2023 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**[1]	**U-M Premier Care**[1,3] **Provider Network 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	Most of Washtenaw and Livingston counties, and portions of Jackson, Lenawee, Monroe, Oakland and Wayne counties	Genessee, Livingston, Macomb, Oakland, Washtenaw and Wayne counties; and portions of Ingham, Jackson, Lapeer, Monroe, and St. Clair 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.	"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% coinsurance up to the annual out-of-pocket maximums, and costs that exceed the BCBSM allowed amount or balance billing when nonparticipating providers are used. Coinsurance 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 allowed amount 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 allowed amount 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).[4]	Annual out-of-pocket maximum is $3,000 (individual) and $6,000 (family).[4]	Annual out-of-pocket maximum is $3,000 (individual) and $6,000 (family) for Network 1 and 2 providers combined.[4]	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 maximum is $3,000 (individual) and $6,000 (family).[4]	Out-of-pocket maximum is $5,000 per individual, $10,000 per family.[4]
Lifetime Maximum Benefit	$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.
Phone Number for Customer Service and Provider Directory	800-658-8878	833-484-8450	800-658-8878	877-790-BLUE	877-790-BLUE	877-790-BLUE
Web Site	bcbsm.com	michigancare.com	bcbsm.com	bcbsm.com	bcbsm.com	bcbsm.com
Hospital Services—Inpatient						
Preauthorization Required	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
Hospital Admissions	Covered	Covered	Covered	Partially covered	Covered	Covered at 50% of BCBS's allowed amount. Visit co-pay may also apply
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; 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
Hospital Physician Service	Covered	Covered	Covered	Partially covered	Covered	Covered at 50% of BCBS's allowed amount. Visit co-pay may also apply
Consultation Between Physicians	Covered	Covered	Covered	Partially covered	Covered	Covered at 50% of BCBS's allowed amount. Visit co-pay may also apply
Surgery	Covered	Covered	Covered	Partially covered	Covered	Covered at 50% of BCBS's allowed amount. Visit co-pay may also apply

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 allowed amount 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[10]	Covered[10]	Covered[10]	Covered[10]	Covered[10]	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 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%[12] of BCBS's allowed amount. Visit co-pay may also apply
Outpatient Physical, Occupational and Speech Therapy	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; limited to 60 visits combined per condition per calendar year	Covered with a $25 co-pay per visit; limited to 60 visits combined per condition per calendar year	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%[12] of BCBS's allowed amount.; limited to 60 visits per year (facility and professional services combined)[6]
Therapeutic Radiology	Covered	Covered	Covered	Partially covered	Covered	Covered at 50% of BCBS's allowed amount. Visit co-pay may also apply
Diagnostic Lab, X-Ray, EKGs	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%[12]
Outpatient Surgery	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%[12]
Routine Immunizations	Covered[10]	Covered[10]	Covered[10]	Covered[10]	Covered[10]	Not covered
Allergy Testing	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%[12]
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%[12]
Other Injections	$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%[12]

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.

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 the plan for the preventive services separately from the office visit.

12 Covered at a percentage of BCBS allowed amount. Member is responsible for 100% of charges in excess of BCBS reimbursement.

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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	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
Inpatient Days of Care	Covered for acute conditions	Covered	Covered for acute conditions	Partially covered	Covered for acute conditions	Covered at 50%[12] for acute conditions
Outpatient Individual Psychiatric Care	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%[12]
Group Therapy	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%[12]
Psychological Testing	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%
Substance Abuse Care						
Preauthorization Required	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
Inpatient Days of Care	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%[12]
Outpatient Individual Therapy	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%[12]
Group Therapy	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%[12]

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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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Maternity Care						
Parental Care, Delivery, Postnatal Care	Covered	Covered	Covered	Partially covered	Covered	Covered at 50%[12]
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 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
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; once every 36 months	Partially covered; once every 36 months	Covered; once every 36 months	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; once every 36 months	Partially covered; once every 36 months	Covered; once every 36 months	Not covered
Hearing Aids	Covered up to allowed amount; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.[8, 9]	Covered up to allowed amount; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.[8, 9]	Covered up to allowed amount; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.[8, 9]	Partially covered; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.[8, 9]	Covered up to allowed amount; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.[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 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
Eyeglasses	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

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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.

12 Covered at a percentage of BCBS allowed amount. Member is responsible for 100% of charges in excess of BCBS reimbursement.

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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 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
Visiting Nurse Home Care	Covered with a $30 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 a BCBSM-approved Home Care Program; no visit limits	Covered	Not covered
Private Duty Nursing	Not covered	Not covered	Not covered	Covered at 70%[12] when medically necessary and approved by the plan	Covered at 70%[12] when medically necessary and approved by the plan.	Covered at 50%[12]
Home Health Aides	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 an approved Home Care Program	Covered	Not covered
Other Services						
Hospice Care	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
Durable Medical Equipment, Prosthetic Appliance	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
Voluntary Sterilization	Covered	Covered	Covered	Covered	Covered	Covered at 50%[12]
Chiropractic Spinal Manipulation	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%[12]; limited to 24 visits per year
Infertility Treatment	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

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4 The out-of-pocket maximum does not include non-covered charges, and costs that exceed the plan's allowed amount 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 Covered at a percentage of BCBS allowed amount. Member is responsible for 100% of charges in excess of BCBS reimbursement..