Blue Care Network of Michigan

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

U of M Premier Care
Benefits-at-a-Glance 2020

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 to covered services. For a complete description of benefits, please see the applicable Blue Care Network Certificates and Riders. Payment amounts are based on the Blue Care Network Approved Amount, less any applicable deductible, coinsurance and copay amounts required by the plan. If there is a discrepancy between this 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 for fully insured plans. **Services must be provided or arranged by member's primary care physician or health plan.**

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

	UM Premier Care Provider Network 1	UM Premier Care Provider Network2 (Requires referral from Provider Network 1)
Deductible Note: Coinsurance and select fixed dollar copays apply once the deductible has been met.	This plan has no deductible.	$2,000 per member $4,000 per contract per year
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	$100 emergency room services $25 urgent care
Coinsurance	20% coinsurance for IVF services	None
Out of Pocket Maximum – combined Network 1 and Network 2 - includes deductible, copays 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

Preventive Services

Health Maintenance Exam	Covered – 100%	Covered – 100%
Annual Gynecological Exam	Covered – 100%	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%	Covered – 100%
Well-Baby and Child Care	Covered – 100%	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%	Covered – 100%
Routine Colonoscopy	Covered – 100%	Covered – 100%
Mammography Screening	Covered – 100%	Covered – 100%
Female Sterilization	Covered – 100%	Covered – 100%
Maternity Pre-Natal Care	Covered – 100%	Covered – 100%

Physician Office Services

PCP Office Visits	Covered – $25 copay	Requires a referral, subject to deductible
Consulting Specialist Care	Covered – $30 copay	Requires a referral, subject to deductible

Emergency Medical Care

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

Diagnostic Services	UM Premier Care Provider Network 1	UM Premier Care Provider Network2 (Requires referral from Provider Network 1)
Laboratory and Pathology Tests	Covered – 100%; Office visit copay may apply per member per visit	Covered – 100%; Office visit copay may apply per member per visit.
Diagnostic Tests and X-rays	Covered – 100%; Office visit copay may apply per member per visit	Requires a referral, subject to deductible
Radiation Therapy	Covered – 100%; Office visit copay may apply per member per visit	Requires a referral, subject to deductible

Maternity Services Provided by a Physician		
Pre-Natal and Post-Natal Care	Covered – 100%	Prenatal - Covered – 100% Postnatal - Requires a referral, subject to deductible
Delivery and Nursery Care	Covered – 100%	Requires a referral, subject to deductible

Hospital Care		
Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 100%; unlimited days	Requires a referral, subject to deductible

Alternatives to Hospital Care		
Skilled Nursing Care Cumulative benefit of 120 days Network 1 & 2	Covered – 100%	Requires a referral, subject to deductible
Hospice Care	Covered – 100%	Requires a referral, subject to deductible
Home Health Care	Covered – 100%	Requires a referral, subject to deductible

Surgical Services		
Surgery – includes all related surgical services and anesthesia	Covered – 100%	Requires a referral, subject to deductible
Voluntary Sterilization	Covered – 100%; Office visit copay may apply	Requires a referral, subject to deductible
Human Organ Transplants: Subject to medical criteria & BCN prior authorization	Covered – 100%	Requires a referral, subject to deductible

Behavioral Health Services		
Inpatient Mental Health Care and Substance Use Disorder When prior authorized by BCN and provided in an approved facility	**Mental Health Care-** Covered – 100%	**Mental Health Care:** Requires a referral, subject to deductible
	Substance Use Disorder -Covered – 100% **Detoxification-**Covered 100%	**Substance Use Disorder**: Requires a referral, subject to deductible **Detoxification** - Requires a referral, subject to deductible
Outpatient Mental Health Care	Covered – $25 copay	Requires a referral, subject to deductible
Outpatient Substance Use Disorder	Covered – $25 copay	Requires a referral, subject to deductible

Autism Spectrum Disorders, Diagnosis and Treatment		
Applied behavioral analyses (ABA) treatment	Covered – $25 copay	Requires a referral, subject to deductible ABA is not covered 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	Requires a referral, subject to deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit	

Other Services	UM Premier Care Provider Network 1	UM Premier Care Provider Network2 (Requires referral from Provider Network 1)
Allergy Testing and Therapy	Covered – 100%; Office visit copay may apply per member per visit; Injections covered 100%	Requires a referral, subject to deductible
Chiropractic Services	Not Covered	Not covered
Outpatient Physical, Speech and Occupational Therapy Cumulative benefit of days Network 1 & 2 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 medical episode per calendar year	Requires a referral, subject to deductible
Cardiac Rehabilitation	Covered in full; up to 36 sessions within an 18 week period per medical episode	Requires a referral, subject to deductible
Pulmonary Rehabilitation	Covered in full; up to 1 program of 12 sessions per year per condition	Requires a referral, subject to deductible
Infertility Assessment	Covered – 100%	Requires a referral, subject to deductible
Infertility – includes in-vitro fertilization and fertility preservation Subject to medical criteria – See Certificate of Coverage	**Limited to U of M providers only** Covered 80% - 20% coinsurance Covered IVF and fertility preservation services are subject to a combined $20,000 lifetime limit	Not covered
Durable Medical Equipment	Covered – 100%	Covered – 100% requires a referral
Prosthetic and Orthotic Appliances	Covered – 100%	Covered – 100% requires a referral
Colonoscopy and Sigmoidoscopy	Covered – 100% requires a referral	Requires a referral, subject to deductible
Routine Vision Exam	Covered – one routine vision exam per year.	Covered – one routine vision exam per year.
Hearing Evaluation, Hearing Aid	Hearing aid evaluation, testing and basic binaural hearing aids, once every 36 months; office visit copay may apply	Requires a referral, subject to deductible
Transgender Services – subject to medical criteria	Covered – 100%	Requires a referral, subject to deductible
	Facial Hair Removal, Facial feminization surgery and Chondrolaryngoplasty are subject to a combined Lifetime Maximum of $30,000 per Member.	
Elective termination of pregnancy first trimester. Medical termination in 2nd or 3rd trimester.	Covered – 100%, office visit copay may apply	Requires a referral, subject to deductible
Weight Reduction Procedures	Covered - $1,000 copay or 50% whichever is less	Not covered
Male Mastectomy for treatment of gynecomastia	Not covered	Not covered
Reconstructive Surgery, subject to medical criteria and BCN prior authorization	Covered – 100%	Requires a referral, subject to deductible
Blue Care Network provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.		

* Services outside of Premier Care Provider Network 1 require a referral from the Premier Care Network 1 Primary Care Physician.

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

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