2016 HEALTH PLAN COVERAGE COMPARISON CHART

PLAN TYPE	MANAGED CARE PLANS			TRADITIONAL PLAN	PREFERRED PROVIDER ORGANIZATION (PPO)	
Plan Name	**GradCare** Only Available to U-M Graduate Students	**U-M Premier Care[1,3] Provider Network 1**	**Health Alliance Plan HMO[1]**	**Comprehensive Major Medical[1]**	**Blue Cross Blue Shield of Michigan Community Blue PPO In-Network[1]**	**Blue Cross Blue Shield of Michigan Community Blue PPO Out-of-Network[1]**
General Information						
Service Area	Only available to GSIs, GSSAs, GSRAs, medical students, and sponsored graduate student groups at the University of Michigan	Genessee, Livingston, Macomb, Oakland, Washtenaw and Wayne counties; and portions of Ingham, Jackson, Lapeer, Monroe, and St. Clair counties	Genesee, Lapeer, Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw, and Wayne counties	Nationwide/Worldwide	Nationwide/Worldwide	Not applicable
Residency Requirement	Level 1 and continuance: U-M academic campus	Participants must reside in the service area	Participants must reside in the service area	Not applicable	Not applicable	Not applicable
Important Information About the Terms Used in This Chart	"Covered" means your services must be provided or authorized by a Primary Care Physician (PCP). The plan co-insurance amount is 100% unless stated otherwise or unless a co-pay is indicated for the covered service. Co-pay means a set dollar amount you pay for a covered service.[2]	"Covered" means your services must be provided or authorized by a Primary Care Physician (PCP). The plan co-insurance amount is 100% unless stated otherwise or unless a co-pay is indicated for the covered service. Co-pay means a set dollar amount you pay for a covered service.[5]	"Covered" means your services must be provided or authorized by a Primary Care Physician (PCP). The plan co-insurance amount is 100% unless stated otherwise or unless a co-pay is indicated for the covered service. Co-pay means a set dollar amount you pay for a covered service.[5]	"Partially covered" means you pay a $500/$1,000 deductible, 20% co-insurance up to the annual out-of-pocket maximums, and costs that exceed the BCBSM fee schedule or balance billing when non-participating providers are used. Co-insurance means the percentage amount of the provider's charge you pay for a covered service.	"Covered" means the plan payment amount for covered charges is 100% unless stated otherwise. You pay costs that exceed the BCBSM fee schedule or balance billing when non-participating providers are used. Co-pay means the set dollar amount you pay for a covered service.[5]	"Covered" means the plan payment amount for covered charges is 100% unless stated otherwise. You pay costs that exceed the BCBSM fee schedule or balance billing when non-participating providers are used. Co-pay means the set dollar amount you pay for a covered service.[5]
Maximum Annual Out-of-Pocket Amount	Annual out-of-pocket maximum is $3,000 (individual) and $6,000 (family).	Annual out-of-pocket maximum is $3,000 (individual) and $6,000 (family) for Network 1 and 2 providers combined.	Annual out-of-pocket maximum is $3,000 (individual) and $6,000 (family).	Including the annual deductible, the maximum out-of-pocket amount is $3,000 per individual and $6,000 per family.[4]	Annual out-of-pocket maximumis $3,000 (individual) and $6,000 (family).	Out-of-pocket maximum is $5,000 per individual, $10,000 per family.[4]
Lifetime Maximum Benefit	None	None	None	None	None	None
Phone Number for Customer Service and Provider Directory	800-658-8878	800-658-8878	800-422-4641	877-790-BLUE	877-790-BLUE	877-790-BLUE
Web Site	bcbsm.com	bcbsm.com	hap.org	bcbsm.com	bcbsm.com	bcbsm.com
Hospital Services—Inpatient						
Hospital Admissions	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%
Days of Care	Unlimited days	Unlimited days	Unlimited days	Unlimited days	Unlimited days	Unlimited days
Room Type	Semi-private room; private room if medically necessary	Semi-private room; private room if medically necessary	Semi-private room; specialty care units if medically necessary	Semi-private room; private room not covered	Semi-private room; private room if medically necessary	Semi-private room; private room if medically necessary
Hospital Physician Service	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%
Consultation Between Physicians	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%
Surgery	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%

This chart is not intended to be a full description of coverage. The complete plan description is contained in the appropriate certificate of coverage or plan document issued by each plan. Every effort has been made to ensure the accuracy of this chart. If statements in this chart differ from applicable contracts, certificates, or riders, then the terms and conditions of those documents prevail. This chart assumes all services are provided by a participating medical care provider when required. All benefits are subject to change.

[1] These plans will coordinate with Medicare. The benefits listed show your costs after Medicare has paid its portion to your physician or hospital.

[2] Coverage described applies to GradCare Level 1. For details on out-of-network services, call BCN.

[3] Coverage described applies to the U-M Premier Care Provider Network 1. Additional providers are available through BCN's statewide network, (Provider Network 2). Network 2 providers are covered with a $2,000 annual deductible for individual, $4,000 annual deductible per family. A Network 1 PCP referral is required to access Network 2 providers.

[4] The out-of-pocket maximum does not include non-covered charges, and costs that exceed the plan's fee allowance for a particular service for all plans.

[5] Co-pays may differ for bargained-for groups.

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Preventive Services						
Routine Physical Exams	Covered[10]	Covered[10]	Covered[10]	Covered[10]	Covered[10]	Not covered
Routine Pediatric Exams	Covered[10]	Covered[10]	Covered[10]	Covered[10]	Covered[10]	Not covered
Pap Smears — Lab and Pathology	Covered[10]	Covered[10]	Covered[10]	Covered[10]	Covered[10]	Not covered
Routine Mammograms	Covered	Covered	Covered	Covered	Covered	Not covered
PSA (Prostate) Test	Covered[10]	Covered[10]	Covered[10]	Covered[10]	Covered[10]	Not covered
Outpatient Services						
Office Visits	Covered with a $25 co-pay if in-network PCP is used, except students pay no co-pay at University Health Service.	Covered with a $25 co-pay	Covered with a $25 co-pay	Partially covered	Covered with a $25 co-pay	Covered at 50%
Outpatient Physical, Occupational and Speech Therapy	Covered with a $25 co-pay per visit; major diagnoses limited to 60 visits per calendar year; minor diagnoses limited to 15 visits per calendar year. Major and minor diagnoses are determined by the plan.[6]	Covered with a $25 co-pay per visit; major diagnoses limited to 60 visits per calendar year; minor diagnoses limited to 15 visits per calendar year. Major and minor diagnoses are determined by the plan.[6]	Covered; up to 60 combined visits per benefit period, may be rendered at home	Partially covered for unlimited treatments[6]	Covered with a $25 co-pay (co-pay applies to professional billed services only); limited to 60 visits per year (facility & professional services combined)[6]	Covered at 50%; limited to 60 visits per year (facility and professional services combined)[6]
Therapeutic Radiology	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%
Diagnostic Lab, X-Ray, EKGs	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%
Outpatient Surgery	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%
Routine Immunizations	Covered[10]	Covered[10]	Covered[10]	Coverd[10]	Covered[7]	Not covered
Allergy Testing	Covered with a $30 co-pay	Covered with a $30 co-pay	Covered with a $30 co-pay	Partially covered	Covered; a $30 co-pay may apply	Covered at 50%
Allergy Injections	Covered; a $30 co-pay may apply	Covered; a $30 co-pay may apply	Covered; a $30 co-pay may apply	Partially covered	Covered; a $30 co-pay may apply	Covered at 50%
Other Injections	$30 office visit co-pay may apply	$30 office visit co-pay may apply	$30 office visit co-pay may apply	Partially covered	Covered; a $30 co-pay may apply	Covered at 50%

[1] These plans will coordinate with Medicare. The benefits listed show your costs after Medicare has paid its portion to your physician or hospital.

[3] Coverage described applies to the U-M Premier Care Provider Network 1. Additional providers are available through BCN's statewide network, (Provider Network 2). Network 2 providers are covered with a $2,000 annual deductible for individual, $4,000 annual deductible per family. A Network 1 PCP referral is required to access Network 2 providers.

[6] Physical, occupational, and speech therapies are covered for acute conditions and subject to prior plan authorization. Administrative guidelines and interpretations may vary among plans. Contact plan for specific coverage provisions before commencing treatment.

[7] Inoculations for travel are not covered.

[10] Your doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that **your plan can require you to pay some costs** of the office visit, if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately for the office visit.

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Emergency Care						
In Area	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted.	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted.	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted.	Partially covered	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted or due to accidental injury.	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted or due to accidental injury.
Out of Area	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted.	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted.	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted.	Partially covered	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted or due to accidental injury.	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted or due to accidental injury.
Ambulance	Covered for emergencies when medically necessary	Covered for emergencies when medically necessary	Covered for emergencies when medically necessary	Partially covered for transfer to or from hospital; includes ground and air when medically necessary.	Covered for emergency transportation when medically necessary	Covered for emergency transportation when medically necessary
Mental Health Care						
Preauthorization Required	All mental health care services must have prior authorization from BCN.	All mental health care services must have prior authorization from BCN.	Call Coordinated Behavioral Health Management for authorization at: 800-444-5755.	Contact BCBSM for specific coverage requirements before mental health care services are provided. These services must be obtained through an approved or participating provider or facility.	Contact BCBSM for specific coverage requirements before mental health care services are provided. These services must be obtained through an approved or participating provider or facility.	No
Inpatient Days of Care	Covered for acute conditions	Covered for acute conditions	Covered for acute conditions	Partially covered	Covered for acute conditions	Covered at 50% for acute conditions
Outpatient Individual Psychiatric Care	Covered with a $25 co-pay for acute conditions	Covered with a $25 co-pay for acute conditions	Covered with a $25 co-pay	Partially covered	Covered with a $25 co-pay	Covered at 50%
Group Therapy	Covered with a $25 co-pay for acute conditions	Covered with a $25 co-pay for acute conditions	Covered with a $25 co-pay	Partially covered	Covered with a $25 co-pay	Covered at 50%
Psychological Testing	Covered with a $25 co-pay for acute conditions	Covered with a $25 co-pay for acute conditions	Covered with a $25 co-pay	Partially covered	Covered with a $25 co-pay	Covered at 50%
Substance Abuse Care						
Preauthorization Required	All substance abuse care services must have prior authorization from BCN.	All substance abuse care services must have prior authorization from BCN.	Call Coordinated Behavioral Health Management for authorization at: 800-444-5755.	Contact BCBSM for specific coverage requirements before these services are provided. Inpatient care for these services is covered when care is received in a participating facility having an approved substance abuse program or an approved non-hospital residential program.	Contact BCBSM for specific coverage requirements before these services are provided. Inpatient care for these services is covered when care is received in a participating facility having an approved substance abuse program or an approved non-hospital residential program.	No

[1] These plans will coordinate with Medicare. The benefits listed show your costs after Medicare has paid its portion to your physician or hospital.

[3] Coverage described applies to the U-M Premier Care Provider Network 1. Additional providers are available through BCN's statewide network, (Provider Network 2). Network 2 providers are covered with a $2,000 annual deductible for individual, $4,000 annual deductible per family. A Network 1 PCP referral is required to access Network 2 providers.

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PLAN TYPE	MANAGED CARE PLANS			TRADITIONAL PLAN	PREFERRED PROVIDER ORGANIZATION (PPO)	
Plan Name	**GradCare** Only Available to U-M Graduate Students	**U-M Premier Care[1,3] Provider Network 1**	**Health Alliance Plan HMO[1]**	**Comprehensive Major Medical[1]**	**Blue Cross Blue Shield of Michigan Community Blue PPO In-Network[1]**	**Blue Cross Blue Shield of Michigan Community Blue PPO Out-of-Network[1]**
Substance Abuse Care *(continued)*						
Inpatient Days of Care	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%
Outpatient Individual Therapy	Covered with a $25 co-pay per visit	Covered with a $25 co-pay per visit	Covered with a $25 co-pay per visit	Partially covered	Covered with a $25 co-pay per visit	Covered at 50%
Group Therapy	Covered with a $25 co-pay per visit	Covered with a $25 co-pay per visit	Covered with a $25 co-pay per visit	Partially covered	Covered with a $25 co-pay per visit	Covered at 50%
Maternity Care						
Parental Care, Delivery, Postnatal Care	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%
Skilled Nursing Facility						
(Non-Custodial Care)	Covered up to 45 days per calendar year if preauthorized by BCN	Covered up to 120 days per calendar year when arranged and authorized by BCN	Covered up to 730 days, renewable after 60 days for authorized services	Partially covered up to 120 days per calendar year	Covered up to 120 days per calendar year	Covered up to 120 days per calendar year
Hearing Care						
Examinations	Covered with a $30 co-pay; once every 36 months	Covered with a $30 co-pay; once every 36 months	Covered with a $30 co-pay	Office visit partially covered only if treated for a medical condition	Covered	Not covered
Tests	Covered with a $30 co-pay; once every 36 months	Covered with a $30 co-pay; once every 36 months	Covered with a $30 co-pay	Not covered	Covered	Not covered
Hearing Aids	Covered; monaural or binaural hearing aid every 36 months[8, 9]	Covered; monaural or binaural hearing aid every 36 months[8, 9]	Covered for authorized conventional hearing aid[8, 9]	Covered; monaural or binaural hearing aid every 36 months[8, 9]	Covered; monaural or binaural hearing aid every 36 months[8, 9]	Not covered
Vision Care						
Eye Examinations	Covered at plan vision providers — one exam per year; at non-plan providers, covered up to $40. Dilation not covered.	Covered at plan vision providers — one exam per year; at non-plan providers, covered up to $40. Dilation not covered.	Covered with a $30 co-pay	Covered; one exam per year. Dilation not covered.	Covered; one exam per year. Dilation not covered.	Covered up to $40; one exam per year. Dilation not covered.
Eyeglasses	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

[1] These plans will coordinate with Medicare. The benefits listed show your costs after Medicare has paid its portion to your physician or hospital.

[3] Coverage described applies to the U-M Premier Care Provider Network 1. Additional providers are available through BCN's statewide network, (Provider Network 2). Network 2 providers are covered with a $2,000 annual deductible for individual, $4,000 annual deductible per family. A Network 1 PCP referral is required to access Network 2 providers.

[8] Hearing aid administration guidelines may differ by plan. Contact plan for specific provisions before commencing treatment.

[9] Includes ordering and fitting of hearing aids.

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PLAN TYPE	MANAGED CARE PLANS			TRADITIONAL PLAN	PREFERRED PROVIDER ORGANIZATION (PPO)	
Plan Name	**GradCare[12]** Only Available to U-M Graduate Students	**U-M Premier Care[1, 3, 12] Provider Network 1**	**Health Alliance Plan HMO[1]**	**Comprehensive Major Medical[1, 4, 11, 12]**	**Blue Cross Blue Shield of Michigan Community Blue PPO In-Network[1, 4, 11, 12]**	**Blue Cross Blue Shield of Michigan Community Blue PPO Out-of-Network[1, 4, 12]**
Nursing Care						
Preauthorization Required	These services must be medically necessary and recommended by your Primary Care Physician or approved by your plan.	These services must be medically necessary and recommended by your Primary Care Physician or approved by your plan.	These services must be medically necessary and recommended by your Primary Care Physician or approved by your plan.	These services must be medically necessary and recommended by the plan physician. Coverage for home health aide services must be provided by a BCBSM-approved agency. Contact BCBSM for specific coverage requirements before these services are provided.	These services must be medically necessary and recommended by the plan physician. Coverage for home health aide services must be provided by a BCBSM approved agency. Contact BCBSM for specific coverage requirements before these services are provided.	Not applicable
Visiting Nurse Home Care	Covered with a $20 co-pay when medically necessary and approved by the plan.	Covered when medically necessary and approved by the plan.	Covered for authorized services.	Partially covered under a BCBSM-approved Home Care Program; no visit limits	Covered	Not covered
Private Duty Nursing	Not covered	Not covered	Not covered	Partially covered with a 50% co-insurance for authorized services	Covered at 50%[11]	Covered at 50%
Home Health Aides	Covered with a $20 co-pay when medically necessary and approved by the plan.	Covered when medically necessary and approved by the plan.	Covered when medically necessary and approved by the plan.	Partially covered under an approved Home Care Program	Covered	Not covered
Other Services						
Hospice Care	Covered when authorized by BCN	Covered when authorized by BCN	Covered, 210 days lifetime	Contact BCBSM for specific coverage levels before these services are provided.	Covered; contact BCBSM for specific coverage levels before these services are provided.	Not covered
Durable Medical Equipment, Prosthetic Appliance	Covered when authorized by BCN	Covered when authorized by BCN	Covered for authorized equipment based on HAP guidelines	Partially covered	Covered when medically necessary	Not covered
Voluntary Sterilization	Covered	Covered	Covered	Covered	Covered	Covered at 50%
Chiropractic Spinal Manipulation	Not covered	Not covered	Not covered	Partially covered; maximum of 38 visits per calendar year	Covered with a $25 co-pay; limited to 24 visits per year	Covered at 50%; limited to 24 visits per year
Reproductive Services	Contact plan	Contact plan	Contact plan	Contact plan	Contact plan	Contact plan

[1] These plans will coordinate with Medicare. The benefits listed show your costs after Medicare has paid its portion to your physician or hospital.

[3] Coverage described applies to the U-M Premier Care Provider Network 1. Additional providers are available through BCN's statewide network, (Provider Network 2). Network 2 providers are covered with a $2,000 annual deductible for individual, $4,000 annual deductible per family. A Network 1 PCP referral is required to access Network 2 providers.

[4] The out-of-pocket maximum does not include non-covered charges, and costs that exceed the plan's fee allowance for a particular service for all plans.

[11] Any expense paid at 50% does not apply to the out-of-pocket maximum for the CMM plan. Private duty nursing expenses do not apply to the out-of-pocket maximum under the BCBSM Community Blue PPO plan.

[12] In Vitro Ferilization – Services can be obtained only at University of Michigan Health System for women through age 42 who have been diagnosed with infertility. Individuals contribute a co-insurance of 20 percent of the cost, and the remainder by the plan up to a $20,000 lifetime maximum. HAP is excluded.