



**READY  
TO HELP**



## Blue Care Network of Michigan — Member Guide

2026 - 2027

### University of Michigan International Student/Scholar Health Plan



[bcbsm.com/umichglobal](https://bcbsm.com/umichglobal)

# Quick reference

## IMPORTANT OR FREQUENTLY USED PHONE NUMBERS

Phone numbers, as well as mail and online options, are listed throughout the book as contact information.

### Customer Service: 1-800-287-4103, TTY: 711

(9 a.m. to 4:30 p.m. Monday through Friday)

Talk to a representative about your plan or benefits.

### Behavioral Health Services: 1-800-482-5982

Talk to a behavioral health manager in an emergency about issues that cause emotional or mental distress, including substance use disorder issues.

### Care while you travel:

### Participating providers outside of Michigan: 1-800-810-BLUE (2583)

Find a doctor from our nationwide network of Blue Plan providers when you're away from Michigan, but still within the U.S.

### Blue Cross Blue Shield Global Core Service Center : 1-800-810-2583 or collect at 1-804-673-1177

Your plan provides full medical coverage while traveling abroad through the Blue Cross Blue Shield Global® Core program.

### Blue Cross Blue Shield Global Solutions Health and Safety Team: Call collect at 1-610-290-0345

You also have Blue Cross Blue Shield Global Solutions, which provides worldwide travel assistance. When calling, please be prepared to provide the following:

- The ID number located on the front of your ID card
- Program name: **BCBSM International MERE Plan**
- Group access code: **GTB9999BCMI1**

## Register for your member account

It's easy and secure. Register one of these ways:



Go to [bcbsm.com/register](https://bcbsm.com/register).



Download our app at [bcbsm.com/app](https://bcbsm.com/app).



Text REGISTER to 222764.\*

## Your BCN plan information at your fingertips

- Access your virtual ID card from your mobile device
- See your coverage information, such as out-of-pocket and deductible balances, depending on your plan.
- Search for doctors, hospitals and pharmacies in your plan's network

\*Message and data rates may apply. Visit [bcbsm.com](https://bcbsm.com) for our *Terms and Conditions of Use* and *Privacy Practices*.

# Welcome

This is a brief description of the University of Michigan International Student/Scholar Health Plan. The plan is available for U-M F-1 and J-1 students and scholars and their eligible dependents. The plan is underwritten by Blue Care Network of Michigan. The exact provisions governing this health plan, including definitions, are contained in the *Certificate of Coverage* issued to the University of Michigan and may be viewed online at [bcbsm.com/umichglobal](https://bcbsm.com/umichglobal). If any discrepancy exists between this member guide and the *Certificate of Coverage*, the *Certificate of Coverage* will govern and control the payment of benefits.

## THE UNIVERSITY OF MICHIGAN INTERNATIONAL STUDENT/SCHOLAR HEALTH PLAN

The University of Michigan International Student/Scholar Health Plan has been developed for U-M F-1 and J-1 international students or scholars and their accompanying dependents. The plan provides coverage for illnesses and injuries that occur on and off campus (worldwide), and includes special cost-saving features to keep the coverage as affordable as possible.

### University of Michigan information:

- A listing of the regents of the University of Michigan can be found at: [regents.umich.edu](https://regents.umich.edu).
- A copy of the *Nondiscrimination Policy Notice* can be found at: [oie.umich.edu/nondiscrimination-policy-notice/](https://oie.umich.edu/nondiscrimination-policy-notice/).

U.S. Government requirements for J1/J2 visa policyholders are satisfied under the University of Michigan International Student/Scholar Health Plan.

**If you have a life-threatening emergency, call 911 or go directly to the nearest hospital emergency room.**

Care options for the immediate area of your campus include, but are not limited to, the following providers:

### **ANN ARBOR CAMPUS**

**University Health & Counseling** (students\*, scholars, spouses or same-sex domestic partners, children age 10 or older) 207 Fletcher Street, Ann Arbor, MI 48109  
**uhc.umich.edu**

For hours of operation, appointments or nurse advice, call **(734) 764-8320**. Nurse advice by phone is always available (24 hours/day, seven days a week).

\*Students enrolled in classes will usually save money by going to University Health & Counseling for nonemergency health care. See **uhc.umich.edu/costs-billing**.

**University Health & Counseling Eye Care Clinic:** Students, scholars and dependents who are at least 3 years old can receive eye care at the University Health & Counseling Eye Care Clinic (see **uhc.umich.edu/eyecare-clinic-optical-shop**). The UHC Eye Care Clinic will bill your international student/scholar health plan for services you receive that are covered by your plan. Students or dependents younger than age 19 will save money by choosing a pediatric vision provider. Visit **vsp.com** or call **1-800-877-7195**.

### **DEARBORN CAMPUS**

Henry Ford Medical Center-Fairlane  
19401 Hubbard Dr. Dearborn, MI 48126  
**(313) 982-8100**  
**henryford.com/locations/fairlane**

Corewell Health Dearborn Hospital  
18101 Oakwood Blvd. Dearborn, MI 48124  
**(313) 593-7000**  
**beaumont.org/locations/beaumont-hospital-dearborn**

### **FLINT CAMPUS**

For care options in the area, visit **bcbsm.com/umichglobal**. Then, scroll down and click on *Flint*.

To find a doctor that participates in the BCN network, visit **bcbsm.com/umichglobal**. Then, scroll down and click on your campus location. You'll be directed to a dashboard based on your location and plan where you can search for a provider by specialty or name. For more information, call the Customer Service number listed on the back of your BCN member ID card.



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# Enrollment

## Coverage periods

1. **Students and scholars:** Coverage for this policy year starts at 12:01 a.m. on September 1, 2026, or for new international students and scholars, on your I-20 or DS-2019 start date, whichever is later each policy year. Your coverage is effective through the end date of your I-20 or DS-2019 form, or for F-1 students on post-completion optional practical training, including the STEM extension of OPT, through the end of the OPT period.

**Note:** International students and scholars on the Dearborn and Flint campuses should refer to the information in this guide that specifically applies to their campuses.

2. **Insured dependents:** Coverage will start on the same date the insured student or scholar's coverage becomes effective. If the dependents arrive in the United States after the covered student, then the coverage start date can be adjusted to be the date of the dependents' arrival. Coverage for insured dependents terminates upon request in accordance with the termination provisions described in the *Certificate of Coverage*. Examples include, but are not limited to, the date the dependent no longer meets the definition of a dependent.

## Rates

Students and scholars will be billed once each month. Note: Dearborn and Flint students and scholars will be assessed each term for the current term (Fall 2026, Winter 2027 and/or Summer 2027) for coverage up to four months.

Note: Students and scholars enrolled in the plan for part or all of a calendar month will be billed for the entire calendar month, since the monthly premium cannot be prorated.

|                                        | Monthly rate |
|----------------------------------------|--------------|
| Student/scholar only                   | \$308.72     |
| Student/scholar +1 dependent           | \$611.94     |
| Student/scholar + 2 or more dependents | \$915.16     |

## Student/scholar coverage

Eligibility for this plan is limited to U-M F-1 international students or J-1 international students or scholars whose Forms I-20 or DS-2019 were issued by the University of Michigan. The accompanying dependents of these students and scholars are also eligible for this plan.

### University of Michigan – Ann Arbor insurance requirement

All U-M (Ann Arbor) F-1 international students whose Forms I-20 were issued by the University of Michigan (Ann Arbor) and their accompanying F-2 dependents are eligible for this plan and must remain enrolled in the plan throughout their stay as U-M F-1 students or F-2 dependents; unless, in the judgment of the University, comparable coverage is in effect under another insurance policy. The specific criteria used to determine comparability are posted on the International Center's website at **[internationalcenter.umich.edu/healthins/standards-waiver](https://internationalcenter.umich.edu/healthins/standards-waiver)**.

All U-M (Ann Arbor) J-1 international students and scholars whose Forms DS-2019 were issued by the University of Michigan (Ann Arbor) and their accompanying J-2 dependents are eligible for this plan and must remain enrolled in the plan throughout their stay as U-M J-1 students or scholars or J-2 dependents; unless, in the judgment of the University, comparable coverage is in effect under another insurance policy. The specific criteria used to determine comparability are posted on the International Center's website at **[internationalcenter.umich.edu/healthins/standards-waiver](https://internationalcenter.umich.edu/healthins/standards-waiver)**.

### University of Michigan – Dearborn insurance requirement

All U-M (Dearborn) F-1 international students whose Forms I-20 were issued by the University of Michigan (Dearborn) and their accompanying F-2 dependents are eligible for this plan and must remain enrolled in the plan throughout the duration of their program end date on their I-20; unless, in the judgment of the University, comparable coverage is in effect under another insurance policy. The specific criteria used to determine comparability are posted on the Office of International Affairs's website at **[umdearborn.edu/office-international-affairs/incoming-international-students-prepare-arrive/health-insurance](https://umdearborn.edu/office-international-affairs/incoming-international-students-prepare-arrive/health-insurance)**.

All U-M (Dearborn) J-1 international students and scholars whose Forms DS-2019 were issued by the University of Michigan (Dearborn) and their accompanying J-2 dependents are eligible for this plan and must remain enrolled in the plan throughout their stay as U-M J-1 students or scholars or J-2 dependents; unless, in the judgment of the University, comparable coverage is in effect under another insurance policy.

Information regarding enrollment, billing or waiver procedures is posted on the Office of International Affairs's website at **[umdearborn.edu/office-international-affairs/incoming-international-students-prepare-arrive/health-insurance](https://umdearborn.edu/office-international-affairs/incoming-international-students-prepare-arrive/health-insurance)**.



## University of Michigan – Flint insurance requirement

All U-M-Flint F-1 international students whose Forms I-20 were issued by the University of Michigan Flint and their accompanying F-2 dependents are eligible for this plan and must remain enrolled in the plan throughout their stay as U-M-Flint F-1 students or F-2 dependents; unless, in the judgment of the University, comparable coverage is in effect under another insurance policy.

All U-M-Flint J-1 international students and scholars whose Forms DS-2019 were issued by the University of Michigan-Flint and their accompanying J-2 dependents are eligible for this plan and must remain enrolled in the plan throughout their stay as U-M-Flint J-1 students or scholars or J-2 dependents; unless, in the judgment of the University, comparable coverage is in effect under another insurance policy.

Information regarding the enrollment, billing or waiver procedures is posted on the Center for Global Engagement website: [umflint.edu/cge/student-resources/health-insurance](http://umflint.edu/cge/student-resources/health-insurance).

## Enrollment

All new U-M F-1 international students or J-1 international students or scholars whose Forms I-20 or DS-2019 were issued by the University of Michigan and their accompanying F-2 and J-2 dependents will be enrolled in the University of Michigan International Student/Scholar Health Plan as soon as the student or scholar has completed the mandatory check-in process. Coverage will start on the student or scholar's Form I-20 or DS-2019 start date (Form I-20, program start date in the program of study box, or Form DS-2019, Item 3).

## Waivers

### University of Michigan – Ann Arbor Campus

If you're eligible for health insurance benefits administered by the U-M Benefits office because you are or will be a U-M employee or a U-M fellowship holder whose fellowship includes GradCare, please enroll yourself and any eligible dependents in that coverage as soon as possible. Be sure to review [hr.umich.edu/benefits-wellness/benefits-enrollment/benefits-enrollment-eligibility/new-employee-benefits-information](http://hr.umich.edu/benefits-wellness/benefits-enrollment/benefits-enrollment-eligibility/new-employee-benefits-information) for an explanation of enrollment procedures and deadlines.

Once you and any accompanying F-2 or J-2 **dependents** are enrolled in these benefits, your International Student/Scholar Health Plan coverage will be cancelled and any needed adjustments (credits) will be made to your insurance account. The cancellation date will depend on the effective date of your U-M benefits. No waiver request form is required; this is an automated process.

International students and J-1 exchange visitors who would like to substitute private insurance or insurance provided by a sponsor for the International Student/Scholar Insurance Plan should fill out and submit the *International Health Insurance Waiver Request Form*, available on the International Center website, to request approval of an insurance waiver and cancellation of International Student/Scholar Health Plan coverage.

More information about requesting a waiver and about the coverage an insurance plan must have in order for a waiver to be approved is available at [internationalcenter.umich.edu/healthins/standards-waiver](http://internationalcenter.umich.edu/healthins/standards-waiver).

### University of Michigan – Dearborn Campus

If you're eligible for health insurance benefits administered by the U-M Benefits office because you are or will be a U-M-Dearborn employee or a U-M fellowship holder whose fellowship includes GradCare, please enroll yourself and any eligible dependents in that coverage as soon as possible by following the procedures given to you by your hiring department. Once the Office of International Affairs is notified that you and any accompanying F-2 or J-2 dependents are enrolled in these benefits, your International Student/Scholar Health Plan coverage will be cancelled and any needed adjustments (credits) will be made to your student account. Since this is not an automatic process, you or your hiring department must inform the Office of International Affairs of your GradCare benefits; otherwise, you may be enrolled in both BCN and GradCare.

Students and scholars who would like to substitute private insurance or insurance provided by a sponsor must request an insurance waiver by filling out the waiver request form and attaching information about the insurance coverage they want to substitute for the BCN plan. Upon approving a waiver, the Office of International Affairs will update Student Accounts and any necessary adjustments (credits) will be made. More information about requesting a waiver and about the coverage an insurance plan must have in order for a waiver to be approved is available at [umdearborn.edu/office-international-affairs/incoming-international-students-prepare-arrive/health-insurance](https://umdearborn.edu/office-international-affairs/incoming-international-students-prepare-arrive/health-insurance).

### University of Michigan – Flint Campus

International students and scholars who would like to substitute private insurance or insurance provided by a sponsor for the International Student/Scholar Health Plan should fill out and submit the *International Health Insurance Waiver Request Form*. Waiver forms can be obtained by logging in to the International Student/Scholar portal, iService ([sunapsis.umflint.edu](https://sunapsis.umflint.edu)). Upon approving the waiver, the **Center for Global Engagement** ([umflint.edu/cge/](https://umflint.edu/cge/)) will update student accounts and make any necessary adjustments.

More information about requesting a waiver and about the coverage an insurance plan must have in order for a waiver to be approved is available at [umflint.edu/cge/student-resources/health-insurance](https://umflint.edu/cge/student-resources/health-insurance).



## Coverage end date

### University of Michigan – Ann Arbor Campus

Your coverage under the International Student/Scholar Health Plan will extend through the end date of your I-20 or DS-2019, or through the end of your F-1 post-completion optional practical training, including the STEM extension of OPT, for students who are recommended for post-completion OPT. If those end dates change, the end date of your health insurance coverage will also change.

### University of Michigan – Flint Campus

Your coverage under the International Student/Scholar Health Plan will extend through the end date of your I-20 or DS-2019. If those end dates change, the end date of your health insurance coverage will also change.

Flint F1 students on post-completion and STEM extension optional practical training are not eligible for the BCN U-M International Student/Scholar Health Plan.

Alternative health insurance options for post-OPT/STEM OPT students:

- Enroll in the BCN Continuation Plan, if you're eligible for it (**see page 8**).
- Enroll in your employer's health insurance plan, if that's available to you.
- Enroll in a spouse's health insurance or in a private health insurance plan, if either is available to you.

### University of Michigan – Dearborn Campus

Your coverage under the International Student/Scholar Health Plan will extend through the program end date of your I-20 or DS-2019. If those end dates change, the end date of your health insurance coverage will also change.

Please note, Dearborn F1 students on post-completion and STEM extension optional practical training are not eligible for BCN's U-M International Student/Scholar Health Plan.

Alternative health insurance options for post-OPT/STEM OPT students are:

- Enroll in the BCN continuation plan, if you're eligible for it (**see page 8**).
- Enroll in employer's health insurance plan, if that's available to you.
- Enroll in spouse's health insurance or a private health insurance plan, if either is available to you.

## Automatic reenrollment in the International Student/Scholar Health Plan

### University of Michigan – Ann Arbor Campus

If your alternative coverage ends before the end of your stay as an F-1 or J-1 student or scholar, you will be reenrolled in the International Student/Scholar Health Plan. Also, if a waiver request form has been approved for private insurance or insurance provided by a sponsor and the time period for which the waiver has been approved has ended and the waiver is not renewed or reapproved, you'll be reenrolled in the International Student/Scholar Health Plan. If you leave the university permanently before the end date of your I-20 or DS-2019, or leave the United States because you have decided not to complete your post-completion optional practical training, login into the *M-Passport* portal:

- Choose *Requests > Departure Form (students)* or *Requests > Notice of Early Departure (scholars)*.
- Follow the instructions to submit the form.

**If your alternative coverage or your insurance waiver ends before your I-20, DS-2019 or (for F-1 students on optional practical training) your OPT end date and you don't submit a departure form, or a notice of early departure, the International Center will not know that you've ended your F-1 or J-1 stay, and you may be billed for health insurance**, either because your enrollment in the International Student/Scholar Health Plan will be continued or because you will be automatically reenrolled in the International Student/Scholar Health Plan.

If your immigration status has changed and you're no longer in F-1 or J-1 immigration status, it's your responsibility to notify the University by following the procedure explained at [internationalcenter.umich.edu/iss/change-status](http://internationalcenter.umich.edu/iss/change-status).

You may have the option of continuing your University of Michigan International Student/Scholar Health Plan for a short period of time after your change of status. Contact the U-M International Center's Health Insurance office [internationalcenter.umich.edu/healthins](http://internationalcenter.umich.edu/healthins) for more information.

### University of Michigan – Dearborn Campus

You'll be reenrolled in the International Student/Scholar Health Plan if you have not yet completed your stay as an F-1 student or J-1 student or scholar and your alternative coverage ends before the end of your stay as an F-1 or J-1 student or scholar. You'll also be reenrolled if a waiver request form has been approved for private insurance or insurance provided by a sponsor and the time period for which the waiver has been approved has ended and the waiver is not renewed or reapproved. If you leave the university permanently before the end date of your I-20 or DS-2019, notify the Office of International Affairs. The office can be reached by phone at **(313) 583-6600** or by email at [umdoia-international@umich.edu](mailto:umdoia-international@umich.edu).

**If you do not notify the Office of International Affairs, they will not know that you have ended your F-1 or J-1 stay, and you may be billed for health insurance**, either because your enrollment in the International Student/Scholar Health Plan will be continued or because you will be automatically reenrolled in the International Student/Scholar Health Plan.

If your immigration status has changed and you're no longer in F-1 or J-1 immigration status, it's your responsibility to notify the university by contacting the Office of International Affairs. The office can be reached by phone at **(313) 583-6600** or by email at **umdoia-international@umich.edu**. You may have the option of continuing your University of Michigan International Student Scholar Health Plan for a short period of time after your change of status. Contact the Office of International Affairs **umdearborn.edu/students/current-international-students/health-insurance** for more information.

### **University of Michigan – Flint Campus**

If you have not yet completed your stay as an F-1 student or J-1 student or scholar and your alternative coverage ends before the end of your stay as an F-1 or J-1 student or scholar, you will be reenrolled in the International Student/Scholar Health Plan. You'll also be automatically reenrolled if a waiver request form has been approved for private insurance or insurance provided by a sponsor and the time period for which the waiver has been approved has ended and the waiver is not renewed or reapproved. If you leave the university permanently before the end date of your I-20 or DS-2019 or leave the United States because you have decided not to complete your post-completion optional practical training, submit the departure form on iService (**sunapsis.umflint.edu**). Follow the instructions on the form that describe when and how to fill out the form.

**If your alternative coverage or your insurance waiver ends before your I-20, DS-2019 or (for F-1 students on optional practical training) your OPT end date and you don't submit a departure form, the Center for Global Engagement won't know that you have ended your F-1 or J-1 stay, and you may be billed for health insurance**, either because your enrollment in the International Student/Scholar Health Plan will be continued or because you'll be automatically reenrolled in the International Student/Scholar Health Plan.

If your immigration status has changed and you're no longer in F-1 or J-1 immigration status, it's your responsibility to notify the University by contacting the **Center for Global Engagement** (**umflint.edu/cge/**).



## Continuation of coverage

Once an international student's or international visiting scholar's status as a U-M F-1 or J-1 visa holder ends, the international student or visiting scholar may be eligible to continue coverage in this plan for a period not to exceed a maximum of three months. The maximum length of the continuation shall be determined by the date your coverage ends under the F-1 or J-1 status with the University (as reported to BCN), and must be purchased in one-, two-, or three-month intervals. The continuation plan may only be purchased once in a policy year (September 1 through August 31) and cannot go beyond the end of a policy year (August 31). To be eligible for continuation, you must have been enrolled under the University of Michigan International Student/Scholar Health Plan prior to the start of the continuation. International students or visiting scholars may also cover eligible dependents under this provision. Coverage for dependents shall be for the same period as the student, and the dependents must have been covered under the plan prior to the continuation start date. Enrollment in the continuation of coverage must be completed by the end of the month in which your eligibility under this provision begins.

Please see the chart below for examples of how this provision may affect you.

| F-1/J-1 Coverage end date | Continuation options | Maximum continuation coverage end date | Deadline to enroll |
|---------------------------|----------------------|----------------------------------------|--------------------|
| 9/30/2026                 | 1, 2 or 3 months     | 12/31/2026                             | 10/31/2026         |
| 10/31/2026                | 1, 2 or 3 months     | 1/31/2027                              | 11/30/2026         |
| 11/30/2026                | 1, 2 or 3 months     | 2/28/2027                              | 12/31/2026         |
| 12/31/2026                | 1, 2 or 3 months     | 3/31/2027                              | 1/31/2027          |
| 1/31/2027                 | 1, 2 or 3 months     | 4/30/2027                              | 2/28/2027          |
| 2/28/2027                 | 1, 2 or 3 months     | 5/31/2027                              | 3/31/2027          |
| 3/31/2027                 | 1, 2 or 3 months     | 6/30/2027                              | 4/30/2027          |
| 4/30/2027                 | 1, 2 or 3 months     | 7/31/2027                              | 5/31/2027          |
| 5/31/2027                 | 1, 2 or 3 months     | 8/31/2027                              | 6/30/2027          |
| 6/30/2027                 | 1 or 2 months        | 8/31/2027                              | 7/31/2027          |
| 7/31/2027                 | 1 month              | 8/31/2027                              | 8/31/2027          |

Note: Coverage under the continuation provision cannot be carried over from one policy year to the next. Coverage under this provision ends on the date this plan ends.

For more information or to enroll into the BCN continuation plan, visit [jcbins.com](https://jcbins.com); then, search for *University of Michigan*, and select *Continuation Plan*.

## Refund policy

A **covered person** entering the armed forces of any country will not be covered under the policy as of the date of such entry. In this case, a pro-rata refund of premium will be made for any such person and any **covered dependents** upon written request received by BCN within **90 days** of withdrawal from school.

**Leaving U-M or not enrolling in classes does not automatically cancel your participation in the International Student/Scholar Health Plan.**

### University of Michigan – Ann Arbor Campus

U-M F-1 or J-1 students or scholars who leave the university permanently earlier than they anticipated, should complete the appropriate departure form so that the International Center can make appropriate adjustments to their SEVIS (Student and Exchange Visitor Information System) records. Once this form is processed, the end date of your insurance coverage will also be adjusted if necessary. To submit a departure form, login to the M-Passport portal:

- Choose *Requests > Departure Form (students)* or *Requests > Notice of Early Departure (scholars)*.
- Then follow the instructions to submit the form.

There are some situations in which you may need to submit a *Change Form* instead of or in addition to a departure form in order to change the end date of your insurance coverage. All *Change Forms* must be approved by the Health Insurance Advisor. For more information, contact the Health Insurance Advisor at [ihi@umich.edu](mailto:ihi@umich.edu).

### University of Michigan – Dearborn Campus

U-M-Dearborn F-1 or J-1 students or scholars who leave the university permanently earlier than they anticipated, must notify the Office of International Affairs by phone at **(313) 583-6600**, or by email at [umdoia-international@umich.edu](mailto:umdoia-international@umich.edu), so the appropriate adjustments to their SEVIS (Student and Exchange Visitor Information System) record can be made. Once the Office of International Affairs updates your SEVIS record, the end date of your insurance coverage will be adjusted if necessary. All coverage cancellation requests or requests to change the end date of your insurance coverage must be approved by the Health Insurance Coordinator. For more information, contact the Health Insurance Coordinator at **(313) 583-6600**, or at [umdoia-international@umich.edu](mailto:umdoia-international@umich.edu).

### University of Michigan – Flint Campus

U-M F-1 or J-1 students or scholars who leave the university permanently earlier than they anticipated, should complete the appropriate departure form and health insurance cancellation form so the Center for Global Engagement can make appropriate adjustments to their SEVIS (Student and Exchange Visitor Information System) records. Once these forms are processed, the end date of your insurance coverage will also be adjusted if necessary. Departure and health insurance cancellation forms are available at [sunapsis.umflint.edu](http://sunapsis.umflint.edu). Follow the instructions on the form. For more information, contact the **Center for Global Engagement** ([umflint.edu/cge/](http://umflint.edu/cge/)).

## Dependent coverage

### Eligibility

**Covered students** may also enroll their lawful spouse or same-sex domestic partner and **dependent** children to **age 26**. **Dependent** eligibility expires concurrently with that of the insured student.

### Enrollment

Accompanying F-2 and J-2 **dependents** of F-1/J-1 international students and visiting scholars will be enrolled in the International Student/Scholar Plan as soon as the student or scholar has completed the mandatory check-in process. Coverage will start on the student's or scholar's Form I-20 or DS-2019 start date (Form I-20, the program start date in the program of study box, or Form DS-2019, Item 3).

If the dependent(s) arrive in the United States after the covered student, their coverage effective date can then be adjusted, upon request, to be the date of the dependents' arrival.

For information or if you have general questions on **dependent** enrollment, please contact:

#### Ann Arbor Campus

University of Michigan International Center  
(734) 647-2303 or [ihl@umich.edu](mailto:ihl@umich.edu)

#### Dearborn Campus

Office of International Affairs  
(313) 583-6600 or [umdoia-international@umich.edu](mailto:umdoia-international@umich.edu)

#### Flint Campus

Center for Global Engagement (CGE)  
(810) 762-0867  
[global.flint@umich.edu](mailto:global.flint@umich.edu)

## Medicare eligibility notice

You're not eligible for health coverage under this student policy if you have Medicare at the time of enrollment in this student plan.

If you obtain Medicare after you enrolled in this student plan, your health coverage under this plan will not end.

As used here, "have Medicare" means that you are entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.



# Your primary care provider

## YOUR CONNECTION TO CARE

### Primary care

When you enroll with Blue Care Network and are a student or scholar on the Ann Arbor campus, we'll assign you a University Health & Counseling primary care provider who's based on the Ann Arbor campus. If you're a student on the Dearborn and Flint campuses, you'll be assigned a Blue Care Network contracted provider in your area. This is your primary care provider, or PCP.

You're not required to get a referral from your PCP prior to receiving health care, but **may be** required to get authorization from your PCP for **select services**. To see a list of services that require authorization, visit [bcbsm.com/importantinfo](https://bcbsm.com/importantinfo) and click *Services that need prior authorization*. You can change your PCP at any time by logging in to your account at [bcbsm.com](https://bcbsm.com).

# What you pay

## KEY TERMS

### Balance billing

Occurs when a provider bills you for the difference between their charge and the BCN-approved amount, also known as the allowed amount. You're responsible for amounts charged by out-of-network providers that exceed the approved or allowed amount. Balance billed charges do not apply towards your out-of-pocket maximum.

### Covered services

These are health care services, prescription drugs and equipment or supplies that are medically necessary, meet requirements and are paid in full or in part by your plan.

### Copayment (or copay)

A fixed dollar amount you pay each time you get certain types of care (for example, \$20 for a visit to your PCP).

### Coinsurance

Your share of the costs of a covered service, calculated as a percentage (for example, you pay 10% of the BCN-approved amount, and BCN pays 90%).

### Deductible

The amount you must pay for most health care services before BCN begins to pay. The deductible may not apply to all services.

### Out-of-pocket maximum

The most you may have to pay for covered health care services during the year. The out-of-pocket maximum includes your medical deductible, copays and coinsurance.

# Medical supplies and lab services

## SPECIAL MEDICAL ITEMS

Sometimes, when you're recovering from an operation or an illness, you may need special equipment, such as a wheelchair or oxygen tank, to maintain your quality of life. These types of items are called **durable medical equipment**.

Your doctor will tell you what you need and write a prescription. BCN only covers basic equipment that you can use at home. If the equipment you want has special features that aren't medically necessary or are considered a luxury, you can choose to pay the cost difference between the basic item and the one with special features.

Northwood Inc. works with BCN to provide durable medical equipment, as well as prosthetic and orthotic appliances for members.

To locate a Northwood provider near you, call Northwood at **1-800-667-8496**. Representatives are available from 8:30 a.m. to 5:30 p.m. Monday through Friday. On-call associates are available after business hours.

### Diabetes supplies

Northwood, Inc. works with BCN to provide diabetes materials, including insulin pumps and blood glucose meters.

For more information, call Northwood at **1-800-667-8496**.

**Note:** If you use J&B for your diabetes supplies, you can continue to use them as a supplier in the Northwood provider network. If you get these items through someone else, you'll be responsible for the cost.

Northwood is an independent company that provides durable medical equipment and diabetes supplies for Blue Care Network of Michigan members.

## LAB SERVICES

BCN contracts with Joint Venture Hospital Laboratories, also known as JVHL, to provide clinical laboratory services throughout Michigan. This gives you access to more than 80 hospitals and 200 service centers that provide 24-hour access and a full range of laboratory services.

The laboratory at University Health & Counseling is a JVHL-approved lab.

For information about lab services near you, call **1-800-445-4979**.

JVHL is an independent company that provides lab services for Blue Care Network of Michigan members.

# Behavioral health coverage

## CARE FOR YOUR MIND AND YOUR BODY

All Blue Care Network members are covered for behavioral health services, including mental health or substance use disorder care. Also covered are other types of conditions that cause emotional or mental distress, such as life adjustment issues, depression and alcoholism.

### Call on a care manager

For routine care issues, you can reach a behavioral health care manager from 8 a.m. to 5 p.m. Monday through Friday at **1-800-482-5982**. TTY users call **711**.

The care manager will evaluate your needs and arrange for the appropriate services. Rest assured that your personal health information, including discussions you have with the care manager, are confidential.

### In case of an emergency

Care managers are available 24 hours a day, seven days a week for behavioral health emergencies at **1-800-482-5982**.

### Getting care out of network

If you're receiving treatment from a behavioral health professional located in the state of Michigan who's not contracted with BCN, you or your health care provider must request authorization from Behavioral Health Services (**1-800-482-5982**). BCN must approve the request for care to be covered. Outpatient treatment received from behavioral health professionals located outside of Michigan does not require BCN authorization for BCN to pay its share.

# Care management

## CARE TO IMPROVE YOUR QUALITY OF LIFE

We have a free health management program that's designed to help you stay healthy, get better or improve your quality of life while living with an illness. This program gives you information, tools and assistance to help you make good health care choices while making the most of the benefits you're paying for.

### Coordinating your care

Managing your care can sometimes be difficult and overwhelming. Our case managers can help you stay on track by coordinating all of your care and working closely with you and your doctor. He or she will also:

- Remind you of needed screenings, lab tests and other services
- Review care instructions provided by your doctor
- Remind you of upcoming appointments
- Answer questions about your benefits
- Identify benefits to get appropriate care
- Arrange for durable medical equipment if needed
- Help find specialists and other providers
- Provide support after surgery and hospitalization

To contact care management, call **1-800-775-2583**. Please note, care management may reach out to you directly if your recent services indicate you may benefit from assistance. Translator services are available for international students.

### Specialized support for you

Know that you're not alone. Many of our case managers are specialists who can assist you with:

- Complex conditions
- High-risk pregnancy
- Neonatal care
- Oncology

# Your drug benefit

## PRESCRIPTION DRUG COVERAGE

For information about what you pay when you fill a prescription, log in to your account at [bcb.sm.com](https://bcb.sm). Then click on *Coverage* then *Prescription*, then *Find & price medications*. See also Page 23 in this booklet for your drug benefit copayment information.

### Providing better value

Drugs are grouped into categories, or tiers, with the safest and least expensive drugs in the lower tiers. Your out-of-pocket cost is defined by one of these tiers.

- **Tier 1: Preferred and nonpreferred generic – Covered with 10% coinsurance**  
These drugs are your most cost-effective option for treatment.
- **Tier 2: Preferred brand – Covered with 10% coinsurance**  
These brand-name drugs cost more because there's no generic equivalent.
- **Tier 3: Nonpreferred brand – Covered with 10% coinsurance**  
These drugs aren't on our list of approved drugs.
- **Tier 4: Preferred and nonpreferred specialty – Covered with 10% coinsurance**  
These drugs treat complex and chronic conditions and require special handling.

### Go generic

Generic drugs are made with the same active ingredients as their brand-name equivalents, making them safe and effective treatment options. Because they cost much less than brand-name drugs, your prescription will automatically be filled with a generic drug when medically appropriate.

### Drug management ensures safety

We review certain drugs to ensure that your prescriptions are safe, affordable and appropriate.

Here are some ways we ensure safety:

- Our quantity limits review ensures that the dose prescribed for you is safe.
- Our pharmacy claims system is programmed to identify harmful drug interactions.



# Virtual care

You and your dependents can get fast, convenient, affordable medical and behavioral health care virtually with a doctor when your primary care provider isn't available.\*

## Convenient virtual care for body and mind

When you or someone in your plan has a minor illness, such as a cold, bladder infection, sprain or other similar condition, simply use your smartphone, tablet or computer to log in and meet face to face with a U.S. board-certified doctor online — 24 hours a day, seven days a week.

Virtual visits also give you more choices for behavioral health care. Schedule an appointment and talk to therapists and psychiatrists about anxiety, grief and other life challenges from the comfort of home.

Virtual care is most convenient when:

- Your primary care provider isn't available.
- You can't leave home or your workplace.
- You're on vacation or traveling for work.
- You're looking for affordable after-hours care.

## Sign up

**Mobile** – Get the Teladoc Health® app

**Web** – Go to [bcbsm.com/virtualcare](https://bcbsm.com/virtualcare)

**Phone** – Call **1-855-636-1578**

**Note:** Add your Blue Care Network health plan information during sign up. You may be charged incorrectly if you don't enter your plan information.

\*U.S. only.

Teladoc Health® is an independent company contracted by Blue Cross Blue Shield of Michigan to provide behavioral health virtual care services to Blue Cross and BCN members.

# Coverage that travels

As a Blue Care Network member, you can receive benefits when you're outside Michigan, but still in the U.S. So can your dependents. You have access to a nationwide network of Blue Plan providers. For more information, call **1-800-810-BLUE (2583)**.

Always carry your BCN member ID card for access to service. You may have to pay your usual out-of-pocket expenses (deductible, copays and coinsurance) for services. But you shouldn't have any other up-front health care expenses if you use a Blue Plan provider.

## Care while traveling outside the U.S.

Your BCN plan provides full medical coverage while traveling abroad through the Blue Cross Blue Shield Global Core Solutions Program. You also have Blue Cross Blue Shield Global Solutions' Medical Evacuation and Repatriation services.

You may be required to pay out-of-pocket for services and seek reimbursement upon returning to the country. Proof of payment, itemized bills and any relevant documentation, including medical records, are required.

For more information:

Call Blue Cross Blue Shield Global Core Service Center at **1-800-810-2583** or collect at **1-804-673-1177**, or visit **bcbsglobalcore.com**.

For Medical Evacuation and Repatriation services, call Blue Cross Blue Shield Global Solutions' global health and safety team toll free at **1-610-290-0345** and share the below plan details:

- Program name: BCBSM International MERE Plan
- Group access code: GTB9999BCMI1.
- You'll receive assistance more quickly if you make contact by phone, but you may also contact Blue Cross Blue Shield Global Solutions by email at **customerservice@bcbsglobalsolutions.com**. In this case, include the program name and group access code as listed above and allow 72 hours for a response.

BCBS Global Solutions is an international health insurance program of Worldwide Insurance Services, which is an independent licensee of the Blue Cross and Blue Shield Association.

Blue Cross Blue Shield Global Core is a registered service mark of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

# Benefits at a glance for The University of Michigan International Student Health Plan 2026-2027

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It's not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable *Certificate of Coverage* and riders. Payment amounts are based on the BCN-approved amount, less any applicable deductible, coinsurance and copayment amounts required by the plan. If there's a discrepancy between these benefits at a glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan. Services must be provided or arranged by your primary care provider or health plan.

## Note:

- When you enroll with Blue Care Network and are a student or scholar on the Ann Arbor campus, we'll assign you a University Health & Counseling primary care provider, who's based on the Ann Arbor campus. If you're a student on the Dearborn and Flint campuses, you'll be assigned a Blue Care Network contracted provider in your area. You can change your primary care provider at any time by logging in to your account at [bcbsm.com](https://bcbsm.com).
- All currently enrolled U-M students on the Ann Arbor campus who pay the health service fee as part of tuition are eligible for services at UHC, and don't pay the International Student/Scholar Health Plan office visit copay when seen at UHC. When appropriate, UHC can bill your insurance for services not supported by the health service fee, such as for medications, certain immunizations, laboratory testing, radiology and eye care. Students and scholars who don't pay the health service fee are still eligible for services at UHC but on a fee-for-service basis.
- Balance billing occurs when a provider bills you for the difference between their charge and the BCN-approved amount, also known as the allowed amount. You're responsible for amounts charged by out-of-network providers that exceed the approved or allowed amount. Balance billed charges don't apply towards your out-of-pocket maximum.

## Member's responsibility: deductible, copays, coinsurance and dollar maximums

**Note:** The deductible will apply to certain services as defined below.

| Benefit description                                                                                                                                                                                                                                                                                                                                                                                                            | BCN network                                                                                                                                                                                                                                                                                                           | Out of network                                                                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Deductible</b><br><b>Note:</b> Coinsurance and select fixed dollar copays apply once the deductible has been met.                                                                                                                                                                                                                                                                                                           | \$100 per individual/\$200 per family per benefit year<br><br>If you use in-network and out-of-network services, separate deductible amounts apply. The deductible for in network and the deductible for out of network aren't combined to satisfy the deductible limit.                                              | \$100 per individual/\$200 per family per benefit year                                                                                                         |
| <b>Fixed dollar copays</b>                                                                                                                                                                                                                                                                                                                                                                                                     | \$20 for primary care provider office visits, \$20 for specialist visits, \$75 per emergency room visit, \$20 per urgent care visit                                                                                                                                                                                   | Not applicable for primary care provider office visits; coinsurance applies for specialist visits: \$75 for emergency room visits, \$20 for urgent care visits |
| <b>Coinsurance</b>                                                                                                                                                                                                                                                                                                                                                                                                             | 10% and 20% for select services as noted below                                                                                                                                                                                                                                                                        | 10% and 20% for select services as noted below                                                                                                                 |
| <b>Annual out-of-pocket maximum</b> – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays.<br><br>Not included in the out-of-pocket maximum: <ul style="list-style-type: none"> <li>• Balance billed charges</li> <li>• Health care this plan doesn't cover</li> <li>• Nonreferred or nonauthorized service</li> <li>• Pediatric dental and vision</li> </ul> | \$3,500 per member/\$7,000 per family per benefit year<br><br>If you use in-network and out-of-network services, separate out-of-pocket maximum amounts apply. The out-of-pocket maximum for in network and the out-of-pocket maximum for out of network are not combined to satisfy the out-of-pocket maximum limit. | \$3,500 per member/\$7,000 per family per benefit year                                                                                                         |

## Member's responsibility: deductible, copays, coinsurance and dollar maximums

| Benefit description                                                                                                                                                                                                                                                           | BCN network                           | Out of network                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------------|
| <b>Preventive services</b> – as defined by the Affordable Care Act and included in your <i>Certificate of Coverage</i> . Additional preventive and early detection services, such as tobacco and depression screenings, are included in your <i>Certificate of Coverage</i> . |                                       |                                                                   |
| Health maintenance exam                                                                                                                                                                                                                                                       | Covered – 100%                        | Covered – 20% coinsurance of the approved amount after deductible |
| Annual gynecological exam                                                                                                                                                                                                                                                     | Covered – 100%                        | Covered – 20% coinsurance of the approved amount after deductible |
| Pap smear screening – laboratory services only                                                                                                                                                                                                                                | Covered – 100%                        | Covered – 20% coinsurance of the approved amount after deductible |
| Well-baby and well-child visits                                                                                                                                                                                                                                               | Covered – 100%                        | Covered – 20% coinsurance of the approved amount after deductible |
| Immunizations-pediatric and adult                                                                                                                                                                                                                                             | Covered – 100%                        | Covered – 20% coinsurance of the approved amount after deductible |
| Prostate specific antigen (PSA) screening – laboratory services only                                                                                                                                                                                                          | Covered – 100%                        | Covered – 20% coinsurance of the approved amount after deductible |
| Routine colonoscopy                                                                                                                                                                                                                                                           | Covered – 100%                        | Covered – 20% coinsurance of the approved amount after deductible |
| Mammography screening                                                                                                                                                                                                                                                         | Covered – 100%                        | Covered – 20% coinsurance of the approved amount after deductible |
| Voluntary female sterilization                                                                                                                                                                                                                                                | Covered – 100%                        | Covered – 20% coinsurance of the approved amount after deductible |
| Breast pumps<br>(DME guidelines apply.)                                                                                                                                                                                                                                       | Covered – 100%                        | Not applicable                                                    |
| Routine prenatal and postnatal care                                                                                                                                                                                                                                           | Covered – 100%                        | Covered – 20% coinsurance of the approved amount after deductible |
| <b>Physician office services</b>                                                                                                                                                                                                                                              |                                       |                                                                   |
| Primary care provider office visits                                                                                                                                                                                                                                           | Covered – \$20 copay                  | Not applicable                                                    |
| Virtual care through the BCN designated vendor                                                                                                                                                                                                                                | Covered – \$20 copay                  | Covered – 20% coinsurance of the approved amount after deductible |
| Consulting specialist care                                                                                                                                                                                                                                                    | Covered – \$20 copay after deductible | Covered – 20% coinsurance of the approved amount after deductible |
| <b>Emergency medical care</b>                                                                                                                                                                                                                                                 |                                       |                                                                   |
| Hospital emergency room – copay waived when admitted as an inpatient                                                                                                                                                                                                          | Covered – \$75 copay                  | Covered – \$75 copay                                              |
| Urgent care services                                                                                                                                                                                                                                                          | Covered – \$20 copay after deductible | Covered – \$20 copay after deductible                             |
| Ambulance services – medically necessary ground and air service                                                                                                                                                                                                               | Covered – 100% after deductible       | Covered – 100% after deductible                                   |



## Member's responsibility: deductible, copays, coinsurance and dollar maximums

| Benefit description                                                                                                      | BCN network                                                                                                                                                | Out of network                                                                                                                          |
|--------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| <b>Diagnostic services</b>                                                                                               |                                                                                                                                                            |                                                                                                                                         |
| Laboratory and pathology tests                                                                                           | Paid in full                                                                                                                                               | Paid in full                                                                                                                            |
| Diagnostic tests and X-rays                                                                                              | Covered – 10% coinsurance after deductible                                                                                                                 | Covered – 20% coinsurance of the approved amount after deductible                                                                       |
| Radiation therapy                                                                                                        | Covered – 10% coinsurance after deductible                                                                                                                 | Covered – 20% coinsurance of the approved amount after deductible                                                                       |
| High technology scans – CAT, MRI, PET; require preauthorization                                                          | Covered – 10% coinsurance after deductible                                                                                                                 | Covered – 20% coinsurance of the approved amount after deductible                                                                       |
| <b>Maternity services provided by a physician</b>                                                                        |                                                                                                                                                            |                                                                                                                                         |
| Routine prenatal and postnatal care                                                                                      | Covered – 100%                                                                                                                                             | Covered – 20% coinsurance of the approved amount after deductible                                                                       |
| Delivery and nursery care                                                                                                | Covered – 10% coinsurance after deductible for professional services (See "Hospital care" for facility charges.) Well newborn nursery care covered at 100% | Covered – 20% coinsurance of the approved amount after deductible for professional services (See "Hospital care" for facility charges.) |
| <b>Hospital care</b>                                                                                                     |                                                                                                                                                            |                                                                                                                                         |
| Inpatient hospital – facility                                                                                            | Covered – \$150 copay after deductible per admission; unlimited days                                                                                       | Covered – 20% coinsurance of the approved amount after deductible; unlimited days                                                       |
| Inpatient hospital – professional                                                                                        | Covered – 10% coinsurance after deductible                                                                                                                 | Covered – 20% coinsurance of the approved amount after deductible                                                                       |
| Outpatient surgery – facility and professional                                                                           | Covered – 10% coinsurance after deductible                                                                                                                 | Covered – 20% coinsurance of the approved amount after deductible                                                                       |
| <b>Alternatives to hospital care</b>                                                                                     |                                                                                                                                                            |                                                                                                                                         |
| Skilled nursing care – facility; unlimited days<br><b>Note:</b> Must meet medical necessity guidelines for skilled care. | Covered – \$150 copay after deductible per admission                                                                                                       | Covered – 20% coinsurance of the approved amount after deductible                                                                       |
| Hospice care – inpatient facility; unlimited days                                                                        | Covered – \$150 copay after deductible per admission                                                                                                       | Covered – 20% coinsurance of the approved amount after deductible                                                                       |
| Home health care                                                                                                         | Covered – 10% coinsurance after deductible                                                                                                                 | Covered – 20% coinsurance of the approved amount after deductible                                                                       |
| <b>Surgical services</b>                                                                                                 |                                                                                                                                                            |                                                                                                                                         |
| Surgery – includes all related surgical services and anesthesia                                                          | Covered – 10% coinsurance after deductible                                                                                                                 | Covered – 20% coinsurance of the approved amount after deductible                                                                       |
| Voluntary male sterilization (See "Preventive services" for voluntary female sterilization.)                             | Covered – 10% coinsurance after deductible                                                                                                                 | Covered – 20% coinsurance of the approved amount after deductible                                                                       |
| Abortion                                                                                                                 | Covered – 10% coinsurance                                                                                                                                  | Covered – 10% coinsurance                                                                                                               |
| Human organ transplants and related services – subject to medical criteria; require preauthorization                     | Covered – 10% coinsurance after deductible                                                                                                                 | Covered – 20% coinsurance of the approved amount after deductible                                                                       |

## Member's responsibility: deductible, copays, coinsurance and dollar maximums

| Benefit description                                                                                                                                                                       | BCN network                                                                 | Out of network                                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <b>Surgical services, continued</b>                                                                                                                                                       |                                                                             |                                                                             |
| Reduction mammoplasty (subject to medical criteria)                                                                                                                                       | Covered – 10% coinsurance after deductible                                  | Covered – 20% coinsurance of the approved amount after deductible           |
| Male mastectomy (subject to medical criteria)                                                                                                                                             | Covered – 10% coinsurance after deductible                                  | Covered – 20% coinsurance of the approved amount after deductible           |
| Temporomandibular joint syndrome                                                                                                                                                          | Covered – 10% coinsurance after deductible                                  | Covered – 20% coinsurance of the approved amount after deductible           |
| Orthognathic surgery                                                                                                                                                                      | Covered – 10% coinsurance after deductible                                  | Covered – 20% coinsurance of the approved amount after deductible           |
| Weight reduction procedures (subject to medical criteria) – one procedure per lifetime                                                                                                    | Covered – 10% coinsurance after deductible                                  | Covered – 20% coinsurance of the approved amount after deductible           |
| <b>Behavioral health</b>                                                                                                                                                                  |                                                                             |                                                                             |
| Inpatient mental health care<br><b>Note:</b> Services require preauthorization from BCN Behavioral Health Management.                                                                     | Covered – \$150 copay after deductible per admission                        | Covered – 20% coinsurance of the approved amount after deductible           |
| Inpatient substance use disorder care<br><b>Note:</b> Services require preauthorization from BCN Behavioral Health Management.                                                            | Covered – \$150 copay after deductible per admission                        | Covered – 20% coinsurance of the approved amount after deductible           |
| Outpatient mental health care<br><b>Note:</b> Out-of-network mental health services received from Michigan providers must be preauthorized by BCN Behavioral Health Management.           | Covered – \$20 copay                                                        | Covered – 20% coinsurance of the approved amount after deductible           |
| Outpatient substance use disorder care<br><b>Note:</b> Outpatient substance use disorder care received from Michigan providers must be preauthorized by BCN Behavioral Health Management. | Covered – \$20 copay                                                        | Covered – 20% coinsurance of the approved amount after deductible           |
| <b>Autism spectrum disorders, diagnoses and treatment</b>                                                                                                                                 |                                                                             |                                                                             |
| Applied behavioral analyses (ABA) treatment<br><b>Note:</b> Services require preauthorization from BCN Behavioral Health Management.                                                      | Covered – \$20 copay                                                        | Covered – 20% coinsurance of the allowed amount after deductible            |
| Outpatient physical therapy, speech therapy, occupational therapy.                                                                                                                        | Covered – \$20 copay after deductible                                       | Covered – 20% coinsurance of the allowed amount after deductible            |
| Other covered services, including mental health services for autism spectrum disorder                                                                                                     | See your outpatient mental health benefit and medical office visit benefit. | See your outpatient mental health benefit and medical office visit benefit. |

## Member's responsibility: deductible, copays, coinsurance and dollar maximums

| Benefit description                                                                                                                                                                                                                                            | BCN network                                                                                                                                              | Out of network                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| <b>Other services</b>                                                                                                                                                                                                                                          |                                                                                                                                                          |                                                                                           |
| Allergy testing, therapy and injections                                                                                                                                                                                                                        | Covered – 10% coinsurance after deductible.                                                                                                              | Covered – 20% coinsurance of the approved amount after deductible                         |
| Chiropractic spinal manipulation                                                                                                                                                                                                                               | Covered – \$20 copay after deductible; unlimited visits                                                                                                  | Covered – 20% coinsurance of the approved amount after deductible; unlimited visits       |
| Outpatient physical, speech and occupational therapy including habilitative services (Requires authorization by BCN.)                                                                                                                                          | Covered – \$20 copay after deductible; unlimited visits                                                                                                  | Covered – 20% coinsurance of the approved amount after deductible; unlimited visits       |
| Durable medical equipment (Requires preauthorization through Northwood.)                                                                                                                                                                                       | Covered – 10% coinsurance of the approved amount after deductible through BCN vendor                                                                     |                                                                                           |
| Prosthetic and orthotic appliances                                                                                                                                                                                                                             | Covered – 10% coinsurance of the approved amount after deductible through BCN vendor                                                                     |                                                                                           |
| Diabetes supplies – through Northwood<br><b>1-800-667-8496</b>                                                                                                                                                                                                 | Covered – 10% coinsurance of the approved amount after deductible through BCN vendor                                                                     |                                                                                           |
| Infertility – counseling and treatment (excluding in-vitro fertilization)                                                                                                                                                                                      | Covered – 10% coinsurance after deductible on all associated costs                                                                                       | Covered – 20% coinsurance of the approved amount after deductible on all associated costs |
| <b>Adult routine vision exam (age 19 and older)</b><br>Note: BCN administers the adult routine vision exam.<br><br>In Michigan: BCN-contracted vision providers are considered in network.<br>Outside Michigan: Blue Plan providers are considered in network. | Covered – \$20 copay                                                                                                                                     | Covered – 20% coinsurance of the approved amount                                          |
|                                                                                                                                                                                                                                                                | Limited to: Two vision exams per member per benefit year and one office visit for the fitting of prescription contact lenses per member per benefit year |                                                                                           |
| Hearing aid                                                                                                                                                                                                                                                    | Covered – 10% coinsurance after deductible                                                                                                               | Covered – 20% coinsurance of the approved amount                                          |
|                                                                                                                                                                                                                                                                | Limited to one hearing aid per ear every six-to-24-month consecutive period per benefit year                                                             |                                                                                           |
| Transplant Services – eligible travel and lodging for initial transplant surgery (Member must submit receipts for reimbursement.)                                                                                                                              | \$10,000 limit<br>Max payable \$50 per night for lodging for recipient<br>Max payable \$50 per night for lodging for each companion                      |                                                                                           |
| Injuries due to intercollegiate sports                                                                                                                                                                                                                         | Not covered                                                                                                                                              |                                                                                           |
| Injuries due to intramural and club sports                                                                                                                                                                                                                     | Covered<br>Applicable out-of-pocket costs based on the service and location of the service                                                               |                                                                                           |
| Acupuncture in lieu of anesthesia                                                                                                                                                                                                                              | Not covered                                                                                                                                              |                                                                                           |
| Out-of-country services                                                                                                                                                                                                                                        | Covered whether or not the country has socialized medicine.<br>Applicable in-network cost sharing applies.                                               |                                                                                           |

## Member's responsibility: deductible, copays, coinsurance and dollar maximums

| Benefit description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | BCN network                                                                                                                                                                                                                                                                                                                               | Out of network                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <b>Pediatric vision (age 18 and younger)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                           |                                                             |
| <p>Eye exam – limited to one per calendar year through the last day of the year in which an individual turns age 19. To find a pediatric vision provider near you, please visit <a href="http://vsp.com">vsp.com</a> or call <b>1-800-877-7195</b>.</p> <p>Prescription glasses – frames (chosen from a select collection) and lenses are covered once a calendar year through the last day of the year in which an individual turns age 19</p>                                                                                                                                                                                                                                          | Covered – 100%                                                                                                                                                                                                                                                                                                                            | Covered – 100% of the approved amount                       |
| <b>Adult dental (age 19 and older)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <p>The <b>annual benefit maximum</b> is \$3,000 per nonpediatric member. The annual maximum is the most we will pay each benefit year for covered services to a nonpediatric member. The maximum applies separately to each nonpediatric member on your contract.</p>                                                                     |                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <p><b>Balance billing</b> occurs when a provider bills you for the difference between their charge and the BCN allowed amount. You're responsible for amounts charged by out-of-network providers that exceed the allowed amount.</p>                                                                                                     |                                                             |
| <p>Administered by Blue Cross Blue Shield of Michigan. If you have benefit questions, call the Dental Customer Service number on the back of your card.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Blue Dental <sup>SM</sup> PPO dentists                                                                                                                                                                                                                                                                                                    | Blue Par Select <sup>SM</sup> and nonparticipating dentists |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <p>Prior to receiving services, have your dentist contact Blue Cross Blue Shield of Michigan at the number on the back of your member ID card to verify what's included in your benefits.</p> <p>To find a PPO dentist near you, please visit <a href="http://mibluedentist.com">mibluedentist.com</a> or call <b>1-888-826-8152</b>.</p> |                                                             |
| <b>Dental deductible</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | N/A                                                                                                                                                                                                                                                                                                                                       | N/A                                                         |
| <ul style="list-style-type: none"> <li>Routine oral evaluations (exams) and prophylaxes (cleanings) – twice every benefit year.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Covered – 100% of allowed amount                                                                                                                                                                                                                                                                                                          | Covered – 100% of allowed amount                            |
| <ul style="list-style-type: none"> <li>Emergency palliative treatment — for temporary pain relief</li> <li>Amalgam and resin-based composite fillings and fillings of similar materials — once per tooth and surface every 48 months for permanent teeth and once per tooth and surface every 24 months for primary teeth</li> <li>Extractions and surgical removal of wisdom teeth                             <ul style="list-style-type: none"> <li>Full mouth, panoramic and periapical X-rays associated with the removal of wisdom teeth (third molars) – once every 60 months</li> <li>General anesthesia or IV sedation — for the removal of wisdom teeth</li> </ul> </li> </ul> | Covered – 90% of allowed amount                                                                                                                                                                                                                                                                                                           | Covered – 90% of allowed amount                             |

## Member's responsibility: deductible, copays, coinsurance and dollar maximums

| Benefit description                                                                                                                                                                                                                                                                | BCN network                                                                                                                                                                                                                                                                                            | Out of network                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| <b>Pediatric dental (age 18 and younger)</b>                                                                                                                                                                                                                                       | <b>Balance billing</b> occurs when a provider bills you for the difference between their charge and the BCN allowed amount. You're responsible for amounts charged by out-of-network providers that exceed the allowed amount. Balance billed charges do not apply towards your out-of-pocket maximum. |                                                                  |
| <b>Pediatric dental</b> – Administered by Blue Cross Blue Shield of Michigan. If you have benefit questions, call the Dental Customer Service number on the back of your member ID card.                                                                                           | Blue Dental PPO dentists                                                                                                                                                                                                                                                                               | Blue Par Select and nonparticipating dentists                    |
|                                                                                                                                                                                                                                                                                    | Prior to receiving services, have your dentist contact Blue Cross Blue Shield of Michigan at the number on the back of your member ID card to verify what's included in your benefits.<br>To find a PPO dentist near you, visit <b>mibluedentist.com</b> or call <b>1-888-826-8152</b> .               |                                                                  |
| <b>Dental deductible</b>                                                                                                                                                                                                                                                           | \$25 per member/\$75 per contract<br>Deductible per benefit year                                                                                                                                                                                                                                       | \$25 per member/\$75 per contract<br>Deductible per benefit year |
| <b>Dental out-of-pocket maximum</b> – Applies to deductible and coinsurance amounts for covered dental services provided by Blue Dental PPO dentists. It doesn't apply to charges that exceed our approved PPO fee, services provided by non-PPO dentists or orthodontic services. | \$450 per member / \$900 per contract per benefit year                                                                                                                                                                                                                                                 | Not applicable                                                   |
| Diagnostic and preventive services, such as oral exams, cleanings, fluoride, bitewing X-rays and sealants                                                                                                                                                                          | Covered – 100% of allowed amount                                                                                                                                                                                                                                                                       | Covered – 100% of allowed amount                                 |
| Basic services, such as fillings, full-mouth X-rays, nonsurgical endodontic and periodontic treatments and extractions of nonimpacted teeth                                                                                                                                        | Covered – 80% of allowed amount after dental deductible                                                                                                                                                                                                                                                | Covered – 80% of allowed amount after dental deductible          |
| Major services, such as crowns, surgical endodontic and periodontic treatments, oral surgery and dentures                                                                                                                                                                          | Covered – 50% of allowed amount after dental deductible                                                                                                                                                                                                                                                | Covered – 50% of allowed amount after dental deductible          |
| Orthodontic services                                                                                                                                                                                                                                                               | Covered – 50% of allowed amount                                                                                                                                                                                                                                                                        | Covered – 50% of allowed amount                                  |
|                                                                                                                                                                                                                                                                                    | Lifetime maximum limit of \$1,000                                                                                                                                                                                                                                                                      |                                                                  |
| <b>Prescription drugs</b>                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                        |                                                                  |
| Prescription drugs – 30-day supply                                                                                                                                                                                                                                                 | Custom Select Drug List                                                                                                                                                                                                                                                                                | Custom Select Drug List                                          |
|                                                                                                                                                                                                                                                                                    | Preferred generic – 10% coinsurance                                                                                                                                                                                                                                                                    | Preferred generic – 10% coinsurance                              |
|                                                                                                                                                                                                                                                                                    | Nonpreferred generic – 10% coinsurance                                                                                                                                                                                                                                                                 | Nonpreferred generic – 10% coinsurance                           |
|                                                                                                                                                                                                                                                                                    | Preferred brand – 10% coinsurance                                                                                                                                                                                                                                                                      | Preferred brand – 10% coinsurance                                |
|                                                                                                                                                                                                                                                                                    | Nonpreferred brand – 10% coinsurance                                                                                                                                                                                                                                                                   | Nonpreferred brand – 10% coinsurance                             |
|                                                                                                                                                                                                                                                                                    | Preferred specialty – 10% coinsurance                                                                                                                                                                                                                                                                  | Preferred specialty – 10% coinsurance                            |
|                                                                                                                                                                                                                                                                                    | Nonpreferred specialty – 10% coinsurance                                                                                                                                                                                                                                                               | Nonpreferred specialty – 10% coinsurance                         |
|                                                                                                                                                                                                                                                                                    | Drugs for the treatment of sexual dysfunction, cough & cold and prenatal vitamins – 10% coinsurance                                                                                                                                                                                                    |                                                                  |
|                                                                                                                                                                                                                                                                                    | Preventive drugs including female contraceptives are covered in full for generic and single-source brand names on the Custom Select Drug List. Multi-source brands are not covered.                                                                                                                    |                                                                  |
|                                                                                                                                                                                                                                                                                    | Drugs for weight loss and compounds aren't covered.                                                                                                                                                                                                                                                    |                                                                  |
|                                                                                                                                                                                                                                                                                    | Specialty drugs are covered only when obtained from a pharmacy in the BCN Exclusive Pharmacy Network for Specialty Drugs.                                                                                                                                                                              |                                                                  |
| 90-day retail and mail order prescription drugs                                                                                                                                                                                                                                    | Not covered                                                                                                                                                                                                                                                                                            |                                                                  |







# Valuable member resources

## Manage your plan online

At [bcbsm.com](https://bcbsm.com), managing your plan online has never been easier. With a secure member account, you'll be able to:

- Check your plan information, deductible and coinsurance levels, claims status, history and more
- Find doctors and hospitals in your plan's network, view doctor reviews from other patients and compare quality for hundreds of services
- Access your virtual ID card from your mobile device

## Get connected to health and well-being

Blue Cross Well-Being<sup>SM</sup> offers a state-of-the-art digital experience with personalized support to help you build and maintain healthy habits, one step at a time. Find health care services and well-being resources that are available through your plan in your member account at [bcbsm.com](https://bcbsm.com).

## Blue365<sup>®</sup>

As a Blue Care Network member, you get exclusive savings on a variety of health-related products and services, including:

- Fitness gear and gym memberships
- Meal delivery kits and weight-loss programs
- Travel and recreation
- LASIK and eye care services, dental care and hearing aids

Cash in by showing your member ID card at participating local retailers or use an offer code online through your member account. View a full list of discount offers from your account at [bcbsm.com](https://bcbsm.com).

## Find us online

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