Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Benefits-at-a-Glance
U of M GradCare
00124316
Effective Date: 01/01/2026

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. **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.

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

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	Level 1	Level 2 Registered Member	Level 3 Out Of Network
Deductible	None	None	None
Fixed Dollar Copays	$25 for PCP office visits $30 for specialist visits	$25 for PCP office visits $30 for specialist visits	$25 for office visits $30 specialist visits
Fixed Dollar Copays: Medical Online Visits	$25 for online visits with the BCN approved online vendor $25 for urgent care visits $100 for emergency room visits $25 for outpatient physical, speech and occupational therapy visits $1,000 for weight reduction procedures	$25 for online visits with the BCN approved online vendor $25 for urgent care visits $100 for emergency room visits $25 for outpatient physical, speech and occupational therapy visits	$25 for online visits with the BCN approved online vendor $25 for urgent care visits $100 for emergency room visits $25 for outpatient physical, speech and occupational therapy visits
Coinsurance	20% for infertility treatment	None	None
Maximums	$450 per member/$900 per family per calendar year for outpatient mental health and substance use office visits $500 per member/$1,000 per family per calendar year for physical therapy visits $20,000 lifetime maximum for infertility treatment per contract		

Annual Out of Pocket Maximum	$3,000 per member/$6,000 per family per calendar year	$3,000 per member/$6,000 per family per calendar year	$3,000 per member/$6,000 per family per calendar year
Out of Pocket Maximum Note	Level 1, Level 2, and Level 3 are combined. Applies to copays, outpatient mental health and substance use disorder copay max, and coinsurance amounts for all covered services. Excludes prescription drug cost sharing.		

Preventive services

Benefits	Level 1	Level 2 Registered Member	Level 3 Out Of Network
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 Well-Child Visits	Covered 100%	Covered 100%	Covered 100%
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%
Voluntary Sterilization of Female Reproductive Organs	Covered 100%	Covered 100%	Covered 100%

Physician office services

Benefits	Level 1	Level 2 Registered Member	Level 3 Out Of Network
PCP Office Visits	$25 copay	$25 copay	$25 copay Member may be responsible for the difference between the BCN fee schedule and the amount changed by the Provider.
Medical Online Visits Note: Online visits by a non-BCN selected vendor are not covered. Not all services delivered virtually are considered an online visit, but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	$25 copay for PCP visits $30 copay for Specialist visits $25 copay for online visits with the BCN approved online vendor	$25 copay for PCP visits $30 copay for Specialist visits $25 copay for online visits with the BCN approved online vendor	$25 copay for PCP visits $30 copay for Specialist visits $25 copay for online visits with the BCN approved online vendor
Specialist Visits - when referred	$30 copay	$30 copay	$30 copay Member may be responsible for the difference between the BCN fee schedule and the amount changed by the Provider.

Emergency medical care

Benefits	Level 1	Level 2 Registered Member	Level 3 Out Of Network
Hospital Emergency Room - copay waived if admitted as inpatient	$100 copay	$100 copay	$100 copay
Urgent Care Center	$25 copay	$25 copay	$25 copay
Ambulance Services - medically necessary	Covered 100%	Covered 100%	Covered 100%

Diagnostic services

Benefits	Level 1	Level 2 Registered Member	Level 3 Out Of Network
Laboratory and Pathology Tests	Covered 100%	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-rays	Covered 100%	Covered 100%	Covered 100%; Member may be responsible for the difference between the BCN fee schedule and the amount charged by the Provider.
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	Covered 100%	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%	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

Benefits	Level 1	Level 2 Registered Member	Level 3 Out Of Network
Prenatal Care Visits	Covered 100%	Covered 100%	Covered 100%; Member may be responsible for the difference between the BCN fee schedule and the amount charged by the Provider.
Postnatal Care Visits	Covered 100%	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%

Hospital care

Benefits	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

Benefits	Level 1	Level 2 Registered Member	Level 3 Out Of Network
Skilled Nursing Care	Covered 100%	Covered 100%	Covered 100% Member may be responsible for the difference between the BCN fee schedule and the amount charged by the Provider.
Skilled Nursing Limits	Limited to 45 days per calendar year for levels 1, 2, and 3 combined		
Hospice Care	Covered 100% - Note: There is a 5th level of 45 days per lifetime that requires preauthorization.	Not covered	Not covered
Home Health Care Visits	$30 copay	$30 copay	$30 copay Member may be responsible for the difference between the BCN fee schedule and the amount charged by the Provider.

Surgical services

Benefits	Level 1	Level 2 Registered Member	Level 3 Out Of Network
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.
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	Covered 100%	Covered 100%	Member may be responsible for the difference between the BCN fee schedule and the amount charged by the Provider.
Elective Abortion	$30 copay - Limited to one procedure per two-year period of membership. **Note:** Abortions are not covered if rendered in a location where abortion is not legal.	$30 copay - Limited to one procedure per two-year period of membership. **Note:** Abortions are not covered if rendered in a location where abortion is not legal.	$30 copay - Limited to one procedure per two-year period of membership. **Note:** Abortions are not covered if rendered in a location where abortion is not legal.
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.
Weight Reduction Surgery (subject to medical criteria) limited to one procedure per lifetime	$1,000 copay or 50% coinsurance, whichever is less	Not covered	Not covered
Reconstructive Surgery (subject to medical criteria)	Covered 100%	Covered 100% for emergency admission only	Covered 100% for emergency admission only;

			Member may be responsible for the difference between the BCN fee schedule and the amount charged by the Provider.
Gender reassignment and gender affirming procedures Subject to medical criteria	Covered 100%	Not covered	Not covered

Behavioral health services (mental health and substance use disorder treatment)

Benefits	Level 1	Level 2 Registered Member	Level 3 Out Of Network
Inpatient Mental Health Care and Substance Use Disorder	**Mental Health Care:** Covered 100% **Substance Use Disorder:** 100% **Detoxification:** 100%	**Mental Health Care:** Covered 100% in an approved facility. No coverage out of area except for emergency admission. **Substance Use Disorder:** 100%; No coverage out of area except for emergency admission **Detoxification:** 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:** 100% in an approved facility. No coverage out of area except for emergency admission **Detoxification:** 100%; No coverage out of area except for emergency admission
Outpatient Mental Health Care - includes online visits by a BCN participating provider or approved online visit vendor **Note:** Online visits by a non-BCN selected vendor are not covered.	$25 copay	$25 copay	$25 copay
Outpatient Mental Health and Substance Use Disorder Limits	$450 per member/$900 per family per calendar year annual copay maximum. Level 1, 2 and 3 are combined for outpatient mental health and substance use disorder visits.		

Autism spectrum disorders, diagnoses and treatment

Benefits	Level 1	Level 2 Registered Member	Level 3 Out Of Network
Applied behavioral analysis (ABA) treatment **Note:** Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC)	$25 copay	$25 copay	$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, and nutritional counseling for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis is unlimited.	$25 copay	$25 copay	$25 copay 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

Benefits	Level 1	Level 2 Registered Member	Level 3 Out Of Network
Allergy Testing, Therapy, and Injections	Covered 100%	Covered 100%	Covered 100% 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 - subject to improvement within 60 days	$25 copay	$25 copay	$25 copay Member may be responsible for the difference between the BCN fee schedule and the amount charged by the Provider.
Outpatient Physical, Speech and Occupational Therapy Limits	Limited to 60 visits per medical episode per calendar year for any combination of therapies. Levels 1, 2, and 3 are combined. Includes coverage for gender affirming voice and communication speech therapy. $500 per member/$1,000 per family per calendar year annual copay maximum for physical therapy visits. Level 1, 2 and 3 visits are combined.		
Outpatient Cardiac and Pulmonary Rehabilitation	$25 copay	$25 copay	$25 copay Member may be responsible for the difference between the BCN fee schedule and the amount charged by the Provider.
Outpatient Cardiac and Pulmonary Rehabilitation Limit	Cardiac rehabilitation is limited to 36 sessions within an 18 week period per medical episode. Levels 1, 2, and 3 combined. Pulmonary Rehabilitation is limited to 1 program of 12 sessions per condition per year. Levels 1, 2, and 3 combined.		
Treatment of Infertility - IVF and fertility preservation services **Note:** Covered treatment procedures are payable only when rendered by the UMHS Center for Reproductive Medicine.	Covered 80% Limited to a $20,000 lifetime max per contract	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.
Diabetic Supplies	Covered 100% Continuous Glucose Monitors are covered only under your pharmacy benefit through Prime Therapeutics	Covered 100% Continuous Glucose Monitors are covered only under your pharmacy benefit through Prime Therapeutics	Not covered
Prosthetic and Orthotic Appliances - includes coverage for foot orthotics and shoe inserts. See certificate for exclusions.	Covered 100%	Covered 100%	Member may be responsible for the difference between the BCN fee schedule and the amount charged by the Provider.

Routine Eye Exam **Note:** Dilation is not covered	Covered 100% One routine vision exam per member per calendar year	Covered up to $40; One routine vision exam per member per calendar year	Covered up to $40; One routine vision exam per member per calendar year
Hearing Evaluation, Hearing Aid	Value Based and Standard Hearing Network - 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.	Out of State BlueCard and non-contracted Audiology providers - 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.	Out of State BlueCard and non-contracted Audiology providers - 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	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		

For Internal Purposes Only
Benefits Selected - UMG26F : DPP,HGC24F,TRVSF