Blue Care Network of Michigan

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

Benefits-at-a-Glance for GradCare 2018

This is intended as an easy-to-read summary. It is not a contract. Refer to the Your Benefits chapter in the Certificate for an official description of benefits. Payment amounts are based on the Blue Care Network (BCN) Approved Amount, less any applicable deductible and/or copay amounts required by your benefit plan. 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. For purposes of the chart below:

"**Level 1**" refers to benefits for services (i) provided by the Member's PCP; or (ii) Referred by the PCP and performed by a Participating Provider.

"**Level 2**" refers to benefits for services provided by any provider outside the GradCare service area to a Member when the Member lives with the Contract Holder outside the GradCare Service Area as part of the Contract Holder's approved off-site academic course of study or other field placement and the Contract Holder has completed a GradCare Out-of-Area Academic Study/Field Placement Registration Form that has been accepted by BCN.

"**Level 3**" refers to benefits for services provided by a Provider outside the GradCare Service Area without a referral from the Member's Primary Care Physician when a Member is traveling temporarily outside the GradCare Service Area (e.g., during a school break.) Member is responsible for any balance billed amounts billed by the Provider that exceed the Approved Amount

Note: Whenever prior authorization is required in connection with a Level 2 or Level 3 service, the Member is responsible for obtaining that authorization.

Member's Responsibility: Deductible, Copays, Coinsurance and Maximums

	Level 1	Level 2 Registered Member	Level 3 Out-of-Network
Deductible Note: Coinsurance and select fixed dollar copays apply once the deductible has been met.	This plan has no deductible.	This plan has no deductible.	This plan has no deductible.
Fixed dollar copays	$25 PCP office visits $30 specialist visits $25 urgent care $100 emergency room services $25 outpatient mental health/substance use visits $1,000 weight reduction procedures	$25 PCP office visits $30 specialist visits $25 urgent care $100 emergency room services $25 outpatient mental health/substance use visits	$25 office visits $30 specialist visits $25 urgent care $100 emergency room services $25 outpatient mental health/substance use visits Member is responsible for any amount billed by the Provider that exceeds the Approved Amount.
Coinsurance	None	None	None
Copayment Maximum- Outpatient Mental Health and Substance Use Office Visits	$700 per member/$1400 per contract per calendar year		
Out of Pocket Maximum Level 1, Level 2 and Level 3 combined – applies to copays, outpatient mental health and substance use copay max and coinsurance amounts for all covered services (excludes prescription drug cost sharing)	$3,000 per member $6,000 per contract per calendar year	$3,000 per member $6,000 per contract per calendar year	$3,000 per member $6,000 per contract per calendar year

Preventive Services

Health Maintenance Exam	Covered – 100%	Covered – 100%	Covered – 100%
Annual Gynecological Exam	Covered – 100%	Covered – 100%	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%	Covered – 100%	Covered – 100%
Well-Baby and Child Care	Covered – 100%	Covered – 100%	Covered – 100%

	Level 1	Level 2 Registered Member	Level 3 Out-of-Network
Immunizations – pediatric and adult	Covered – 100%	Covered – 100%	Covered – 100%
Prostate Specific Antigen (PSA) Screening	Covered – 100%	Covered – 100%	Covered – 100%
Routine Colonoscopy	Covered – 100%	Covered – 100%	Covered – 100%
Mammography Screening	Covered – 100%	Covered – 100%	Covered – 100%
Female Sterilization	Covered – 100%	Covered – 100%	Covered – 100%
Maternity Pre-natal care	Covered – 100%	Covered – 100%	Covered – 100%

Physician Office Services

Office Visits	Covered – $25 copay	Covered – $25 copay	Covered – $25 copay Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.
Consulting Specialist Care – when referred	Covered – $30 copay	Covered – $30 copay	Covered – $30 copay Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered – $100 copay	Covered – $100 copay	Covered – $100 copay
Urgent Care Center	Covered – $25 copay	Covered – $25 copay	Covered – $25 copay
Ambulance Services – medically necessary	Covered – 100%, ground and air services	Covered – 100%, ground and air services	Covered – 100%, ground and air services

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100%	Covered – 100%	Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.
Diagnostic Tests and X-ray	Covered – 100%	Covered – 100%	Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.
Radiation Therapy	Covered – 100%	Covered – 100%	Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – 100%	Covered – 100%	Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.
Delivery and Nursery Care	Covered – 100%	Covered – 100%	Covered – 100%

Hospital Care	Level 1	Level 2 Registered Member	Level 3 Out-of-Network
Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies.	Covered – 100%	Covered – 100% for emergency admission; newborn delivery and nursery care only	Covered – 100% for emergency admission; newborn delivery and nursery care only

Alternatives to Hospital Care

Skilled Nursing Care 45 days per calendar year maximum benefit under Levels 1, 2 and 3 combined	Covered – 100%	Covered – 100%	Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.
Hospice Care	Covered – 100%	Not covered	Not covered
Home Health Care Visits	Covered – $30 copay	Covered – $30 copay	Covered - $30 copay Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.

Surgical Services

Inpatient Surgery – includes all related surgical services and anesthesia	Covered – 100%	Covered – 100% for emergency admissions and newborn delivery and nursery care only. Not covered for non emergent admissions.	Covered – 100% for emergency admissions and newborn delivery and nursery care only. Not covered for non emergent admissions.
Ambulatory Surgery	Covered – 100%	Covered – 100%	Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.
Voluntary Sterilization	Covered – 100% Office visit copay may apply per member per visit	Covered – 100% Office visit copay may apply per member per visit	Office visit copay may apply per member per visit Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.
Human Organ Transplants Subject to medical criteria	Covered – 100%	Covered for emergency admissions only. Not covered for non emergent admissions.	Covered for emergency admissions only. Not covered for non emergent admissions Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.

Mental Health Care and Substance Use Treatment

Inpatient/Residential Mental Health Care and Substance Use Care Requires BCN prior authorization	**Mental Health Care:** Covered – 100% in an approved facility **Substance Use Care:** Covered – 100% in an approved facility **Detoxification** Covered – 100%	**Mental Health Care:** Covered – 100% in an approved facility. No coverage out of area except for emergency admission. **Substance Use Care:** Covered – 100%; No coverage out of area except for emergency admission **Detoxification** Covered – 100%; No coverage out of area except for emergency admission	**Mental Health Care:** Covered – 100% in an approved facility. No coverage out of area except for emergency admission. **Substance Use Care:** Covered – 100% in an approved facility. No coverage out of area except for emergency admission **Detoxification** Covered – 100%; No coverage out of area except for emergency admission

	Level 1	Level 2 Registered Member	Level 3 Out-of-Network
Outpatient Mental Health Care – requires BCN prior authorization	Covered – $25 copay per visit	Covered – $25 copay per visit	Covered - $25 copay per visit
	$700/$1400 annual copay maximum. Level 1, 2 and 3 are combined for outpatient mental health and substance use visits.		
Outpatient Substance Use Care Requires BCN prior authorization	Covered – $25 copay per visit	Covered - $25 copay per visit	Covered - $25 copay per visit
	$700/$1400 annual copay maximum. Level 1, 2 and 3 are combined for outpatient mental health and substance use visits.		

Autism Spectrum Disorders, Diagnosis and Treatment

Applied behavioral analysis (ABA) treatment	Covered – $25 copay per visit	Covered – $25 copay per visit	Covered – $25 copay Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider. **Note**: *ABA services are not available outside of Michigan.*
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18 Physical, speech and occupational therapy for autism spectrum disorder is unlimited.	Covered – $25 copay per visit	Covered – $25 copay per visit	Covered – $25 copay per visit Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit		

Other Services

Allergy Testing and Therapy and Injections	Covered – 100% Office visit copay may apply per member per visit	Covered – 100% Office visit copay may apply per member per visit	Covered – Office visit copay may apply per member per visit Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.
Chiropractic Services	Not covered	Not covered	Not covered
Outpatient Physical, Speech and Occupational Therapy Levels 1, 2 and 3 combined Note: Major and minor diagnoses as defined by Group	Covered – $25 copay per visit Major Diagnoses - limited to 60 visits per medical episode per calendar year Minor Diagnoses – limited to 15 visits per calendar year	Covered – $25 copay per visit Major Diagnoses - limited to 60 visits per medical episode per calendar year Minor Diagnoses – limited to 15 visits per calendar year	Covered – $25 copay per visit Major Diagnoses - limited to 60 visits per per medical episode calendar year Minor Diagnoses – limited to 15 visits per per medical episode calendar year Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.
Cardiac Rehabilitation 36 sessions within a 18 week period maximum benefit under Levels 1, 2 and 3 combined	$25 copay per visit	$25 copay per visit	$25 copay per visit Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.

	Level 1	Level 2 Registered Member	Level 3 Out-of-Network
Pulmonary Rehabilitation 1 program of 12 sessions per condition per year maximum benefit under Levels 1, 2 and 3 combined.	$25 copay per visit	$25 copay per visit	$25 copay per visit Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.
Infertility Assessment	Covered – 100%	Covered – 100%	Covered – $30 office visit copay may apply; diagnostic coverage only - treatment not covered Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.
Infertility – In Vitro fertilization Requires preauthorization based on medical criteria – See Benefit Document	Limited to U of M providers only Covered 80% - 20% coinsurance up to $20,000 lifetime limit	Not Covered	Not Covered
Durable Medical Equipment	Covered – 100%	Covered – 100%	Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.
Prosthetic and Orthotic Appliances Foot orthotics/shoe inserts included	Covered – 100%	Covered – 100%	Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.
Colonoscopy and Sigmoidoscopy Requires a referral	Covered – 100%	Covered – 100%	Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.
Routine Vision Exam	Covered - One routine vision exam per member per calendar year	Covered - Up to $40 One exam per member per calendar year	Covered - Up to $40 One exam per member per calendar year
Hearing Evaluation, Hearing Aid	Hearing aid evaluation, testing and basic binaural hearing aids once every 36 months; office visit copay may apply	Hearing aid evaluation, testing and basic binaural hearing aids once every 36 months; office visit copay may apply	Hearing aid evaluation, testing and basic binaural hearing aids once every 36 months; office visit copay may apply Member may be responsible for the difference between the BCNSC fee schedule and the amount charged by the Provider.
Transgender Surgery	Covered – 100%	Not covered	Not covered
Elective termination of pregnancy first trimester Medical termination in 2nd or 3rd trimester	Covered – 100% Office visit copay may apply per member per visit	Covered – 100% Office visit copay may apply per member per visit	Not covered
Weight Reduction Surgery	Covered - $1,000 copay or 50% whichever is less	Not covered	Not covered
Reconstructive Surgery	Covered – 100%	Not covered	Not covered
Male Mastectomy	Not covered	Not covered	Not covered

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