2024 Health Plan Coverage Comparison Chart

Plan Type	Managed Care Plans			Preferred Provider Organization (PPO)		Traditional Plan	Consumer-Directed with Health Savings Account
Plan Name	**Michigan Care**	**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**		**Comprehensive Major Medical**	**BCBSM Consumer-Directed Health Plan**
				In-Network	**Out-of-Network**		
General Information							
Deductible	$0	$0 for Network 1	$0	$0		$500 individual $1,000 family	$1,600 individual $3,200 family[3]
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[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 $9,450 family (in-network)[3,4] $11,000 individual $18,900 family (out-ofnetwork)[3,4]
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).	$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).
Important Information About the Terms Used in This Chart	"Covered" means the plan payment amount for covered charges is 100% unless stated otherwise. Co-pay means a set dollar amount you pay for a covered service.[5]	"Covered" means the plan payment amount for covered charges is 100% unless stated otherwise. Co-pay means a set dollar amount you pay for a covered service.[2,5]	"Covered" means the plan payment amount for covered charges is 100% unless stated otherwise. Co-pay means a set dollar amount you pay for a covered service.[1]	"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]		"Partially covered" means you pay a $500/$1,000 deductible, then 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.	"Partially covered" means you pay a $1,600/$3,200[3] deductible then 10% 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.
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.	Prior authorization is required for some services. These services must be medically necessary. Contact the health plan for additional information.
Preventive Services							
Routine Physical Exams	Covered[10]	Covered[10]	Covered[10]	Covered[10]	Not covered	Covered[10]	Covered[10]
Routine Pediatric Exams	Covered[10]	Covered[10]	Covered[10]	Covered[10]	Not covered	Covered[10]	Covered[10]
Routine Immunizations	Covered[10]	Covered[10]	Covered[10]	Covered[10]	Not covered	Covered[10]	Covered[10]
Pap Smears — Lab and Pathology	Covered[10]	Covered[10]	Covered[10]	Covered[10]	Not covered	Covered[10]	Covered[10]
Routine Mammograms	Covered[10]	Covered[10]	Covered[10]	Covered[10]	Not covered	Covered[10]	Covered[10]
PSA (Prostate) Test	Covered[10]	Covered[10]	Covered[10]	Covered[10]	Not covered	Covered[10]	Covered[10]

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. Coverage described applies to GradCare Level 1. For details on out- of-network services, call BCN.
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 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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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. Co-pays may differ for bargained-for groups.
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.

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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	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	20% coinsurance after deductible	10% coinsurance after deductible
Outpatient Physical, Occupational and Speech Therapy	Covered with a $25 co-pay per visit; limited to 60 visits combined per condition per calendar year[6]	Covered with a $25 co-pay per visit; limited to 60 visits combined per condition per calendar year[6]	Covered with a $25 co-pay per visit; limited to 60 visits combined per condition per calendar year[6]	Covered with a $25 co-pay; limited to 60 visits per year combined (facility and professional services combined)[6]	Covered at 50%[12] of BCBS's allowed amount.; limited to 60 visits per year combined (facility and professional services combined)[6]	20% coinsurance after deductible, unlimited treatment[6]	10% coinsurance after deductible; limited to 60 visits per year combined (facility & professional services combined)[6]
Hospital Services — Inpatient							
Hospital Admissions	Covered	Covered	Covered	Covered	Covered at 50% of BCBS's allowed amount. Visit co-pay may also apply	20% coinsurance after deductible	10% coinsurance after deductible
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 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	Covered at 50% of BCBS's allowed amount. Visit co-pay may also apply	20% coinsurance after deductible	10% coinsurance after deductible
Consultation Between Physicians	Covered	Covered	Covered	Covered	Covered at 50% of BCBS's allowed amount. Visit co-pay may also apply	20% coinsurance after deductible	10% coinsurance after deductible
Surgery	Covered	Covered	Covered	Covered	Covered at 50% of BCBS's allowed amount. Visit co-pay may also apply	20% coinsurance after deductible	10% coinsurance after deductible
Therapeutic Radiology	Covered	Covered	Covered	Covered	Covered at 50%[12] of BCBS's allowed amount. Visit co-pay may also apply	20% coinsurance after deductible	10% coinsurance after deductible
Diagnostic Lab, X-Ray, EKGs	Covered	Covered	Covered	Covered	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Outpatient Surgery	Covered	Covered	Covered	Covered	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Allergy Testing	Covered; a $30 co-pay may apply	Covered with a $30 co-pay	Covered with a $30 co-pay	Covered; a $30 co-pay may apply	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Allergy Injections	Covered; a $30 co-pay may apply	Covered; a $30 co-pay may apply	Covered; a $30 co-pay may apply	Covered; a $30 co-pay may apply	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Other Injections	Covered, a $30 co-pay may apply	$30 office visit co-pay may apply	$30 office visit co-pay may apply	Covered; a $30 co-pay may apply	Covered at 50%[12]	20% coinsurance after deductible	10% 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 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 may be subject to plan prior authorization. Administrative guidelines and interpretations may vary among plans. Contact plan for specific coverage provisions before commencing treatment.
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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				In-Network	**Out-of-Network**		
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.	Covered for accidental or acute medical emergency. Outpatient hospital treatment covered with a $100 co-pay; co-pay waived if patient admitted.		20% coinsurance after deductible for accidental or acute medical emergency.	10% coinsurance after deductible for accidental or acute medical emergency.
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.	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.		20% coinsurance after deductible for accidental or acute medical emergency.	10% coinsurance after deductible for accidental or acute medical emergency.
Ambulance	Covered for emergencies when medically necessary	Covered for emergencies when medically necessary	Covered for emergencies when medically necessary	Covered for emergency transportation when medically necessary		20% coinsurance after deductibled. For transfer to or from hospital; includes ground and air when medically necessary.	10% coinsurance after deductible. For transfer to or from hospital; includes ground and air when medically necessary.
Mental Health Care							
Inpatient Days of Care	Covered	Covered for acute conditions	Covered for acute conditions	Covered for acute conditions	Covered at 50%[12] for acute conditions	20% coinsurance after deductible for acute conditions	10% coinsurance after deductible 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	Covered with a $25 co-pay	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Group Therapy	Covered with a $25 co-pay	Covered with a $25 co-pay	Covered with a $25 co-pay	Covered with a $25 co-pay	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Psychological Testing	Covered with a $25 co-pay	Covered with a $25 co-pay	Covered with a $25 co-pay	Covered with a $25 co-pay	Covered at 50%	20% coinsurance after deductible	10% coinsurance after deductible
Substance Use Care							
Inpatient Days of Care	Covered	Covered	Covered	Covered	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Outpatient Individual Therapy	Covered with a $25 copay	Covered with a $25 co-pay per visit	Covered with a $25 co-pay per visit	Covered with a $25 co-pay per visit	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Group Therapy	Covered with a $25 copay	Covered with a $25 co-pay per visit	Covered with a $25 co-pay per visit	Covered with a $25 co-pay per visit	Covered at 50%[12]	20% coinsurance after deductible	10% 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 annual deductible for individual, $4,000 annual deductible per family. A Network 1 PCP referral is required to access Network 2 providers.
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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				In-Network	**Out-of-Network**		
Maternity Care							
Parental Care, Delivery, Postnatal Care	Covered	Covered	Covered	Covered	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Skilled Nursing Facility							
(Non-Custodial Care)	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	Covered up to 45 days per calendar year if preauthorized by BCN	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
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	Covered; once every 36 months	Not covered	20% coinsurance after deductible; once every 36 months	10% coinsurance after deductible; once every 36 months
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	Covered; once every 36 months	Not covered	20% coinsurance after deductible; once every 36 months	10% coinsurance after deductible; once every 36 months
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]	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	20% coinsurance after deductible. Monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.[8, 9]	10% coinsurance after deductible. Monaural or binaural hearing aid every 36 months. Member may be balance billed for amounts above allowed amount.[8, 9]
Vision Care							
Eye Examinations	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 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 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
Eyeglasses	Not covered	Not covered	Not covered	Not Covered		Not covered	Not covered

2. Coverage described applies to the U-M Premier Care Provider Network. 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.
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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				BCBSM Community Blue PPO			
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Nursing Care							
Visiting Nurse Home Care	Covered	Covered	Covered with a $30 co-pay when medically necessary and approved by the plan.	Covered	Not covered	20% coinsurance after deductible	10% coinsurance after deductible
Private Duty Nursing	Not covered	Not covered	Not covered	30% coinsurance[12]	50% coinsurance[12]	30% coinsurance[12]	30% coinsurance[12]
Home Health Aides	Covered	Covered	Covered	Covered	Not covered	20% coinsurance after deductible	10% coinsurance after deductible
Other Services							
Hospice Care	Covered when authorized by Physicians Health Plan	Covered when authorized by BCN	Covered when authorized by BCN	Covered; contact BCBSM for specific coverage levels before these services are provided	Not covered	Contact BCBSM for specific coverage levels before these services are provided	10% coinsurance after deductible
Durable Medical Equipment, Prosthetic Appliance	Covered when authorized by Physicians Health Plan	Covered when authorized by BCN	Covered when authorized by BCN	Covered when medically necessary	Not covered	20% coinsurance after deductible	10% coinsurance after deductible
Voluntary Sterilization	Covered	Covered	Covered	Covered	Covered at 50%[12]	20% coinsurance after deductible	10% coinsurance after deductible
Chiropractic Spinal Manipulation	Covered with a $25 copay; limited to 24 visits per year for spinal manipulation	Not covered	Not covered	Covered with a $25 co-pay limited to 24 visits per year	Covered at 50%[12] 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
Gender Affirming Procedures	Covered. Subject to medical criteria	Covered. Subject to medical criteria		Covered. Subject to medical criteria	50% coinsurance	20% coinsurance after deductible. Subject to medical criteria	10% coinsurance after deductible. Subject to medical criteri
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 UM 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 UM 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 UM 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 UM 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 UM 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 UM health plans. Contact plan for details

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