Eaton County BCBS Plans - Side by Side Comparison

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. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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 BCBSM 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. Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility. Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.
BCBSM provides administrative claims services only. Your employer is financially responsible for claims.

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Blue Cross Blue Shield of Michigan	BCBS Community Blue - CB6	BCBS Community Blue - CB12
Member's responsibility In-Network (deductibles, copays, coinsurance and dollar maximums)		
Deductible s (In-network)	$250 for one member, $500 for the family each calendar year (when two or more members are covered under your contract) ***Note:*** *Deductible waived if service is performed in a PPO physician's office*	$1,000 for one member, $2,000 for the family each calendar year (when two or more members are covered under your contract) ***Note:*** *Deductible waived if service is performed in a PPO physician's office*
Flat-dollar copays	• $20 copay for office visits and office consultations • $5 copay for online visits • $20 copay for chiropractic services and osteopathic manipulative therapy $75 copay for emergency room visits	• $20 copay for office visits and office consultations • $5 copay for online visits • $20 copay for chiropractic services and osteopathic manipulative therapy $150 copay for emergency room visits
Coinsurance amounts **Note:** Copays apply once the deductible has been met.	• 50% of approved amount for private duty nursing care • 10% of approved amount for mental health care and substance abuse treatment • 10% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)	• 50% of approved amount for private duty nursing care • 20% of approved amount for mental health care and substance abuse treatment • 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)
Coinsurance maximums - applies to coinsurance amounts for all covered services - including mental health and substance abuse services but does not apply to deductibles , flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost sharing amounts.	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year.	$2,500 for one member, $5,000 for the family (when two or more members are covered under your contract) each calendar year.
Annual out of pocket maximums - applies to deductibles, copays and coinsurance amounts for all covered services - including cost sharing amounts for prescription drugs, if applicable.	$6,350 for one member $12,700 for two or more members each calendar year.	$6,350 for one member $12,700 for two or more members each calendar year.
Dollar maximums	None	None

Blue Cross Blue Shield of Michigan	BCBS Community Blue 6 - CB6	BCBS Community Blue 12 - CB12
Preventive services		
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based upon medical necessity.	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based upon medical necessity.
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based upon medical necessity.	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based upon medical necessity.
Pap smear screening – laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	100% (no deductible or copay/coinsurance), one per member per calendar year
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Contraceptive injections	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Well-baby and child care	100% (no deductible or copay/coinsurance) • 8 visits per year, birth through 12 months • 6 visits per year, 13 months through 23 months • 6 visits per year, 24 months through 35 months • 2 visits per year, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	100% (no deductible or copay/coinsurance) • 8 visits per year, birth through 12 months • 6 visits per year, 13 months through 23 months • 6 visits per year, 24 months through 35 months • 2 visits per year, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	100% (no deductible or copay/coinsurance), one per member per calendar year
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	100% (no deductible or copay/coinsurance), one per member per calendar year
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	100% (no deductible or copay/coinsurance), one per member per calendar year
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) ***Note:*** *Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay* One per member per calendar year	100% (no deductible or copay/coinsurance) ***Note:*** *Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay* One per member per calendar year
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) ***Note:*** *Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.* One per member per calendar year	100% (no deductible or copay/coinsurance) ***Note:*** *Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.* One per member per calendar year
Physician office services		
Office visits- must be medically necessary	$20 copay per office visit	$20 copay per office visit
Outpatient and home medical care visits- must be medically necessary	90% after in-network deductible	80% after in-network deductible
Office consultations- must be medically necessary	$20 copay per office visit	$20 copay per office visit
Urgent care visits- must be medically necessary	$20 copay per office visit	$20 copay per office visit

Blue Cross Blue Shield of Michigan	BCBS Community Blue 6 - CB6	BCBS Community Blue 12 - CB12
Emergency medical care		
Hospital emergency room	$75 copay per visit (copay waived if admitted or for an accidental injury)	$150 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	90% after in-network deductible	80% after in-network deductible
Diagnostic services		
Laboratory and pathology services	90% after in-network deductible	80% after in-network deductible
Diagnostic tests and x-rays	90% after in-network deductible	80% after in-network deductible
Therapeutic radiology	90% after in-network deductible	80% after in-network deductible
Maternity services provided by a physician		
Prenatal care visits	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Postnatal care visits	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Delivery and nursery care	90% after in-network deductible	80% after in-network deductible
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note**: Nonemergency services must be rendered in a **participating** hospital	90% after in-network deductible	80% after in-network deductible
	Unlimited days	Unlimited days
Inpatient consultations	90% after in-network deductible	80% after in-network deductible
Chemotherapy	90% after in-network deductible	80% after in-network deductible
Alternatives to hospital care		
Skilled nursing care- must be in a **participating** skilled nursing facility	90% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	Limited to a maximum of 120 days per member per calendar year
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a participating hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, for 90-day periods - provided through a participating hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)
Home health care: • must be medically necessary • must be provided by a participating home health care agency	90% after in-network deductible	80% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization – consult with your doctor	90% after in-network deductible	80% after in-network deductible
Surgical services		
Surgery-includes surgical services and medially necessary facility services by a **participating** ambulatory surgery facility	90% after in-network deductible	80% after in-network deductible
Presurgery consultations	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Voluntary sterilization for males Note: For voluntary sterilizations for females, see "Preventive care services."	90% after in-network deductible	80% after in-network deductible
Human organ transplants		
Specified human organ transplants - in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

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Bone marrow – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	90% after in-network deductible	80% after in-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	90% after in-network deductible	80% after in-network deductible
Kidney, cornea and skin transplants	90% after in-network deductible	80% after in-network deductible
Mental health care and substance abuse treatment		
Note: Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health and substance abuse service is considered by BCBSM to be comparable to an office visit, you pay only for an office visit as described in your certificate or related riders.		
Inpatient mental health care and substance abuse treatment	90% after in-network deductible	80% after in-network deductible
	Unlimited days	Unlimited days
Outpatient mental health care • Facility and clinic	90% after in-network deductible	80% after in-network deductible
• Physician's office	90% after in-network deductible	80% after in-network deductible
Outpatient substance abuse treatment - in approved treatment facilities **only**	90% after in-network deductible	80% after in-network deductible
Other covered services		
Outpatient Diabetes Management Program (ODMP) Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	90% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay/coinsurance)) for diabetes self-management training	80% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay) for diabetes self-management training
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Chiropractic spinal manipulation	$20 copay per office visit	$20 copay per office visit
	Limited to a **combined** maximum of 6 visits per member per calendar year	Limited to a **combined** maximum of 12 visits per member per calendar year
Outpatient physical, speech and occupational therapy - provided for rehabilitation	90% after in-network deductible	80% after in-network deductible
	Limited to a **combined** maximum of 60 visits per calendar year	Limited to a **combined** maximum of 60 visits per calendar year
Durable medical equipment Note: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	90% after in-network deductible	80% after in-network deductible
Prosthetic and Orthotic Appliances	90% after in-network deductible	80% after in-network deductible
Private duty nursing	50% after in-network deductible	50% after in-network deductible
Prescription Drugs		
Drug Copays	$5 generic/$30 brand/$45 non formulary; 90 day supply for 2 co-pays, Step Therapy/Prior Authorization	$10 generic/$40 brand/$80 non preferred; 90 day supply for 2 co-pays, Step Therapy/Prior Authorization, Mandatory MAC