Blue Cross Blue Shield of Michigan

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

U-M Health
Gold Plan
Community Blue℠ 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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Eligibility Information

Members	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)

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - U-M Health Regional Plans	Tier 2 - BCBSM PPO In-Network Providers	
Deductible	None	$500 for one member, $1,000 for the 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 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
Flat-dollar copays	• $10 copay for office visits and office consultations with a **primary care physician** • $15 copay for office visits and office consultations with a **specialist** • $10 copay for medical online visits • $15 copay for chiropractic and osteopathic manipulative therapy • $25 copay for urgent care visits • $150 copay for ambulance services • $15 copay for acupuncture • $100 copay for emergency room visits	• $30 copay for office visits and office consultations with a **primary care provider** • $50 copay for office visits and office consultations with a **specialist** • $30 copay for medical online visits • $50 copay for urgent care visits • $150 copay for ambulance services • $150 copay for emergency room visits	• $150 copay for ambulance services • $150 copay for emergency room visits

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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	
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 10% of approved amount for private duty nursing care • 10% of approved amount for mental health care and substance use disorder treatment • 10% of approved amount for select covered services (coinsurance waived for covered services performed in an Tier 1 physician's office)	• 30% of approved amount for private duty nursing care • 20% of approved amount for mental health care and substance use disorder treatment • 20% of approved amount for select covered services (coinsurance waived for covered services performed in an Tier 2 physician's office)	Not covered
Annual out-of-pocket maximums - applies to deductibles, flat-dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year	$3,000 for one member, $6,000 for the family (when two or more members are covered under your contract) each calendar year	Not applicable
Lifetime dollar maximum	$10,000 for all covered infertility services per contract 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

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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	
	• 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		
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 coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.	100% (no deductible or 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 **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.	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 per member per calendar year		

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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 **Note:** This includes mental health and substance use disorder services equivalent to medical office visits.	• $10 copay for each office visit with a **primary care physician** • $15 copay for each office visit with a **specialist**	• $30 copay per office visit with a **primary care provider** • $50 copay per office visit with **specialist**	Not covered
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.	$10 copay per online visit	$30 copay per online visit	Not covered
Outpatient and home medical care visits - must be medically necessary	90% (no deductible)	80% after Tier 2 deductible	Not covered
Office consultations - must be medically necessary	• $10 copay for each office consultation with a **primary care physician** • $15 copay for each office consultation with a **specialist**	• $30 copay per office consultation with a **primary care provider** • $50 copay per office consultation with a **specialist**	Not covered
Urgent care visits - must be medically necessary	$25 copay per urgent care visit	$50 copay per urgent care visit	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 copay per visit (copay waived if admitted or for an accidental injury)	$150 copay per visit (copay waived if admitted or for an accidental injury)	$150 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	$150 copay per trip	$150 copay per trip	$150 copay per trip

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	90% (no deductible)	80% after Tier 2 deductible	Not covered
Diagnostic tests and x-rays	90% (no deductible)	80% after Tier 2 deductible	Not covered
Therapeutic radiology	90% (no deductible)	80% after Tier 2 deductible	Not covered

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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 visit	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
Delivery and nursery care **Note:** For facility services See "Hospital Care"	90% (no deductible)	80% 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.	90% (no deductible)	80% after Tier 2 deductible	Not covered
	Unlimited days		
Inpatient consultations	90% (no deductible)	80% after Tier 2 deductible	Not covered
Chemotherapy	90% (no deductible)	80% 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	90% (no deductible)	80% after Tier 2 deductible	Not covered
	Limited to a maximum of 120 days per member per calendar year		
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	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	90% (no deductible)	80% 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	
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	90% (no deductible)	80% 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	90% (no deductible)	80% after Tier 2 deductible	Not covered
Presurgical consultations	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
Voluntary sterilization of male reproductive organs **Note:** For voluntary sterilization of female reproductive organs, see **"Preventive care services."**	90% (no deductible)	80% after Tier 2 deductible	Not covered
Elective Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	90% (no deductible)	80% 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% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	90% (no deductible)	80% after Tier 2 deductible	Not covered

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Benefits	PPO Network		Tier 3 - Out-of-Network
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Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	90% (no deductible)	80% after Tier 2 deductible	Not covered
Kidney, cornea and skin transplants	90% (no deductible)	80% after Tier 2 deductible	Not covered

Behavioral Health Services (Mental Health and Substance Use Disorder)

Note: Some mental health and substance use disorder services are considered by BCBSM to be equivalent to an office visit or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be equivalent to an office visit or medical online visit, we will process the claim under your 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	
Inpatient mental health care and **inpatient** substance use disorder treatment **Note:** Facility services are covered in participating facilities only.	90% (no deductible) Unlimited days	80% after Tier 2 deductible	Not covered
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	90% (no deductible)	80% after Tier 2 deductible	Not covered
Outpatient mental health care: • Facility and clinic **Note:** Facility services are covered in participating facilities only.	$10 copay per visit	$15 copay per visit	Not covered
• Online visits - for services equivalent to a medical online visit **Note:** Online visits by a vendor are not covered.	$10 copay per online visit	$15 copay per online visit	Not covered
• Physician's office **Note:** For services equivalent to a medical office visit. See "**Physician Office Services**".	$10 copay per visit	$15 copay per visit	Not covered
Outpatient substance use disorder treatment - in approved facilities **only**	$10 copay per visit	$15 copay per visit	Not covered

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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).	$10 copay per office visit	$15 copay per office visit	Not covered
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder	90% (no deductible)	80% after Tier 2 deductible	Not covered
	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	90% (no deductible)	80% 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.	• 90% after (no deductible) for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	• 80% after Tier 2 deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	Not covered
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
Chiropractic spinal manipulation and osteopathic manipulative therapy	$15 copay	80% after Tier 2 deductible	Not covered
	Limited to a **combined** 24-visit maximum per member per calendar year		
Outpatient physical, speech and occupational therapy - provided for rehabilitation	90% (no deductible)	80% after Tier 2 deductible	Not covered
	Limited to a **combined** 60-visit maximum per member per calendar year		

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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	
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.	90% (no deductible)	80% after Tier 2 deductible	Not covered
Prosthetic and orthotic appliances	90% (no deductible)	80% after Tier 2 deductible	Not covered
Private duty nursing care	90% (no deductible)	70% after Tier 2 deductible	Not covered
Approved infertility services - including medical evaluation, diagnostic services and assisted reproductive technology treatment to manage infertility.	90% (no deductible)	80% after Tier 2 deductible	Not covered
Acupuncture treatment - limit to 24 visits per member, per calendar year.	$15 copay	80% after Tier 2 deductible	Not covered
Prescription drugs	Not covered	Not covered	Not covered

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U-M Health
Gold Plan
Hearing Care Coverage
Effective Date: On or after January 2026
Benefits-at-a-glance

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Member's responsibility (deductible and copay)

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	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.

ADM HCR-RXOC;ASCMOD 11436MED;AT ASC;CB ASC;CB-AMB ASC;CB-ET $150 ASC;CB-MTC $30 ASC;CB-OPMIN 3K ASC;CB-OPMON 6K ASC;CB-SP-OV $50ASC;CB-UC- $50 ASC;CBC 20%-IN ASC;CBD $1K-ON ASC;CBD $500-IN ASC;CBPCP-OV$30 ASC;DC 26-ME ASC;EHB-VCO-ES ASC;HC (A) ASC;INFS ASC;NFAX-3 ASC