



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

NORTHERN MICHIGAN UNIVERSITY

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Community Blue PPOSM ASC

Effective Date: On or after January 2022

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.

Preauthorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by 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.

Preauthorization 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 preauthorization of the drugs. **If preauthorization 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.

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

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

Benefits	In-network	Out-of-network
Deductible	<p>\$500 for one member, \$1,000 for the family (when two or more members are covered under your contract) each calendar year (no 4th quarter carry-over)</p> <p>Note: Deductible may be waived for covered services performed in an in-network 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.</p>	<p>\$1,000 for one member, \$2,000 for the family (when two or more members are covered under your contract) each calendar year (no 4th quarter carry-over)</p> <p>Note: Out-of-network deductible amounts also count toward the in-network deductible.</p>
Flat-dollar copays	<ul style="list-style-type: none"> • \$20 copay for office visits and office consultations • \$10 copay for medical online visits • \$20 copay for chiropractic and osteopathic manipulative therapy • \$150 copay for emergency room visits • \$20 copay for urgent care visits 	<ul style="list-style-type: none"> • \$150 copay for emergency room visits
<p>Coinsurance amounts (percent copays)</p> <p>Note: Coinsurance amounts apply once the deductible has been met.</p>	<ul style="list-style-type: none"> • 50% 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 most other covered services (coinsurance waived for covered services performed in an in-network physician's office) 	<ul style="list-style-type: none"> • 50% of approved amount for private duty nursing care • 40% of approved amount for mental health care and substance use disorder treatment • 40% of approved amount for most other covered services
<p>Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but does not apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts</p>	<p>\$2,000 for one member, \$4,000 for the family (when two or more members are covered under your contract) each calendar year</p>	<p>\$4,000 for one member, \$8,000 for the family (when two or more members are covered under your contract) each calendar year</p> <p>Note: Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.</p>
<p>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</p>	<p>\$8,700 for one member, \$17,400 for the family (when two or more members are covered under your contract) each calendar year</p>	<p>\$17,400 for one member, \$34,800 for the family (when two or more members are covered under your contract) each calendar year</p> <p>Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.</p>
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.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and child care 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 	Not covered
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)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
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, if applicable.	60% after out-of-network deductible Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.

One per member per calendar year

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Benefits	In-network	Out-of-network
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, if applicable.	60% after out-of-network deductible

One per member per calendar year

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	\$20 copay per office visit	60% after out-of-network deductible
Online visits - by physician or BCBSM selected vendor must be medically necessary	\$10 copay per online visit	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	\$20 copay per office consultation	60% after out-of-network deductible
Urgent care visits - must be medically necessary	\$20 copay per urgent care visit	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	\$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	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

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)	60% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

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Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	80% after in-network deductible	60% after out-of-network deductible

Unlimited days

Note: Nonemergency services must be rendered in a **participating** hospital.

Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a participating skilled nursing facility	80% after in-network deductible	80% after in-network deductible

Limited to a maximum of 120 days per member per calendar year

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)
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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 in-network deductible	80% after in-network deductible
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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 preauthorization - consult with your doctor 	80% after in-network deductible	80% after in-network deductible
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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 in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males	80% after in-network deductible	60% after out-of-network deductible

Note: For voluntary sterilizations for females, see "**Preventive care services.**"

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 in-network deductible	60% after out-of-network deductible

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Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

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 or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit or medical online visit, we will process the claim under your office visit or medical online visit benefit.

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance use disorder treatment	80% after in-network deductible	60% after out-of-network deductible
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 must be preauthorized subject to medical criteria 	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> Facility and clinic 	80% after in-network deductible	80% after in-network deductible in participating facilities only
<ul style="list-style-type: none"> Online visits - by physician or BCBSM selected vendor must be medically necessary 	\$10 copay per online visit	60% after out-of-network deductible
<ul style="list-style-type: none"> Physician's office 	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities only	80% after in-network deductible	60% after out-of-network deductible (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 behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization	80% after in-network deductible	80% after in-network deductible
Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.		
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible
Other covered services, including mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible

Physical, speech and occupational therapy **with an autism diagnosis** is unlimited

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 in-network cost-sharing when rendered by an in-network 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 in-network deductible for diabetes medical supplies 100% (no deductible or copay/coinsurance) for diabetes self-management training 	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$20 copay per visit	60% after out-of-network deductible
Limited to a combined 24-visit maximum per member per calendar year		
Outpatient physical, speech and occupational therapy - provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible
<p>Note: Services at nonparticipating outpatient physical therapy facilities are not covered.</p> <p>Limited to a combined 60-visit maximum per member per calendar year</p>		
<p>Durable medical equipment</p> <p>Note: DME items 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. For a list of covered DME items required under PPACA, call BCBSM.</p>	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible



**Blue Cross
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Hearing Care Coverage

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Benefits-at-a-glance

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Member's responsibility (deductible and copay)

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.

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