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 MNA
# 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<br>**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 | $20 PCP office visit<br>$20 for specialist visits including online visits<br>$20 copay for online visits with the BCN approved online vendor<br>$20 for urgent care visits<br>$20 copay for outpatient behavioral health visits<br>$75 for emergency room services<br>$1,000 for weight reduction procedures | $20 for urgent care visits<br>$75 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 | $20 copay | Must select a PCP from Premier Care Provider Network 1 |
| Online Visits<br><br>**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. | $20 copay for PCP visits;<br>$20 copay for Specialist visits;<br>$20 copay for Blue Cross Online Visits | Requires referral; subject to deductible |
| Specialist Visits - when referred | $20 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 | $75 copay | $75 copay |
| Urgent Care Center | $20 copay | $20 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% |

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| 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 |

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| 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.<br>**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.<br>**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<br><br>**Note:** Online visits by a non-BCBSM selected vendor are not covered. | $20 copay | Requires a referral, subject to deductible |
| Outpatient Substance Use Disorder Treatment | $20 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<br><br>**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) | $20 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. | $20 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 | $20 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 | $20 copay per visit - limited to 15 visits per medical episode per calendar year | 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<br><br>**Note:** Covered treatment procedures are payable only when rendered by the UMHS Center for Reproductive Medicine. | 20% coinsurance<br><br>Limited to $20,000 lifetime maximum per contract | Not covered |
| Durable Medical Equipment | Covered 100% | Covered 100%, requires a referral |
| Diabetic Supplies | Covered 100%<br>Note: Continuous Glucose Monitors are only covered under your pharmacy benefit through Prime Therapeutics | Covered 100%, requires a referral<br>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%<br>One routine vision exam per member per calendar year<br>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 |

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| | 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:<br>- Under 3 years of age: 4X every 12 months per hearing aid<br>- Age 3 up to 13 years of age: 2X every 12 months per hearing aid<br>- 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,UMPCUF