



**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 International POS Student Health Plan

September 1, 2023

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.	



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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

Physician Office Services

PCP Office Visits – Note: Applicable cost sharing applies when other services are received in the office.	Covered – \$20 copay	Not Applicable
Medical 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



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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

Prenatal and Postnatal Care	Covered – 100%	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



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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



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Other Services

In-network

Out-of-network

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	<ul style="list-style-type: none"> • \$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	
Acupuncture in lieu of anesthesia	Not covered	
Out-of-Country Services	Covered regardless if the country has socialized medicine. Applicable in-network cost sharing applies	



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Prescription Drugs

	In-network	Out-of-network
Prescription Drugs – 30-day supply	Custom Select Drug List: Preferred Generics – 10% coinsurance Non-Preferred Generics – 10% coinsurance Preferred Brand – 10% coinsurance Non-Preferred Brand – 10% coinsurance Preferred Specialty- 10% coinsurance Non-Preferred Specialty - 10% coinsurance	Custom Select Drug List: Preferred Generics – 10% coinsurance Non-Preferred Generics – 10% coinsurance Preferred Brand – 10% coinsurance Non-Preferred Brand – 10% coinsurance
	Drugs for the treatment of Sexual Dysfunction, Cough & Cold and prenatal vitamins – 10% Coinsurance	
	<ul style="list-style-type: none"> 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 and 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
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 PS10UM, UM35PM
 HA1020