Blue Cross Blue Shield of Michigan

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

U-M Health
Bronze Plan
Simply Blue℠ HSA PPO ASC
Effective Date: On or after January 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.

Provider Networks
Your health care benefits include three provider networks or tiers

- **Tier 1: U-M Health Regional Plans**
  Members will experience the **least** out-of-pocket cost when facility and professional services are provided at U-M Health Regional. This network is also referred to as **Tier 1** throughout the coverage specifications.
- **Tier 2: BCBSM PPO In-network Facility and Professional Providers**
  When services are performed by a provider who is part of BCBSM's PPO in-network, members will experience **greater** out-of-pocket costs.This tier is referred to as **Tier 2** throughout the coverage specifications.
- **Tier 3: Out-of-network Facility and Professional Providers**
  Members are subject to the **greatest** out-of-pocket expenses when treatment is sought and received from non-panel providers without an authorized referral or in absence of an emergency. This tier is referred to as **Tier 3** throughout the coverage specifications.

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

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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.

Eligibility Information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26
No-fault automobile accidents, option 3	Clarifies how payment for medical services will be coordinated between BCBSM and a member's motor vehicle insurance carrier when a member is involved in a motor vehicle accident. In all instances: • BCBSM will be the **secondary** plan when paying benefits for injuries that are a direct or indirect result of a motor vehicle accident, regardless of the provisions contained in a member's no-fault motor vehicle insurance policy, and • BCBSM will not duplicate benefits available under a member's no-fault motor vehicle insurance policy. **Note:** The BCBSM payment, when combined with any payment a member receives under their no-fault motor vehicle insurance policy, will not be more than 100 percent of the BCBSM approved amount for covered services.

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	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
Deductibles **Note:** Your deductible combines deductible amounts paid under your Simply Blue HSA medical coverage **and** a pharmacy benefit manager for prescription drug coverage. **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 one member, $3,400 per family (when two or more members are covered under your contract) each calendar year **Note:** Deductible may be waived for covered services performed in a Tier 1 physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.	$3,000 for a one-person contract $6,000 for a family contract (two or more members) each calendar year **Note:** Deductible may be waived for covered services performed in a Tier 2 physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office	Not applicable
	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	• $250 copay for ambulance services	• $250 copay for ambulance services
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	None	• 30% of approved amount for most covered services	Not covered

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Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
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.	$3,000 for a one-person contract $6,000 for a family contract (two or more members) each calendar year	$5,000 for a one-person contract $10,000 for a family contract (two or more members) each calendar year	$8,300 for a one-person contract $16,600 for a family contract (two or more members) each calendar year
Lifetime dollar maximum	$10,000 for all covered infertility services except approved laboratory services.		

Preventive care services

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance) **Note:** Additional well-women visits may be allowed based on medical necessity.	100% (no deductible or copay/coinsurance) **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
	One per member per calendar year		
Gynecological exam	100% (no deductible or copay/coinsurance) **Note:** Additional well-women visits may be allowed based on medical necessity.	100% (no deductible or copay/coinsurance) **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
	Two per member per calendar year		
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
	One per member per calendar year		
Voluntary sterilization of female reproductive organs	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
Contraceptive injections	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
Well-baby and Well-child visits	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
	• 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		

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
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)	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
	One per member per calendar year		
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
	One per member per calendar year		
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
	One per member per calendar year		
Routine mammogram and related reading	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	Not covered
	One per member per calendar year		
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy	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.	Not covered
	One routine colonoscopy per member per calendar year		

Physician office services

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
Office visits - must be medically necessary	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered

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Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
Online visits - by physician must be medically necessary **Note:** Online visits by a 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.	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Outpatient and home medical care visits - must be medically necessary	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Office consultations - must be medically necessary	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Urgent care visits - must be medically necessary	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered

Emergency medical care

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
Hospital emergency room	100% after Tier 1 deductible	70% after Tier 2 deductible	70% after Tier 2 deductible
Ambulance services - must be medically necessary	100% after Tier 1 deductible	$250 copay after Tier 2 deductible	$250 copay after Tier 2 deductible

Diagnostic services

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
Laboratory and pathology services	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Diagnostic tests and x-rays	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Therapeutic radiology	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered

Maternity services provided by a physician or certified nurse midwife

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
Prenatal care visits	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
Postnatal care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
Delivery and nursery care **Note:** For facility services See "Hospital Care"	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered

Hospital care

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
	Unlimited days		
Inpatient consultations	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Chemotherapy	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered

Alternatives to hospital care

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
Skilled nursing care - must be in a **participating** skilled nursing facility	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
	Limited to a maximum of 90 days per member per calendar year		
Hospice care	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
	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)		
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
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	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered

Surgical services

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Presurgical consultations	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Voluntary sterilization of male reproductive organs **Note:** For voluntary sterilization of female reproductive organs, see **"Preventive care services."**	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Elective Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered

Human organ transplants

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Kidney, cornea and skin transplants	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
Inpatient mental health care and **inpatient** substance use disorder treatment **Note:** Facility services are covered in participating facilities only.	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
	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	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Outpatient mental health care: • Facility and clinic **Note:** Facility services are covered in participating facilities only.	100% after Tier 1 deductible	100% after Tier 2 deductible	Not covered
• Online visits **Note:** Online visits by a vendor are not covered.	100% after Tier 1 deductible	100% after Tier 2 deductible	Not covered
• Physician's office	100% after Tier 1 deductible	100% after Tier 2 deductible	Not covered
Outpatient substance use disorder treatment - in approved facilities **only**	100% after Tier 1 deductible	100% after Tier 2 deductible	Not covered

Autism spectrum disorders, diagnoses and treatment

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
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).	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered

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Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
	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	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered

Other covered services

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
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.	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Allergy testing and therapy	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
	Limited to a **combined** 24-visits maximum per member per calendar year		
Outpatient physical, speech and occupational therapy - provided for rehabilitation	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
	Limited to a **combined** 30-visit maximum per member per calendar year		
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.	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Prosthetic and orthotic appliances	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Private duty nursing care	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Approved infertility services - including medical evaluation, diagnostic services and assisted reproductive technology treatment to manage infertility.	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
Acupuncture treatment **Note:** Limited to 24 visits per member, per calendar year.	100% after Tier 1 deductible	70% after Tier 2 deductible	Not covered
Prescription drugs	Not covered	Not covered	Not covered

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U-M Health
Bronze Plan
Hearing Care Coverage
Effective Date: On or after January 2026
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Member's responsibility (deductible and copay/coinsurance)

Note: Limited to a benefit maximum of $5,000 for monaural hearing aids and binaural hearing aids every 36 months per member for participating providers

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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