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 Premier Care
00124316
Effective Date: 01/01/2026

This is intended as an easy-to-read summary. **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.**

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 **https://bcbsm.com/priorauth**.

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	Premier Care Provider Network 1	Premier Care Provider Network 2
Deductible **Note:** Coinsurance and select fixed dollar copays apply once the deductible has been met.	None	$2,000 per member/$4,000 per family per calendar year
Flat-dollar Copays	$25 for PCP office visits including online visits $30 for specialist visits including online visits $25 copay for online visits with the BCN approved online vendor $25 for urgent care visits $25 for outpatient behavioral health visits and outpatient physical, speech and occupational therapy $100 for emergency room services $1,000 for weight reduction procedures	$25 for urgent care visits $100 for emergency room services
Coinsurance	20% for infertility treatment	None
Annual Out-of-Pocket Maximum - Includes deductible, copays, and coinsurance amounts for all covered services. Excludes prescription drug cost sharing. Network 1 and Network 2 are combined.	$3,000 per member/ $6,000 per family per calendar year	$3,000 per member/ $6,000 per family per calendar year
Lifetime Dollar Maximums	$20,000 for infertility treatment per contract	

Preventive services

Benefits	Premier Care Provider Network 1	Premier Care Provider Network 2
Health Maintenance Exam	Covered 100%	Covered 100%
Annual Gynecological Exam	Covered 100%	Covered 100%
Pap Smear Screening	Covered 100%	Covered 100%
Voluntary Sterilization of Female Reproductive Organs	Covered 100%	Covered 100%
Well-Baby and Well-Child Visits	Covered 100%	Covered 100%
Immunizations- pediatric and adult	Covered 100%	Covered 100%
Prostate Specific Antigen (PSA) Screening	Covered 100%	Covered 100%
Routine Colonoscopy	Covered 100%	Covered 100%
Routine Mammography Screening	Covered 100%	Covered 100%
Contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	Covered 100%	Covered 100%

Physician office services

Benefits	Premier Care Provider Network 1	Premier Care Provider Network 2
PCP Office Visits	$25 copay	Must select a PCP from Premier Care Provider Network 1
Online Visits **Note:** Online visits by a non-BCBSM 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 visits with the BCN approved online vendor	$25 copay; Requires a referral, subject to deductible
Specialist Visits - when referred	$30 copay	$30 copay; Requires a referral, subject to deductible

Emergency medical care

Benefits	Premier Care Provider Network 1	Premier Care Provider Network 2
Hospital Emergency Room - copay waived if admitted as an inpatient	$100 copay	$100 copay
Urgent Care Center	$25 copay	$25 copay
Ambulance Services - medically necessary	Covered 100%	Covered 100%

Diagnostic services

Benefits	Premier Care Provider Network 1	Premier Care Provider Network 2
Laboratory and Pathology Tests	Covered 100%	Covered 100%

Diagnostic Tests and X-rays	Covered 100%	Requires a referral, subject to deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	Covered 100%	Requires a referral, subject to deductible
Radiation Therapy	Covered 100%	Requires a referral, subject to deductible

Maternity services provided by a physician

Benefits	Premier Care Provider Network 1	Premier Care Provider Network 2
Prenatal Care Visits	Covered 100%	Covered 100%
Postnatal Care Visits	Covered 100%	Covered 100%
Delivery and Nursery Care	Covered 100%	Requires a referral, subject to deductible

Hospital care

Benefits	Premier Care Provider Network 1	Premier Care Provider Network 2
Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies - unlimited days	Covered 100%	Requires a referral, subject to deductible
Outpatient Facility Services	Covered 100%	Requires a referral, subject to deductible

Alternatives to hospital care

Benefits	Premier Care Provider Network 1	Premier Care Provider Network 2
Skilled Nursing Care	Covered 100%	Requires a referral, subject to deductible
Skilled Nursing Limits	Limited to a maximum of 120 days per member, per calendar year; Network 1 & 2 combined	
Hospice Care	Covered 100%	Requires a referral, subject to deductible
Hospice Limit	There is a fifth level of 45 days per lifetime that requires preauthorization.	
Home Health Care Visits	Covered 100%	Requires a referral, subject to deductible

Surgical services

Benefits	Premier Care Provider Network 1	Premier Care Provider Network 2
Inpatient hospital - includes all related surgical services and anesthesia	Covered 100%	Requires a referral, subject to deductible

Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	Covered 100%	Requires a referral, subject to deductible
Elective Abortion	Covered 100% - 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.	Requires a referral, subject to deductible - 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%	Requires a referral, subject to deductible
Weight Reduction Procedures (subject to medical criteria) limited to one per lifetime	$1,000 copay or 50% coinsurance, whichever is less	Not covered
Reconstructive Surgery (subject to medical criteria)	Covered 100%	Requires a referral, subject to deductible
Gender reassignment and gender affirming procedures (subject to medical criteria)	Covered 100%	Requires a referral, subject to deductible

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

Benefits	Premier Care Provider Network 1	Premier Care Provider Network 2
Inpatient Mental Health Care	Covered 100%	Requires a referral, subject to deductible
Residential Substance Use Disorder	Covered 100%	Requires a referral, subject to deductible
Outpatient Mental Health Care - includes online visits by a BCN Participating Provider or BCN approved online visit vendor **Note:** Online visits by a non-BCBSM selected vendor are not covered.	$25 copay	$25 copay; Requires a referral, subject to deductible
Outpatient Substance Use Disorder Treatment	$25 copay	$25 copay; Requires a referral, subject to deductible

Autism spectrum disorders, diagnoses and treatment

Benefits	Premier Care Provider Network 1	Premier Care Provider Network 2
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; Requires a referral, subject to deductible. ABA is not covered outside of Michigan.
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	$25 copay	$25 copay; Requires a referral, subject to deductible
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	Premier Care Provider Network 1	Premier Care Provider Network 2
Allergy Testing, Therapy and Injections	Covered 100%	Requires a referral, subject to deductible
Chiropractic Spinal Manipulation and Osteopathic Manipulative Therapy	$25 copay per visit	Requires a referral, subject to deductible
Chiropractic Limits	Limited to 24 visits per calendar year. Network 1 and 2 visits are combined.	
Outpatient Physical, Speech and Occupational Therapy - subject to improvement within 60 days	$25 copay per visit	Requires a referral, subject to deductible
Outpatient Physical, Speech and Occupational Therapy Limits	Limited to 60 visits per medical episode per member per calendar year for any combination of PT/OT/ST visits. Network 1 and 2 visits are combined. Includes coverage for gender affirming voice and communication speech therapy	
Cardiac Rehabilitation	Covered 100%	Requires a referral, subject to deductible
Cardiac Rehabilitation Limit	Limited to 36 sessions per 18-week period per medical episode; Network 1 & 2 visits are combined	
Pulmonary Rehabilitation	Covered 100%	Requires a referral, subject to deductible
Pulmonary Rehabilitation Limit	Limited to 1 program of 12 sessions per condition per year. Network 1 and 2 visits are 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.	20% coinsurance Limited to $20,000 lifetime maximum per contract	Not covered
Durable Medical Equipment	Covered 100%	Covered 100%, requires a referral
Diabetic Supplies	Covered 100% Note: Continuous Glucose Monitors are only covered under your pharmacy benefit through Prime Therapeutics	Covered 100%, requires a referral Note: Continuous Glucose Monitors are only covered under your pharmacy benefit through Prime Therapeutics
Prosthetic and Orthotic Appliances - includes coverage for foot orthotics/shoe inserts	Covered 100%	Covered 100%, requires a referral
Routine Eye Exam	Covered 100% One routine vision exam per member per calendar year Dilation is not covered	
Hearing Evaluation and Hearing Aids	Value Based Hearing Network: Hearing aid evaluation, testing and basic binaural hearing aids, once every 36 months; office visit copay may apply.	Standard Hearing Network: Hearing aid evaluation, testing and basic binaural hearing aids, once every 36 months; office visit copay may apply. Member may be balance billed for the difference between the BCN Allowed Amount and the

	provider charge for the standard model.
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

* Services outside of Premier Care Provider Network 1 require a referral from the Premier Care Network 1 Primary Care Physician.

For Internal Purposes Only
Benefits Selected - UMP26F : DPP,HUM24F,TRVSF