

# 2022

## HEALTH PLAN PROFILES

PLAN TYPE	MANAGED CARE PLANS			TRADITIONAL PLAN	PPO
	GradCare Only Available to U-M Graduate Students	Michigan Care Administered by Physicians Health Plan (PHP)	U-M Premier Care	Comprehensive Major Medical	Blue Cross Blue Shield of Michigan Community Blue PPO
<b>Address</b>	20500 Civic Center Dr. Southfield, MI 48076	1400 E. Michigan Ave Lansing MI 48912	20500 Civic Center Dr. Southfield, MI 48076	600 Lafayette East Detroit, MI 48226	600 Lafayette East Detroit, MI 48226
<b>Questions?</b>	800-658-8878	833-484-8450	800-658-8878	877-790-2583	877-790-2583
<b>Directory or Contact Information</b>	bcbsm.com or call: 800-658-8878	michiganicare.com or call: 833-484-8450	bcbsm.com or call: 800-658-8878	On the Web at: bcbsm.com or call: 877-790-2583	On the Web at: bcbsm.com or call: 877-790-2583
<b>Type of Plan</b>	Plan for U-M graduate students only	Managed Care Plan	Managed Care Plan	Traditional fee-for-service plan	PPO
<b>Group Number</b>	001243160002	L0002184	001243160001	7005187	7005187
<b>Number of Members</b>	7,200	6,496	70,227	More than 5 million	More than 4 million
<b>Number of PCPs</b>	Network 1 1,827	689	Network 1 1,827	National network. Contact plan for provider information.	National network. Contact plan for provider information.
<b>Number of Specialists</b>	21,502	3,426	21,502	National network. Contact plan for provider information.	National network. Contact plan for provider information.
<b>Number of Hospitals</b>	43	9	43	National network. Contact plan for provider information.	National network. Contact plan for provider information.
<b>Percentage of Board Certified PCPs</b>	91%	90%	91%	National network. Contact plan for provider information.	National network. Contact plan for provider information.
<b>Percentage of Board Certified Specialists</b>	86%	85%	86%	National network. Contact plan for provider information.	National network. Contact plan for provider information.
<b>Policy for Selecting and Changing PCPs or Physicians</b>	GradCare Level 1, contact BCN Customer Service or visit bcbsm.com	Contact PHP Customer service or visit michiganicare.com	Contact BCN Customer Service or visit bcbsm.com	Not applicable	Not applicable
<b>Three Reasons You Should Choose this Plan (Provided by the Plan)</b>	<ol style="list-style-type: none"> <li>1. Excellent medical care for graduate students at a fair and reasonable price.</li> <li>2. Worldwide access to care.</li> <li>3. Access to outstanding provider network, great customer service, money saving programs, and award winning health management programs.</li> </ol>	<ol style="list-style-type: none"> <li>1. Access to well known, highly respected provider network that includes Michigan Medicine, University Health Services and Trinity Health.</li> <li>2. Robust benefits including chiropractic services and expanded telehealth services.</li> <li>3. Lower monthly contributions and uncompromised quality and service.</li> </ol>	<ol style="list-style-type: none"> <li>1. Dedicated customer service line.</li> <li>2. Worldwide access to care.</li> <li>3. Access to outstanding provider network, great customer service, money saving programs, and award winning health management programs.</li> </ol>	<ol style="list-style-type: none"> <li>1. Blue ID card access to all hospitals and doctors nationwide.</li> <li>2. Valuable online resources, including health management programs and member discounts.</li> <li>3. Worldwide access to care.</li> </ol>	<ol style="list-style-type: none"> <li>1. Blue ID card access to all hospitals and doctors nationwide.</li> <li>2. Valuable online resources, including health management programs and member discounts.</li> <li>3. Worldwide access to care.</li> </ol>

# 2022

## 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	Michigan Care <sup>1</sup>	U-M Premier Care <sup>1,3</sup> Provider Network 1	Comprehensive Major Medical <sup>1</sup>	Blue Cross Blue Shield of Michigan Community Blue PPO In-Network <sup>1</sup>	Blue Cross Blue Shield of Michigan Community Blue PPO Out-of-Network <sup>1</sup>
<b>General Information</b>						
<b>Service Area</b>	Only available to GSIs, GSSAs, GSRAs, medical students, and sponsored graduate student groups at the University of Michigan	Most of Washtenaw and Livingston counties, and portions of Jackson, Lenawee, Monroe, Oakland and Wayne counties	Genesee, Livingston, Macomb, Oakland, Washtenaw and Wayne counties; and portions of Ingham, Jackson, Lapeer, Monroe, and St. Clair counties	Nationwide/Worldwide	Nationwide/Worldwide	Not applicable
<b>Residency Requirement</b>	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
<b>Important Information About the Terms Used in This Chart</b>	"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. <sup>2</sup>	"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.	"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. <sup>5</sup>	"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. <sup>5</sup>	"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. <sup>5</sup>
<b>Maximum Annual Out-of-Pocket Amount</b>	Annual out-of-pocket maximum is \$3,000 (individual) and \$6,000 (family). <sup>4</sup>	Annual out-of-pocket maximum is \$3,000 (individual) and \$6,000 (family). <sup>4</sup>	Annual out-of-pocket maximum is \$3,000 (individual) and \$6,000 (family) for Network 1 and 2 providers combined. <sup>4</sup>	Including the annual deductible, the maximum out-of-pocket amount is \$3,000 per individual and \$6,000 per family. <sup>4</sup>	Annual out-of-pocket maximums \$3,000 (individual) and \$6,000 (family). <sup>4</sup>	Out-of-pocket maximum is \$5,000 per individual, \$10,000 per family. <sup>4</sup>
<b>Lifetime Maximum Benefit</b>	\$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined). \$30,000 lifetime maximum benefit across all plans for selected gender affirming services.	\$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined). \$30,000 lifetime maximum benefit across all plans for selected gender affirming services.	\$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined). \$30,000 lifetime maximum benefit across all plans for selected gender affirming services.	\$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined). \$30,000 lifetime maximum benefit across all plans for selected gender affirming services.	\$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined). \$30,000 lifetime maximum benefit across all plans for selected gender affirming services.	\$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined). \$30,000 lifetime maximum benefit across all plans for selected gender affirming services.
<b>Phone Number for Customer Service and Provider Directory</b>	800-658-8878	833-484-8450	800-658-8878	877-790-BLUE	877-790-BLUE	877-790-BLUE
<b>Web Site</b>	bcbsm.com	michiganicare.com	bcbsm.com	bcbsm.com	bcbsm.com	bcbsm.com
<b>Hospital Services—Inpatient</b>						
<b>Preauthorization Required</b>	Prior authorization is required for some services. Contact plan for additional information.	Prior authorization is required for some services. Contact plan for additional information.	Prior authorization is required for some services. Contact plan for additional information.	Prior authorization is required for some services. Contact plan for additional information.	Prior authorization is required for some services. Contact plan for additional information.	No
<b>Hospital Admissions</b>	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%
<b>Days of Care</b>	Unlimited days	Unlimited days	Unlimited days	Unlimited days	Unlimited days	Unlimited days
<b>Room Type</b>	Semi-private room; private room if medically necessary	Semi-private room; private room if medically necessary	Semi-private room; private room 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
<b>Hospital Physician Service</b>	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%
<b>Consultation Between Physicians</b>	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%
<b>Surgery</b>	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.

<sup>1</sup> These plans will coordinate with Medicare. The benefits listed show your costs after Medicare has paid its portion to your physician or hospital.

<sup>2</sup> Coverage described applies to GradCare Level 1. For details on out-of-network services, call BCN.

<sup>3</sup> 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.

<sup>4</sup> 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.

<sup>5</sup> Co-pays may differ for bargained-for groups.

# 2022

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Plan Name	GradCare Only Available to U-M Graduate Students	Michigan Care <sup>1</sup>	U-M Premier Care <sup>1,3</sup> Provider Network 1	Comprehensive Major Medical <sup>1</sup>	Blue Cross Blue Shield of Michigan Community Blue PPO In-Network <sup>1</sup>	Blue Cross Blue Shield of Michigan Community Blue PPO Out-of-Network <sup>1</sup>
<b>Preventive Services</b>						
<b>Routine Physical Exams</b>	Covered <sup>10</sup>	Covered <sup>10</sup>	Covered <sup>10</sup>	Covered <sup>10</sup>	Covered <sup>10</sup>	Not covered
<b>Routine Pediatric Exams</b>	Covered <sup>10</sup>	Covered <sup>10</sup>	Covered <sup>10</sup>	Covered <sup>10</sup>	Covered <sup>10</sup>	Not covered
<b>Pap Smears – Lab and Pathology</b>	Covered <sup>10</sup>	Covered <sup>10</sup>	Covered <sup>10</sup>	Covered <sup>10</sup>	Covered <sup>10</sup>	Not covered
<b>Routine Mammograms</b>	Covered	Covered <sup>10</sup>	Covered	Covered	Covered	Not covered
<b>PSA (Prostate) Test</b>	Covered <sup>10</sup>	Covered <sup>10</sup>	Covered <sup>10</sup>	Covered <sup>10</sup>	Covered <sup>10</sup>	Not covered
<b>Outpatient Services</b>						
<b>Office Visits</b>	Covered with a \$25 co-pay for visits with PCPs and \$30 for visits with specialists	Covered with a \$25 co-pay for visits with PCPs and \$30 for visits with specialists	Covered with a \$25 co-pay for visits with PCPs and \$30 for visits with specialists	Partially covered	Covered with a \$25 co-pay for visits with PCPs and \$30 for visits with specialists	Covered at 50%
<b>Outpatient Physical, Occupational and Speech Therapy</b>	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. <sup>6</sup>	Covered with a \$25 co-pay per visit; limited to 60 visits combined per condition per calendar year	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. <sup>6</sup>	Partially covered for unlimited treatments <sup>6</sup>	Covered with a \$25 co-pay (co-pay applies to professional billed services only); limited to 60 visits per year (facility & professional services combined) <sup>6</sup>	Covered at 50%; limited to 60 visits per year (facility and professional services combined) <sup>6</sup>
<b>Therapeutic Radiology</b>	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%
<b>Diagnostic Lab, X-Ray, EKGs</b>	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%
<b>Outpatient Surgery</b>	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%
<b>Routine Immunizations</b>	Covered <sup>10</sup>	Covered <sup>10</sup>	Covered <sup>10</sup>	Covered <sup>10</sup>	Covered <sup>10</sup>	Not covered
<b>Allergy Testing</b>	Covered with a \$30 co-pay	Covered; a \$30 co-pay may apply	Covered with a \$30 co-pay	Partially covered	Covered; a \$30 co-pay may apply	Covered at 50%
<b>Allergy Injections</b>	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%
<b>Other Injections</b>	\$30 office visit co-pay may apply	Covered, a \$30 co-pay may apply	\$30 office visit co-pay may apply	Partially covered	Covered; a \$30 co-pay may apply	Covered at 50%

<sup>1</sup> These plans will coordinate with Medicare. The benefits listed show your costs after Medicare has paid its portion to your physician or hospital.

<sup>3</sup> 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.

<sup>6</sup> 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.

<sup>10</sup> 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 the plan for the preventive services separately from the office visit.

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<b>Emergency Care</b>						
<b>In Area</b>	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.
<b>Out of Area</b>	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.
<b>Ambulance</b>	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
<b>Mental Health Care</b>						
<b>Preauthorization Required</b>	Prior authorization is required for some services. Contact plan for additional information.	Prior authorization is required for some services. Contact plan for additional information.	Prior authorization is required for some services. Contact plan for additional information.	Prior authorization is required for some services. Contact plan for additional information.	Prior authorization is required for some services. Contact plan for additional information.	No
<b>Inpatient Days of Care</b>	Covered for acute conditions	Covered	Covered for acute conditions	Partially covered	Covered for acute conditions	Covered at 50% for acute conditions
<b>Outpatient Individual Psychiatric Care</b>	Covered with a \$25 co-pay	Covered with a \$25 co-pay	Covered with a \$25 co-pay	Partially covered	Covered with a \$25 co-pay	Covered at 50%
<b>Group Therapy</b>	Covered with a \$25 co-pay	Covered with a \$25 co-pay	Covered with a \$25 co-pay	Partially covered	Covered with a \$25 co-pay	Covered at 50%
<b>Psychological Testing</b>	Covered with a \$25 co-pay	Covered with a \$25 co-pay	Covered with a \$25 co-pay	Partially covered	Covered with a \$25 co-pay	Covered at 50%
<b>Substance Abuse Care</b>						
<b>Preauthorization Required</b>	Prior authorization is required for some services. Contact plan for additional information.	Prior authorization is required for some services. Contact plan for additional information.	Prior authorization is required for some services. Contact plan for additional information.	Prior authorization is required for some services. Contact plan for additional information.	Prior authorization is required for some services. Contact plan for additional information.	No

<sup>1</sup> These plans will coordinate with Medicare. The benefits listed show your costs after Medicare has paid its portion to your physician or hospital.

<sup>3</sup> 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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<b>Substance Abuse Care</b> (continued)						
<b>Inpatient Days of Care</b>	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%
<b>Outpatient Individual Therapy</b>	Covered with a \$25 co-pay per visit	Covered with a \$25 copay	Covered with a \$25 co-pay per visit	Partially covered	Covered with a \$25 co-pay per visit	Covered at 50%
<b>Group Therapy</b>	Covered with a \$25 co-pay per visit	Covered with a \$25 copay	Covered with a \$25 co-pay per visit	Partially covered	Covered with a \$25 co-pay per visit	Covered at 50%
<b>Maternity Care</b>						
<b>Parental Care, Delivery, Postnatal Care</b>	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%
<b>Skilled Nursing Facility</b> (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 Physicians Health Plan	Covered up to 120 days per calendar year when arranged and authorized by BCN	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
<b>Hearing Care</b>						
<b>Examinations</b>	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; once every 36 months	Partially covered; once every 36 months	Covered; once every 36 months	Not covered
<b>Tests</b>	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; once every 36 months	Partially covered; once every 36 months	Covered; once every 36 months	Not covered
<b>Hearing Aids</b>	Covered up to allowed amount; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount. <sup>8,9</sup>	Covered up to allowed amount; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount. <sup>8,9</sup>	Covered up to allowed amount; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount. <sup>8,9</sup>	Partially covered; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount. <sup>8,9</sup>	Covered up to allowed amount; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount. <sup>8,9</sup>	Not covered
<b>Vision Care</b>						
<b>Eye Examinations</b>	Covered at plan vision providers – one exam per year; at non-plan providers, covered up to \$40. Dilation not covered.	Covered at plan 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; 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.
<b>Eyeglasses</b>	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

<sup>1</sup> These plans will coordinate with Medicare. The benefits listed show your costs after Medicare has paid its portion to your physician or hospital.

<sup>3</sup> 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.

<sup>8</sup> Hearing aid administration guidelines may differ by plan. Contact plan for specific provisions before commencing treatment.

<sup>9</sup> Includes ordering and fitting of hearing aids.

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<b>Nursing Care</b>						
<b>Preauthorization Required</b>	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 the 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
<b>Visiting Nurse Home Care</b>	Covered 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 a BCBSM-approved Home Care Program; no visit limits	Covered	Not covered
<b>Private Duty Nursing</b>	Not covered	Not covered	Not covered	Partially covered with a 50% co-insurance for authorized services	Covered at 50% <sup>11</sup>	Covered at 50%
<b>Home Health Aides</b>	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
<b>Other Services</b>						
<b>Hospice Care</b>	Covered when authorized by BCN	Covered when authorized by Physicians Health Plan	Covered when authorized by BCN	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
<b>Durable Medical Equipment, Prosthetic Appliance</b>	Covered when authorized by BCN	Covered when authorized by Physicians Health Plan	Covered when authorized by BCN	Partially covered	Covered when medically necessary	Not covered
<b>Voluntary Sterilization</b>	Covered	Covered	Covered	Covered	Covered	Covered at 50%
<b>Chiropractic Spinal Manipulation</b>	Not covered	Covered with a \$25 copay; limited to 24 visits per year for spinal manipulation	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
<b>Infertility Treatment</b>	In vitro fertilization and fertility preservation services received at Michigan Medicine may be covered if criteria are met with a 20% coinsurance and a lifetime maximum payment of \$20,000. Contact plan for details.	In vitro fertilization and fertility preservation services received at Michigan Medicine may be covered if criteria are met with a 20% coinsurance and a lifetime maximum payment of \$20,000. Contact plan for details.	In vitro fertilization and fertility preservation services received at Michigan Medicine may be covered if criteria are met with a 20% coinsurance and a lifetime maximum payment of \$20,000. Contact plan for details.	In vitro fertilization and fertility preservation services received at Michigan Medicine may be covered if criteria are met with a 20% coinsurance and a lifetime maximum payment of \$20,000. Contact plan for details.	In vitro fertilization and fertility preservation services received at Michigan Medicine may be covered if criteria are met with a 20% coinsurance and a lifetime maximum payment of \$20,000. Contact plan for details.	In vitro fertilization and fertility preservation services received at Michigan Medicine may be covered if criteria are met with a 20% coinsurance and a lifetime maximum payment of \$20,000. Contact plan for details.

<sup>1</sup> These plans will coordinate with Medicare. The benefits listed show your costs after Medicare has paid its portion to your physician or hospital.

<sup>3</sup> 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.

<sup>4</sup> 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.

<sup>11</sup> 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.