2026 Health Plan Coverage Comparison Chart

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 plan documents 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. Contact the health plan for detailed information about benefit coverage and medical necessity requirements.

Plan Type	Managed Care (HMO) Plans		Preferred Provider Organization (PPO)		Traditional Plan	Consumer-Directed with Health Savings Account	
Plan Name	**U-M Premier Care Provider Network 1**[2]	**GradCare** Only available to GSIs, GRAs, med students and sponsored grad student groups	**BCBSM Community Blue PPO** In-Network	**BCBSM Community Blue PPO** Out-of-Network	**Comprehensive Major Medical**	**Consumer-Directed Health Plan** In-Network	**Consumer-Directed Health Plan** Out-of-Network
General Information							
Deductible	$0 for Network 1	$0	$0		$500 individual $1,000 family	$1,700 individual $3,400 family[3]	$1,700 individual $3,400 family[3,5]
Annual Out-of-Pocket Maximum	$3,000 individual $6,000 family[4]	$3,000 individual $6,000 family[4]	$3,000 individual $6,000 family (in-network)[4]	$5,000 individual $10,000 family (out-of-network)[4]	$3,000 individual $6,000 family[4]	$5,500 individual $10,600 family[3,4]	$11,000 individual $21,200 family[3,4,5]
Lifetime Maximum Benefit	$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined).	$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined).	$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined).	Not covered	$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined).	$20,000 lifetime maximum benefit across all plans for in vitro fertilization and fertility preservation services (combined).	Not covered
Important Information About the Terms Used in This Chart	Covered means the plan payment amount for covered charges is 100% unless stated otherwise. Copay means a set dollar amount you pay for a covered service.[2,6]	Covered means the plan payment amount for covered charges is 100% unless stated otherwise. Copay means a set dollar amount you pay for a covered service.	Covered means the plan payment amount for covered charges is 100% unless stated otherwise. Copay means the set dollar amount you pay for a covered service.[2,6]	Covered at a percentage of BCBS allowed amount. Member is responsible for 100% of charges in excess of BCBS reimbursement.	Partially covered means you pay a $500/$1,000 deductible, then 20% coinsurance up to the annual out-of-pocket maximums. Coinsurance means a percentage of the BCBS allowed amount you pay for a covered service.	Partially covered means you pay a $1,700/$3,400[3] deductible then 10% coinsurance up to the annual out-of-pocket maximums. Coinsurance means a percentage of the BCBS allowed amount you pay for a covered service.	Partially covered means you pay a $1,700/$3,400[3] deductible then 50% coinsurance up to the annual out-of-pocket maximums. Coinsurance means a percentage of the BCBS allowed amount you pay for a covered service.
Preauthorization Required	Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.	Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.	Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.		Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.	Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.	
Preventive Services[7,8]							
Routine Physical Exams	Covered	Covered	Covered	Not covered	Covered	Covered	Not covered
Routine Pediatric Exams	Covered	Covered	Covered	Not covered	Covered	Covered	Not covered
Routine Immunizations	Covered	Covered	Covered	Not covered	Covered	Covered	Not covered
Cervical Cancer Screen	Covered	Covered	Covered	Not covered	Covered	Covered	Not covered
Breast Cancer Screen	Covered	Covered	Covered	Not covered	Covered	Covered	Not covered
Prostate Cancer Screen	Covered	Covered	Covered	Not covered	Covered	Covered	Not covered

2 Coverage described applies to the U-M Premier Care Provider Network 1. Network 2 providers (BCN statewide network) are covered with a $2,000-individual $4,000-family annual deductible. A Network 1 PCP referral is required to access Network 2 providers.
3 Deductible and out-of-pocket is medical and pharmacy combined.
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 In-network and out-of-network services accumulate separately toward the associated deductible and out-of-pocket maximum.
6 Copays may differ for individuals represented by a union.
7 Preventive Services as recommended under the Affordable Care Act.
8 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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			In-Network	**Out-of-Network**		**In-Network**	**Out-of-Network**
Hospital Services — Inpatient							
Hospital Admissions	Covered	Covered	Covered	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Days of Care	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 if medically necessary	Semi-private room; private room if medically necessary	
Hospital Physician Service	Covered	Covered	Covered	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Consultation Between Physicians	Covered	Covered	Covered	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Surgery	Covered	Covered	Covered	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Outpatient Services							
Office Visits	$25 copay for PCP $30 copay for specialist	$25 copay for PCP $30 copay for specialist	$25 copay for PCP $30 copay for specialist	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Outpatient Physical, Occupational and Speech Therapy[9]	$25 copay per visit; limited to a combined 60 visits per condition per year	$25 copay per visit; limited to a combined 60 visits per condition per year	$25 copay per visit; limited to a combined 60 visits per year	Covered at 50% ; limited to a combined 60 visits per year	20% coinsurance after deductible; unlimited visits	10% coinsurance after deductible; limited to a combined 60 visits per year	50% coinsurance after deductible; limited to a combined 60 visits per year
Applied Behavioral Analysis for ASD	$25 copay per visit	$25 copay per visit	$25 copay per visit	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Therapeutic Radiology	Covered	Covered	Covered	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Diagnostic Lab, X-Ray, EKGs	Covered	Covered	Covered	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Outpatient Surgery	Covered	Covered	Covered	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Allergy Testing	$30 copay	$30 copay	$30 copay	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Injections[10]	Covered	Covered	Covered	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible

2 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 individual, $4,000 annual deductible per family. A Network 1 PCP referral is required to access Network 2 providers.
9 Physical, occupational, and speech therapies are covered for acute conditions and may be subject to plan prior authorization/medical necessity. Administrative guidelines and interpretations may vary among plans. Contact plan for specific coverage provisions before commencing treatment.
10 Provider may charge office visit when receiving an injection.

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			In-Network	**Out-of-Network**		**In-Network**	**Out-of-Network**
Emergency Care							
Ambulance	Covered for emergencies when medically necessary	Covered for emergencies when medically necessary	Covered for emergencies when medically necessary		20% coinsurance after deductible when medically necessary.	10% coinsurance after deductible when medically necessary	
Emergency Department	$100 copay copay waived if admitted	$100 copay copay waived if admitted	$100 copay copay waived if admitted		20% coinsurance after deductible	10% coinsurance after deductible	
Observation Stay	$100 ER copay. All services provided while in observation are covered at the outpatient benefit level	$100 ER copay. All services provided while in observation are covered at the outpatient benefit level	$100 ER copay. All services provided while in observation are covered at the outpatient benefit level		20% coinsurance after deductible. All services provided while in observation are covered at the outpatient benefit level	10% coinsurance after deductible. All services provided while in observation are covered at the outpatient benefit level	Emergency room coinsurance applies. All services provided while in observation are covered at the outpatient benefit level, 50% coinsurance after deductible.
Mental Health Care							
Inpatient Days of Care	Covered	Covered	Covered	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Outpatient Individual Therapy	$25 copay	$25 copay	$25 copay	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Group Therapy	$25 copay	$25 copay	$25 copay	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Psychological Testing	$25 copay	$25 copay	$25 copay	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Substance Use Care							
Inpatient Days of Care	Covered	Covered	Covered	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Outpatient Individual Therapy	$25 copay	$25 copay	$25 copay	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Group Therapy	$25 copay	$25 copay	$25 copay	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible

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			In-Network	**Out-of-Network**		**In-Network**	**Out-of-Network**
Maternity Care							
Prenatal and Postnatal Care[11]	Covered	Covered	Covered	Covered at 50%	Covered	Covered	50% coinsurance after deductible
Delivery	Covered	Covered	Covered	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
Skilled Nursing Facility							
Non-Custodial Care	Covered up to 120 days per calendar year	Covered up to 120 days per calendar year	Covered up to 120 days per calendar year		20% coinsurance after deductible. Up to 120 days per calendar year	10% coinsurance after deductible. Up to 120 days per calendar year	
Hearing Services[12]							
Examinations	$30 copay; once every 36 months	$30 copay; once every 36 months	Covered; once every 36 months	Not covered	20% coinsurance after deductible; once every 36 months	10% coinsurance after deductible; once every 36 months	Not covered
Tests	$30 copay; once every 36 months	$30 copay; once every 36 months	Covered; once every 36 months	Not covered	20% coinsurance after deductible; once every 36 months	10% coinsurance after deductible; once every 36 months	Not covered
Hearing Aids[13]	Covered up to allowed amount; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.	Covered up to allowed amount; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.	Covered up to allowed amount; monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.	Not covered	20% coinsurance after deductible. Monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.	10% coinsurance after deductible. Monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.	Not covered
Vision Care							
Eye Examinations	Covered. One exam per year. Out-of-network providers covered up to $40. Dilation not covered	Covered. One exam per year. Out-of-network providers covered up to $40. Dilation not covered	Covered; one exam per year. Dilation not covered	Covered up to $40; one exam per year. Dilation not covered.	20% coinsurance after deductible; one exam per year. Dilation not covered	10% coinsurance after deductible; one exam per year. Dilation not covered	50% coinsurance after deductible 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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11 When billed as a preventive visit.
12 Hearing aid administration guidelines may differ by plan. Contact plan for specific provisions before commencing treatment.
13 Includes ordering and fitting of hearing aids.

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Home Health Services							
Home Health Care	Covered	$30 copay	Covered	Covered	20% coinsurance after deductible	10% coinsurance after deductible	
Private Duty Nursing	Not covered	Not covered	30% coinsurance	Covered at 50%	30% coinsurance after deductible	10% coinsurance after deductible.	50% coinsurance after deductible
Other Services							
Hospice Care	Covered	Covered	Covered	Covered	Covered	10% coinsurance after deductible	
Durable Medical Equipment, Orthotics, Prosthetic Appliance	Covered when authorized by the plan	Covered when authorized by the plan	Covered when medically necessary	Not covered	20% coinsurance after deductible	10% coinsurance after deductible	
Voluntary Sterilization	Covered	Covered	Covered	Covered at 50%	Covered after deductible	Covered after deductible	50% coinsurance after deductible
Chiropractic Spinal Manipulation	$25 copay limited to 24 visits per year	Not covered	$25 copay limited to 24 visits per year	Covered at 50%; limited to 24 visits per year	20% coinsurance after deductible, limited to 38 visits per calendar year	10% coinsurance after deductible, limited to 24 visits per year	50% coinsurance after deductible, limited to 24 visits per year
Gender Affirming Services	$30 copay	$30 copay	$30 copay	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible	50% coinsurance after deductible
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 across all U-M health plans. 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 across all U-M health plans. 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 across all U-M health plans. Contact plan for details	Not covered[14]	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 across all U-M health plans. Contact plan for details[14]	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 across all U-M health plans. Contact plan for details	Not covered[14]

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14 Contact the health plan if you live outside of Michigan.