



Blue Cross
Blue Shield
of Michigan

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

HOPE COLLEGE BLUE PLAN 007013084 Effective Date: 07/01/2026

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Prior authorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, receive prior authorization or approved by BCBSM except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at bcbsm.com/importantinfo. Select **Approving covered services**.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Prior authorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request prior authorization of the drugs. **If prior authorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

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

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Eligibility Information

Members	Eligibility Criteria
Dependents	<ul style="list-style-type: none"> Subscriber's legal spouse Dependent children: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26
No-fault automobile accidents, option 2	Excludes BCBSM from responsibility for any services related to an injury that is a direct or indirect result of a motor vehicle accident. This applies whether or not a member has no-fault motor vehicle insurance.

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

Note: Member cost-sharing requirements are administered on a benefit year basis. Your benefit year begins on July 1 and ends the following year on June 30.

Benefits	In-network	Out-of-network
Deductible	\$1,250 for one member, \$2,500 for the family (when two or more members are covered under your contract) each benefit year Note: Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.	\$2,250 for one member, \$4,500 for the family (when two or more members are covered under your contract) each benefit year Note: Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	<ul style="list-style-type: none"> \$25 copay for office visits and office consultations with a primary care provider \$50 copay for office visits and office consultations with a specialist \$10 copay for medical online visits \$40 copay for chiropractic and osteopathic manipulative therapy \$250 copay for emergency room visits \$50 copay for urgent care visits 	<ul style="list-style-type: none"> \$250 copay for emergency room visits
Coinsurance amounts (percent copays)	<ul style="list-style-type: none"> 30% of approved amount for private duty nursing care 20% of approved amount for mental health care and substance use disorder treatment 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office) 50% of approved amount for professional services for bariatric surgery 	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 40% of approved amount for mental health care and substance use disorder treatment 40% of approved amount for most other covered services 50% of approved amount for professional services for bariatric surgery
Note: Coinsurance amounts apply once the deductible has been met.		

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Benefits	In-network	Out-of-network
Annual out-of-pocket maximums - applies to deductibles, flat-dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	\$4,250 for one member, \$8,500 for the family (when two or more members are covered under your contract) each benefit year	\$8,250 for one member, \$16,500 for the family (when two or more members are covered under your contract) each benefit year Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per benefit year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), two per member per benefit year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per benefit year	Not covered
Voluntary sterilization of female reproductive organs	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and Well-child visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> 8 visits, birth through 12 months 6 visits, 13 months through 23 months 6 visits, 24 months through 35 months 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per benefit year under the health maintenance exam benefit 	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per benefit year	Not covered

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Benefits	In-network	Out-of-network
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per benefit year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per benefit year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) Note: Subsequent medically necessary mammograms performed during the same benefit year are subject to your deductible and coinsurance.	60% after out-of-network deductible Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
One per member per benefit year		
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy Note: Medically necessary colonoscopies performed during the same benefit year are subject to your deductible and coinsurance.	60% after out-of-network deductible
One per member per benefit year		

Physician office services		
Benefits	In-network	Out-of-network
Office visits - must be medically necessary Note: This includes mental health and substance use disorder services equivalent to medical office visits.	<ul style="list-style-type: none"> \$25 copay per office visit with a primary care provider \$50 copay per office visit with specialist 	60% after out-of-network deductible
Online visits - by physician or BCBSM selected vendor must be medically necessary Note: Online visits by a non-BCBSM selected vendor are not covered. Not all services delivered virtually are considered an online visit, but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	\$10 copay per online visit	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	<ul style="list-style-type: none"> \$25 copay per office consultation with a primary care provider \$50 copay per office consultation with a specialist 	60% after out-of-network deductible
Urgent care visits - must be medically necessary	\$50 copay per urgent care visit	60% after out-of-network deductible

Emergency medical care		
Benefits	In-network	Out-of-network
Hospital emergency room	\$250 copay per visit (copay waived if admitted)	\$250 copay per visit (copay waived if admitted)
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Benefits	In-network	Out-of-network
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

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

Maternity services provided by a physician or certified nurse midwife		
Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible
Note: For facility services See "Hospital Care"		

Hospital care		
Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	80% after in-network deductible	60% after out-of-network deductible
Unlimited days		
Note: Nonemergency services must be rendered in a participating hospital.		
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care		
Benefits	In-network	Out-of-network
Skilled nursing care - must be in a participating skilled nursing facility	80% after in-network deductible	80% after in-network deductible
Limited to a maximum of 120 days per member, per benefit year		
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a participating hospice program only ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)		

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Benefits	In-network	Out-of-network
Home health care: <ul style="list-style-type: none"> • must be medically necessary • must be provided by a participating home health care agency 	80% after in-network deductible	80% after in-network deductible
Infusion therapy: <ul style="list-style-type: none"> • must be medically necessary • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • may use drugs that require prior authorization - consult with your doctor 	80% after in-network deductible	80% after in-network deductible

Surgical services		
Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization of male reproductive organs	80% after in-network deductible	60% after out-of-network deductible
Note: For voluntary sterilization of female reproductive organs, see "Preventive care services."		
Elective Abortion Services	Not covered	Not covered
Bariatric and gastric restrictive surgery and related anesthesia - professional services only.	50% after in-network deductible	50% after out-of-network deductible
Note: Covered facility services for bariatric/gastric restrictive surgery remain subject to the contract deductible and coinsurance requirements.		

Human organ transplants		
Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities only
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

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Behavioral Health Services (Mental Health and Substance Use Disorder)

Note: Some mental health and substance use disorder services are considered by BCBSM to be equivalent to an office visit or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be equivalent to an office visit or medical online visit, we will process the claim under your Physician Office Services.

Note: BCBSM will cover mental health services performed - MD, DO, Fully Licensed Psychologists and Clinical Licensed Master's Social Workers (CLMSWs), Limited Licensed Psychologists (LLPs), Social Workers who have the following social work degrees/certifications: MMSW, MSSW.

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance use disorder treatment	80% after in-network deductible	60% after out-of-network deductible
Unlimited days		
Note: Facility services are covered in participating facilities only. Residential psychiatric treatment facility: <ul style="list-style-type: none"> covered mental health services must be performed in a residential psychiatric treatment facility treatment requires prior authorization subject to medical criteria 	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> Facility and clinic 	80% after in-network deductible	80% after in-network deductible
Note: Facility services are covered in participating facilities only. <ul style="list-style-type: none"> Online visits - for services equivalent to a medical online visit 	\$25 copay per online visit	60% after out-of-network deductible
Note: Online visits by a non-BCBSM selected vendor are not covered. <ul style="list-style-type: none"> Physician's office 	80% after in-network deductible	60% after out-of-network deductible
Note: For services equivalent to a medical office visit. See " Physician Office Services ".		
Outpatient substance use disorder treatment - in approved facilities only	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavior analysis (ABA) treatment - subject to prior authorization	\$25 copay per office visit	60% after out-of-network deductible
Note: Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).		Note: Services rendered by an approved licensed behavior analyst (LBA) will apply the in-network cost-sharing.
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible
	Physical, speech and occupational therapy with an autism diagnosis is unlimited	
Other covered services, including nutritional counseling and mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible

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Other covered services

Benefits	In-network	Out-of-network
<p>Outpatient Diabetes Management Program (ODMP)</p> <p>Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider.</p> <p>Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.</p>	<ul style="list-style-type: none"> 80% after in-network deductible for diabetes medical supplies 100% (no deductible or copay/coinsurance) for diabetes self-management training 	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$40 copay per visit	60% after out-of-network deductible
Limited to a combined 24-visit maximum per member per benefit year		
<p>Outpatient physical, speech and occupational therapy - provided for rehabilitation</p> <p>Note: Benefits are payable for professional and facility physical therapy for chronic conditions and pain management.</p>	80% after in-network deductible	60% after out-of-network deductible
Limited to a combined 60-visit maximum per member, per benefit year		
<p>Durable medical equipment</p> <p>Note: DME items required under the preventive benefit provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of preventive DME items that PPACA requires to be covered at 100%, call BCBSM.</p>	50% after in-network deductible	50% after in-network deductible
Prosthetic and orthotic appliances	50% after in-network deductible	50% after in-network deductible
Private duty nursing care	70% after in-network deductible	50% after out-of-network deductible
Prescription drugs	Not covered	Not covered

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