



**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, 2019

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 Specialty 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 |



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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, 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 |



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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 (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 |



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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 | 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 | <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: 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 | |
| | <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. | Covered-100% | Covered- 100% of the approved amount |
| 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 | | |



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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 | |



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U-M INTERNATIONAL STUDENT AND SCHOLAR HEALTH PLAN

00287637

Effective Date: 09/01/2019

Dental Coverage

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.

Network access information

With Blue Dental PPO, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.¹

Blue Dental PPO network- Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 438,000 dentist locations² nationwide. PPO dentists agree to accept our approved amount as full payment for covered services - 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**.

¹Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.

²A 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 would be two dentist locations.

Blue Par SelectSM arrangement- Most non-PPO 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 - members pay only applicable coinsurance and deductibles. 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 | <ul style="list-style-type: none"> 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) | None (covered at 100%) | 100% |
| • Class I services | | |
| • Class II services | 90% | 90% |
| • Class III services | 90% | 90% |

Class I services

| Benefits | In-network | Out-of-network |
|-------------------------------------|-------------------------|-------------------------|
| Oral exams | 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 |