Blue Care Network of Michigan

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Benefits-at-a-Glance for GradCare January 2021

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.**

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	20% for IVF	None	None
Copayment Maximum- Outpatient Mental Health and Substance Use Office Visits	$500 per member/$1,000 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%

Preventive Services Cont.	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 BCN 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 BCN 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 BCN 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 BCN fee schedule and the amount charged by the Provider.
Radiation Therapy	Covered – 100%	Covered – 100%	Member may be responsible for the difference between the BCN 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 BCN fee schedule and the amount charged by the Provider.
Delivery and Nursery Care	Covered – 100%	Covered – 100%	Covered – 100%

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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 BCN 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 BCN 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 BCN 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 BCN 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 BCN fee schedule and the amount charged by the Provider.

Behavioral Health Services

Inpatient Mental Health Care and Substance Use Disorder Requires BCN prior authorization	**Mental Health Care:** Covered – 100% in an approved facility **Substance Use Disorder:** 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 Disorder:** 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 Disorder:** 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

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	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
	$500/$1000 annual copay maximum. Level 1, 2 and 3 are combined for outpatient mental health and substance use visits.		
Outpatient Substance Use Disorder Requires BCN prior authorization	Covered – $25 copay per visit	Covered - $25 copay per visit	Covered - $25 copay per visit
	$500/$1000 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 BCN 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. Includes coverage for gender affirming voice and communication speech therapy.	Covered – $25 copay per visit	Covered – $25 copay per visit	Covered – $25 copay per visit Member may be responsible for the difference between the BCN 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 BCN 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 medical episode 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 medical episode per calendar year	Covered – $25 copay per visit Major Diagnoses - limited to 60 visits per per medical episode per calendar year Minor Diagnoses – limited to 15 visits per per medical episode per calendar year Member may be responsible for the difference between the BCN 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 BCN 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 BCN 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 BCN fee schedule and the amount charged by the Provider.
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 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 BCN fee schedule and the amount charged by the Provider.
	Diabetes prevention program to reduce the risk of developing Type 2 diabetes is covered in full.		Not Covered
Prosthetic and Orthotic Appliances Foot orthotics/shoe inserts included	Covered – 100%	Covered – 100%	Member may be responsible for the difference between the BCN 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 BCN 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
Transgender Services – subject to medical criteria	Covered – 100% Facial Hair Removal, Facial feminization surgery and Chondrolaryngoplasty are subject to a combined Lifetime Maximum of $30,000 per Member.	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 for gynecomastia	Not covered	Not covered	Not covered

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	Value Based and Standard Hearing Network	Out of State BlueCard and non-contracted Audiology providers	Out of State BlueCard and non-contracted Audiology providers
Hearing Evaluation, Hearing Aid, Custom Ear Molds	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 BCN fee schedule and the amount charged by the Provider.	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 BCN fee schedule and the amount charged by the Provider.	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 BCN fee schedule and the amount charged by the Provider.
	Custom ear molds for children under the age of 18 are covered according to the following schedule: • Under 3 years of age: 4X every 12 months per hearing aid • Age 3 up to 13 years of age: 2X every 12 months per hearing aid • Age 13 up to 18 years of age: 1X every 12 months per hearing aid		

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

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.

UMGR21F, DPP