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 Student Health Plan
September 1, 2020

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 **Note:** Coinsurance and select fixed dollar copays apply once the deductible has been met.	$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
Coinsurance Maximum	None	None
Annual out-of-pocket maximums (OOPM) – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug cost-sharing amounts	$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 – laboratory services only	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 – laboratory services only	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	Covered – $20 copay	Not Applicable
Online Visits	Covered – $20 copay	Covered – 20% coinsurance of the approved amount after deductible
Consulting Specialist Care	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 – medically necessary	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, 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 (subject to medical criteria) -	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible
Reduction mammoplasty (subject to medical criteria)	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible
Male Mastectomy (subject to medical criteria)	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 10% coinsurance after deductible	Covered – 20% coinsurance of the approved amount after deductible
Orthognathic Surgery (subject to medical criteria)	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 Abuse Care - facility	Covered – $150 copay after deductible per admission	Covered – 20% coinsurance of the approved amount after deductible
Outpatient Mental Health Care	Covered – $20 copay	Covered – 20% coinsurance of the approved amount after deductible
Outpatient Substance Abuse Care	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 through age 18	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	Covered – 10% coinsurance after deductible through BCN Vendor	
Prosthetic and Orthotic Appliances	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	
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: Tier 1A – 10% coinsurance, Tier 1B – 10% coinsurance, Tier 2 – 10% coinsurance, Tier 3 – 10% coinsurance, Tier 4- 10% coinsurance, Tier 5- 10% coinsurance	Custom Select Drug List: Tier 1A – 10% coinsurance, Tier 1B – 10% coinsurance, Tier 2 – 10% coinsurance, Tier 3 – 10% coinsurance
	Drugs for the treatment of Sexual Dysfunction, Cough & Cold and prenatal vitamins – 10% Coinsurance	
	• 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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Pediatric dental

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.	$350 per member/ $700 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	