Blue Cross Blue Shield of Michigan

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

UNIVERSITY OF MICHIGAN
COMPREHENSIVE MAJOR MEDICAL (CMM)
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.

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 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) **Note:** Coinsurance amounts apply once the deductible has been met.	• 30% of approved amount for private duty nursing • 20% of approved amount for most other covered services
Annual out-of-pocket maximums -applies to coinsurance amounts for all covered services - including mental health and substance use disorder services - but does not apply to private duty nursing coinsurance amounts.	$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	• $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 **Note:** Additional well-women visits may be allowed based on medical necessity.
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.
Pap smear screening-laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year
Voluntary sterilization of female reproductive organs	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 Well-child visits • 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	100% (no deductible or copay/coinsurance)

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 **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy, one per member per calendar year **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.

Physician office services

Benefits	Coverage
Office visits	80% after 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.	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	100% (no deductible or copay/coinsurance)
Delivery and nursery care **Note:** For facility services See "Hospital Care"	80% after deductible

Hospital care

Benefits	Coverage
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **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	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 **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.
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	80% after 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	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)
Voluntary sterilization of male reproductive organs **Note:** For voluntary sterilization of female reproductive organs, see **"Preventive care services."**	100% (no deductible or copay/coinsurance)

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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.

Benefits	Coverage
Elective Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	80% after deductible
Radial keratotomy surgery and related anesthesia - professional charges only	Not covered
Gender reassignment and gender affirming procedures **Note:** Certain gender affirming services are payable by participating providers. 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 **Note:** Facility services are covered in participating facilities only.	80% after deductible, unlimited days
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment requires prior authorization • subject to medical criteria	80% after deductible
Outpatient mental health care	80% after deductible
Online visits **Note:** Online visits by a non-BCBSM selected 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 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).	80% after deductible

Benefits	Coverage
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder	80% after deductible
Other covered services, including nutritional counseling and mental health services, for autism spectrum disorder	80% after deductible

Other covered services

Benefits	Coverage
Outpatient Diabetes Management Program (ODMP) **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. **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.	• 100% (no deductible or copay/coinsurance) for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training
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 **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	70% after 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 deductible, limited to $20,000 lifetime maximum per contract
Routine eye examination - one per member, per calendar year	100% (no deductible or copay/coinsurance), 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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UNIVERSITY OF MICHIGAN 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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