductible	50% after out-of-network deductible

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Benefits	In-network	Out-of-network
• Physician's office	90% after in-network deductible	50% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	90% after in-network deductible	50% after out-of-network 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 behavior analysis (ABA) treatment - subject to prior authorization **Note:** Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).	90% after in-network deductible	50% after out-of-network deductible **Note:** Services rendered by an approved licensed behavior analyst (LBA) will apply the in-network cost-sharing.
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder	90% after in-network deductible	50% after out-of-network deductible
	Physical, speech and occupational therapy with **an autism diagnosis** is unlimited	
Other covered services, including nutritional counseling and mental health services, for autism spectrum disorder	90% after in-network deductible	50% after out-of-network 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. **Note:** Continuous glucose monitor supplies and devices are not covered.	90% after in-network deductible	50% after out-of-network deductible
Allergy testing and therapy	90% after in-network deductible	50% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	90% after in-network deductible	50% after out-of-network deductible
	Limited to a **combined** 24-visits maximum per member per calendar year	
Outpatient physical, speech and occupational therapy - provided for rehabilitation	90% after in-network deductible	50% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visits maximum per member per calendar year	

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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.	90% after in-network deductible	90% after in-network deductible
Prosthetic and orthotic appliances	90% after in-network deductible	90% after in-network deductible
Private duty nursing care	90% after in-network deductible	50% after out-of-network 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% after in-network deductible, limited to $20,000 lifetime maximum	Not covered
Prescription drugs	Not covered	Not covered
Routine eye examination - one per member, per calendar year	90% after in-network deductible	50% after out-of-network deductible and subject to an annual maximum of $40 per service
Nutritional counseling when performed to treat the following conditions: anorexia nervosa, bulimia nervosa and eating disorder not otherwise specified	90% after in-network deductible	50% after out-of-network deductible

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UNIVERSITY OF MICHIGAN HEARING CARE COVERAGE Effective Date: 01/01/2026 Benefits-at-a-glance

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Member's responsibility (deductible and copay/coinsurance)

Benefits	Participating provider	Nonparticipating provider
Deductible **Note**: You are required to meet the annual calendar year deductible under your Simply Blue HSA coverage **before** using your hearing care benefits	**Your Simply Blue HSA hearing care benefits are subject to the same deductible required under your Simply Blue HSA medical coverage.** Hearing care benefits are **not** payable until after you have met the Simply Blue HSA annual deductible.	Not applicable
Copay/coinsurance	**Your Simply Blue HSA hearing care benefits are subject to the same coinsurance required under your Simply Blue HSA medical coverage.**	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 after Simply Blue HSA deductible and coinsurance	Not covered
Hearing aid evaluation- one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered
Ordering and fitting the hearing aid (a monaural or binaural hearing aid) - one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered
Hearing aid conformity test- one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered

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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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