



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

U-M HEALTH

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Effective Date: 01/01/2026

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

- **First provider network:** Edward W. Sparrow Hospital, Sparrow Clinton Memorial Hospital, Sparrow Carson City Hospital, Sparrow Ionia County Memorial Hospital and Sparrow Eaton Hospital. Members will experience the least out-of-pocket costs when facility services are provided at one of these providers. Please refer to the ASC PLAN MODIFICATION (ASC MOD) document under the Certificates and Riders section of the BCBSM portal.
- **Second provider network:** 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.
- **Third provider network:** Out-of-network Facility and Professional Providers. Members are subject to the greatest out-of-pocket expenses when treatment is received from out-of-network providers without an authorized referral or in absence of an emergency situation.

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

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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 coverage through the last day of the month the dependent turns age 26
No-fault automobile accidents, option 3	<p>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.</p> <p>In all instances:</p> <ul style="list-style-type: none"> 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. <p>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.</p>

Member's responsibility (deductibles, copays and dollar maximums)

Note: 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.

Benefits	In-network	Out-of-network
Deductibles	\$500 for one member, \$1,000 for a family (when two or more members are covered under your contract) each calendar year	
Flat-dollar copays	<ul style="list-style-type: none"> \$15 copay for select office visits \$15 copay for medical online visits 	<ul style="list-style-type: none"> \$15 copay for select office visits
Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.	<ul style="list-style-type: none"> 30% of approved amount for private duty nursing 20% of approved amount for most other covered services 	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing 20% of approved amount for most other covered services <p>Note: You are responsible for an additional 20% of approved amount for covered services when you go to an out-of-network provider. (This amount is in addition to applicable CMM deductible, copay and coinsurance amounts.)</p>
Annual out-of-pocket maximums -applies to coinsurance amounts for all covered services - including mental health and substance use disorder services - but does not apply to flat-dollar copays and private duty nursing coinsurance amounts, if applicable	\$1,500 for one member, \$3,000 for a family (when two or more members are covered under your contract) each calendar year	

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Benefits	In-network	Out-of-network
		Note: The additional 20% out-of-network coinsurance for covered services from an out-of-network provider is limited to \$1,000 for all covered family members each calendar year. (This amount does not count toward the annual out-of-pocket maximum.)
Lifetime dollar maximum	None	

Preventive care services		
Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity.	100% (no deductible or copay/coinsurance) plus an additional 20% out-of-network coinsurance
Gynecological exam	100% (no deductible or copay/coinsurance), two per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity.	100% (no deductible or copay/coinsurance) plus an additional 20% out-of-network coinsurance
Pap smear screening-laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	100% (no deductible or copay/coinsurance) plus an additional 20% out-of-network coinsurance
Voluntary sterilization of female reproductive organs	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) plus an additional 20% out-of-network coinsurance
Prescription contraceptive devices-includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after deductible plus an additional 20% out-of-network coinsurance
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after deductible plus an additional 20% out-of-network coinsurance
Well-baby and Well-child visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> • 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 	100% (no deductible or copay/coinsurance) plus an additional 20% out-of-network coinsurance
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) plus an additional 20% out-of-network coinsurance

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Benefits	In-network	Out-of-network
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	100% (no deductible or copay/coinsurance) plus an additional 20% out-of-network coinsurance
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	100% (no deductible or copay/coinsurance) plus an additional 20% out-of-network coinsurance
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	100% (no deductible or copay/coinsurance) plus an additional 20% out-of-network coinsurance
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance. One per member per calendar year	80% after deductible plus an additional 20% out-of-network coinsurance
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. One per member per calendar year	80% after deductible plus an additional 20% out-of-network coinsurance

Physician office services		
Benefits	In-network	Out-of-network
Office visits	\$15 copay per office visit	\$15 copay per office visit plus an additional 20% out-of-network coinsurance
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.	\$15 copay per visit	Not covered
Outpatient and home medical care visits	\$15 copay per visit	\$15 copay per office visit plus an additional 20% out-of-network coinsurance
Office consultations	\$15 copay per office consultation	\$15 copay per office visit plus an additional 20% out-of-network coinsurance

Emergency medical care		
Benefits	In-network	Out-of-network
Hospital emergency room	80% after deductible	80% after deductible
Ambulance services-must be medically necessary	80% after deductible	80% after deductible

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Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance
Diagnostic tests and x-rays	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance
Therapeutic radiology	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after deductible plus an additional 20% out-of-network coinsurance
Postnatal care	100% (no deductible or copay/coinsurance)	80% after deductible plus an additional 20% out-of-network coinsurance
Delivery and nursery care	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance
Note: For facility services See "Hospital Care"		

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance
Unlimited days		
Note: Nonemergency services must be rendered in a participating hospital.		
Inpatient consultations	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance
Chemotherapy	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care-must be in a participating skilled nursing facility	Not covered	Not covered

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Benefits	In-network	Out-of-network
Hospice care	100% (no deductible or copay/coinsurance) 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)	100% (no deductible or copay/coinsurance)
Home health care: <ul style="list-style-type: none"> must be medically necessary must be provided by a participating home health care agency 	80% after deductible	80% after deductible
Infusion therapy: <ul style="list-style-type: none"> 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 	80% after deductible	80% after deductible

Surgical services		
Benefits	In-network	Out-of-network
Surgery-includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance
Presurgical consultations	100% (no deductible or copay/coinsurance)	80% after deductible plus an additional 20% out-of-network coinsurance
Voluntary sterilization of male reproductive organs	Not covered	Not covered
Note: For voluntary sterilization of female reproductive organs, see "Preventive care services."		
Elective Abortion Services Note: Abortions are not covered if rendered in a location where abortions are not legal.	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance

Human organ transplants		
Benefits	In-network	Out-of-network
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)-in designated facilities only
Bone marrow transplants-must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance
Specified oncology clinical trials Note: BCBSM covers clinical trials in compliance with PPACA.	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance
Kidney, cornea and skin transplants	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance

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Behavioral Health Services (Mental Health and Substance Use Disorder)

Note: Some mental health and substance use disorder services are considered by BCBSM to be comparable to an office visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit, we will pay \$15 copay when obtained from an in-network

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance use disorder treatment Note: Facility services are covered in participating facilities only.	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance Unlimited days
Residential psychiatric treatment facility: <ul style="list-style-type: none"> covered mental health services must be performed in a residential psychiatric treatment facility treatment requires prior authorization subject to medical criteria 	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance
Outpatient mental health care <ul style="list-style-type: none"> Facility and clinic Note: Facility services are covered in participating facilities only.	80% after deductible	80% after deductible, in participating facilities only
Online visits Note: Online visits by a vendor are not covered. <ul style="list-style-type: none"> Physician's office 	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance
Outpatient substance use disorder treatment-in approved facilities only	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance(in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
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).	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance Note: Services rendered by an approved licensed behavior analyst (LBA) will apply the in-network cost-sharing.
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance
Other covered services, including nutritional counseling and mental health services, for autism spectrum disorder	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance

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Other covered services

Benefits	In-network	Out-of-network
<p>Outpatient Diabetes Management Program (ODMP)</p> <p>Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no cost-sharing when rendered by a participating provider.</p> <p>Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.</p>	<ul style="list-style-type: none"> 80% after deductible for diabetes medical supplies 100% (no deductible or copay/coinsurance) for diabetes self-management training 	80% after deductible plus an additional 20% out-of-network coinsurance
Allergy testing and therapy	\$15 copay per visit	80% after deductible plus an additional 20% out-of-network coinsurance
Chiropractic spinal manipulation and osteopathic manipulative therapy	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance
	Limited to a combined 38-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy- provided for rehabilitation	80% after deductible	80% after deductible plus an additional 20% out-of-network coinsurance
		Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
Durable medical equipment	80% after deductible	80% after deductible
<p>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.</p>		
Prosthetic and orthotic appliances	80% after deductible	80% after deductible
Private duty nursing	70% after deductible	50% after deductible

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Preferred Rx Program ASC

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Specialty Pharmaceutical Drugs - The preferred pharmacy for specialty drugs is **Walgreens Specialty Pharmacy**. Specialty drugs are covered only when dispensed through the Walgreens Specialty Pharmacy or any in-network participating pharmacy.

A list of specialty drugs is available on our website at bcbsm.com/pharmacy. Click What are specialty drugs, then click Specialty Drug Program Rx Benefit Member Guide. The guide is updated monthly.

If you have additional questions, you can call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that Blue Cross defines as a "specialty pharmaceutical". We may make exceptions if a member requires more than a 30-day supply. Blue Cross reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay or coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

Benefits	In-network pharmacy	Out-of-network pharmacy
Copay	You pay 20% of the approved amount, but not less than \$5 or more than \$100	You pay 20% of the approved amount, but not less than \$5 or more than \$100 plus an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	Copay for up to a 90 day supply: <ul style="list-style-type: none"> You pay 20% of the approved amount, but not less than \$5 or more than \$100 	Not covered

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs.

Covered services

Benefits	In-network pharmacy	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved generic and select brand-name prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	75% of approved amount
Other FDA-approved brand-name prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

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Benefits	In-network pharmacy	Out-of-network pharmacy
Adult and childhood select preventive 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% of approved amount	75% of approved amount
FDA-approved generic and select brand-name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	75% of approved amount
Other FDA-approved brand-name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug
Note: Needles and syringes have no copay/coinsurance.		
Select diabetic supplies and devices (test strips, lancets and glucometers)	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy .		

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs.

Features of your prescription drug plan

Clinical Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.
Prescription drug preferred therapy	<p>A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications before prescribing a more expensive brand-name drug. It applies only to prescriptions being filled for the first time of a targeted medication.</p> <p>Before filling your initial prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at bcbsm.com/pharmacy, along with the preferred medications.</p> <p>If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect all targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.</p>
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Maximum allowable cost drugs	<p>When you receive a generic maximum allowable cost (MAC) drug from an in-network pharmacy, you pay your cost share as noted in your coverage.</p> <p>However, if you request a brand-name drug and the prescriber did not write "Dispense as Written" or "DAW" on the prescription, you must pay the difference between the maximum allowable cost and the Blue Cross Blue Shield of Michigan approved amount for the brand-name drug, plus your copayment.</p> <p>If the prescriber wrote "Dispense as Written" or "DAW" on the prescription, we will pay the pharmacy the approved amount for the brand-name drug, after deduction of your copayment.</p>

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