2024

EMU Benefits Comparison

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Blue Cross® Blue Shield® of Michigan: 888-288-1726 • **bcbsm.com**
Vision Service Plan: 800-877-7195 • **vsp.com**
Blue Care Network: 800-662-6667 • **mibcn.com**

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. 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.

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

Note: If a PPO provider refers you to a non-network provider, all covered services obtained from that non-network provider will be subject to applicable out-of-network cost-sharing.

	Simply Blue℠ (HSA)		Community Blue℠ PPO Option 5	
Benefits	**In-Network**	**Out-of-Network***	**In-Network**	**Out-of-Network***
Deductibles	$2,400 for a one-person contract or $4,800 for a family contract (2 or more members) each calendar year (**no 4th quarter carry-over**)	$4,800 for a one-person contract or $9,600 for a family contract (2 or more members) each calendar year (**no 4th quarter carry-over**)	$500 for one member, $1,000 for two person **Note:** Deductible may be waived if service is performed in a PPO physician's office.	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also apply toward the in-network deductible.
	Deductibles are based on amounts defined annually by the federal government for Simply Blue-related health plans. Please call your customer service center for an annual update.			
Fixed dollar copays	None	None	• $20 copay for office visits except for chiropractic which is $15 • $50 copay for emergency room visits	$50 copay for emergency room visits – waived if admitted
Percent coinsurance **Note:** Copays apply once the deductible has been met.	10% of approved amount	30% of approved amount	• 70% of approved amount for private duty nursing • 10% of approved amount for most other covered services (copay waived if service is performed in a PPO physician's office)	• 50% of approved amount for private duty nursing • 30% of approved amount for most other covered services
Annual out-of-pocket maximums – includes deductible, fixed dollar medical and Rx copays, and coinsurance.	$3,500 for one member $7,000 for two or more members each calendar year	$7,000 for one member $14,000 for two or more members each calendar year **Note**: Out-of-network cost-sharing does not count toward the in-network out-of-pocket maximum.	$4,000 for one member $8,000 for two or more members each calendar year	$8,000 for one member $16,000 for two or more members each calendar year **Note**: Out-of-network cost-sharing does not count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None		None	
Preventive care services				
Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay), one per member per calendar year	Not covered	100% (no deductible or copay), one per member per calendar year	Not covered
Gynecological exam	100% (no deductible or copay), one per member per calendar year	Not covered	100% (no deductible or copay), one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay), one per member per calendar year	Not covered	100% (no deductible or copay), one per member per calendar year	Not covered

Services from a provider for which there is no Michigan PPO network and services from a non-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.

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	Simply Blue℠ (HSA)		Community Blue℠ PPO Option 5	
Benefits	**In-Network**	**Out-of-Network***	**In-Network**	**Out-of-Network***
Well-baby and child care visits	100% (no deductible or copay) • 8 visits for first 12 months • 6 visits from 13 months to 23 months • 6 visits from 24 to 35 months • 2 visits per 12 months age 36 to 47 months • 1 visit per 12 months age 48 months to adult If older than age restrictions or subsequent tests, services should process according to current group specific benefits.	Not covered	100% (no deductible or copay) • 8 visits for first 12 months • 6 visits from 13 months to 23 months • 6 visits from 24 to 35 months • 2 visits per 12 months age 36 to 47 months • 1 visit per 12 months age 48 months to adult If older than age restrictions or subsequent tests, services should process according to current group specific benefits.	Not covered
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)	Not covered	100% (no deductible or copay)	Not covered
Fecal occult blood screening	100% (no deductible or copay), one per member per calendar year	Not covered	100% (no deductible or copay), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay), one per member per calendar year	Not covered	100% (no deductible or copay), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay), one per member per calendar year	Not covered	100% (no deductible or copay), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	70% after out-of-network deductible **Note:** Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.	100% (no deductible or copay) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	70% after out-of-network deductible **Note:** Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
	One per member per calendar year		One per member per calendar year	
Routine screening colonoscopy	100% (no deductible or copay) for routine colonoscopy **Note:** Medically necessary colonoscopies are subject to your deductible and percent copay.	70% after out-of-network deductible	100% (no deductible or copay) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	70% after out-of-network deductible
	One routine colonoscopy per member per calendar year		One per member per calendar year	
Voluntary sterilizations for females	100% (no deductible or copay/ coinsurance)	70% after out-of-network deductible	100% (no deductible or copay/ coinsurance)	70% after out-of-network deductible
Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/ coinsurance)	100% after out-of-network deductible	100% (no deductible or copay/ coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/ coinsurance)	70% after out-of-network deductible	100% (no deductible or copay/ coinsurance)	70% after out-of-network deductible
Physician office services				
Office visits – must be medically necessary	90% after in-network deductible	70% after out-of-network deductible	$20 copay per office visit	70% after out-of-network deductible, must be medically necessary
Outpatient and home medical care visits – must be medically necessary	90% after in-network deductible	70% after out-of-network deductible	90% after in-network deductible	70% after out-of-network deductible, must be medically necessary

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	Simply Blue℠ (HSA)		Community Blue℠ PPO Option 5	
Benefits	**In-Network**	**Out-of-Network***	**In-Network**	**Out-of-Network***
Office consultations – must be medically necessary	90% after in-network deductible	70% after out-of-network deductible	$20 copay per office visit	70% after out-of-network deductible, must be medically necessary
Urgent care visits – must be medically necessary	90% after in-network deductible	70% after out-of-network deductible	$45 copay per office visit	70% after out-of-network deductible, must be medically necessary
Emergency medical care				
Hospital emergency room	90% after in-network deductible	90% after in-network deductible	$150 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	90% after in-network deductible	100% if medically necessary	100% if medically necessary
Diagnostic services				
Laboratory and pathology services	90% after in-network deductible	70% after out-of-network deductible	90% after in-network deductible	70% after out-of-network deductible
Diagnostic tests and x-rays	90% after in-network deductible	70% after out-of-network deductible	90% after in-network deductible	70% after out-of-network deductible
Therapeutic radiology	90% after in-network deductible	70% after out-of-network deductible	90% after in-network deductible	70% after out-of-network deductible
Maternity services provided by a physician				
Prenatal care visits	100% (no deductible or copay)	70% after in-network deductible	100% (no deductible or copay)	70% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife		Includes covered services provided by a certified nurse midwife	
Postnatal care visits	90% (no deductible or copay)	70% after in-network deductible	100% (no deductible or copay)	70% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife		Includes covered services provided by a certified nurse	
Delivery and nursery care	90% after in-network deductible	70% after out-of-network deductible	90% after in-network deductible	70% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife		Includes covered services provided by a certified nurse midwife	
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	70% after out-of-network deductible	90% after in-network deductible	70% after out-of-network deductible
	Unlimited days		Unlimited days	
Inpatient consultations	90% after in-network deductible	70% after out-of-network deductible	90% after in-network deductible	70% after out-of-network deductible
Chemotherapy	90% after in-network deductible	70% after out-of-network deductible	90% after in-network deductible	70% after out-of-network deductible
Alternatives to hospital care				
Skilled nursing care – must be in a **participating** skilled nursing facility	90% after in-network deductible	90% after in-network deductible	100%	100%
	Limited to a maximum of 90 days per member per calendar year		Limited to a maximum of 120 days per member per calendar year	

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	Simply Blue℠ (HSA)		Community Blue℠ PPO Option 5	
Benefits	**In-Network**	**Out-of-Network***	**In-Network**	**Out-of-Network***
Hospice care	90% after in-network deductible	90% after in-network deductible	100% (no deductible or copay)	100% (no deductible or copay)
	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, 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)	
Home health care – must be medically necessary and provided by a **participating** home health care agency	90% after in-network deductible	90% after in-network deductible	90% (professional services only)	90% (professional services only)
Home infusion therapy – must be medically necessary and given by **participating** home infusion therapy providers	90% after in-network deductible	90% after in-network deductible	90% after in-network deductible	90% after in-network deductible
Surgical services				
Surgery – includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	90% after in-network deductible	70% after out-of-network deductible	90% after in-network deductible	70% after out-of-network deductible
Presurgical consultations	90% after in-network deductible	70% after out-of-network deductible	100% (no deductible or copay)	70% after out-of-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)	90% after in-network deductible	90% after in-network deductible – in designated facilities only	100% (no deductible or copay)	100% (no deductible or copay) – in designated facilities only
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	90% after in-network deductible	70% after out-of-network deductible	90% after in-network deductible	70% after out-of-network deductible
Specified oncology clinical trials	90% after in-network deductible	70% after out-of-network deductible	90% after in-network deductible	70% after out-of-network deductible
Kidney, cornea and skin transplants	90% after in-network deductible	70% after out-of-network deductible	90% after in-network deductible	70% after out-of-network deductible
Mental health care and substance abuse treatment				
Note: If your employer has **51 or more** employees (including seasonal and part-time) and is subject to the MHP law, covered mental health and substance abuse services are subject to the following frequency limits. If you receive your health care benefits through a collectively bargained agreement, please contact your employer and/or union to determine when or if this benefit level applies to your plan.				
Inpatient mental health care and inpatient substance abuse treatment	90% after in-network deductible	70% after out-of-network deductible	90% after in-network deductible	70% after out-of-network deductible
	Unlimited days		Unlimited days	
• Outpatient clinic	90% after in-network deductible	90% after in-network deductible, in participating facilities only	100% (no deductible or copay)	70% after out-of-network deductible, must be medically necessary

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		Simply Blue℠ (HSA)		Community Blue℠ PPO Option 5	
Benefits		**In-Network**	**Out-of-Network***	**In-Network**	**Out-of-Network***
• Outpatient physician's office		90% after in-network deductible	70% after out-of-network deductible	100% (no deductible or copay)	70% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities only		90% after in-network deductible	70% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)	100% (no deductible or copay)	70% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)
Autism		100% after in-network deductible	70% after out-of-network deductible	100% (no deductible or copay)	70% after out-of-network deductible
Other covered services					
Outpatient Diabetes Management Program (ODMP) **Note:** Effective July 1, 2012, 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) for diabetes self-management training	70% after out-of-network deductible	90% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay) for diabetes self-management training	70% after out-of-network deductible
Allergy testing and therapy		90% after in-network deductible	70% after out-of-network deductible	100% (no deductible or copay)	70% after out-of-network deductible
Outpatient physical, speech and occupational therapy – provided for rehabilitation		90% after in-network deductible	70% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.	90% after in-network deductible	70% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
		Limited to a **combined** maximum of 60 visits per member per calendar year		Limited to a **combined** maximum of 60 visits per member per calendar year	
Durable medical equipment		90% after in-network deductible	90% after in-network deductible	90% after in-network deductible	90% after in-network deductible
Prosthetic and orthotic appliances		90% after in-network deductible	90% after in-network deductible	90% after in-network deductible	90% after in-network deductible
Private duty nursing		90% after in-network deductible	90% after in-network deductible	70% after in-network deductible	50% after in-network deductible
Hearing Services		Covers two hearing aids every 36 months	Not covered	Covers two hearing aids every 36 months	Not covered
Chiropractic Services		90% after in-network deductible, but limited to 24 visits	70% after deductible, but limited to 24 visits	Covered – $15 copay, up to a combined maximum of 24 visits per member calendar year	Covered – 70% after deductible, up to a combined maximum of 24 visits per member per calendar year
Prescription drugs For the Simply Blue (HSA), you must pay full cost (copays and coinsurance) until the deductible is met.	CAMPUS MEDICAL	**Note: If you seek prescriptions drugs through Campus Medical, you can fill Tier I drugs at a $3 copay or $7 for 90-day supply (applies to all three plans)**			
		34-day supply: Tier 1 – $3 copay Tier 2 – $30 copay Tier 3 – $60 copay Tier 4 – $75 copay 90-day supply: Tier 1 – $7 copay Tier 2 – $60 copay Tier 3 – $120 copay Tier 4 – N/A	Additional 20% of approved amount	34-day supply: Tier 1 – $3 copay Tier 2 – $30 copay Tier 3 – $60 copay Tier 4 – $75 copay 90-day supply: Tier 1 – $7 copay Tier 2 – $60 copay Tier 3 – $120 copay Tier 4 – N/A	Additional 25% of approved amount
		Tier 1 – $10 copay after deductible Tier 2 – $30 copay after deductible Tier 3 – $60 copay after deductible Tier 4 – $75 copay after deductible		Tier 1 – $10 copay Tier 2 – $30 copay Tier 3 – $60 copay Tier 4 – $75 copay	
		Mail order: Tier 1 – $10 (35 to 90 day, $25) Tier 2 – $30 (35 to 90 day, $75) Tier 3 – $60 (35 to 90 day, $150)		Mail order: Tier 1 – $10 (35 to 90 day, $25) Tier 2 – $30 (35 to 90 day, $75) Tier 3 – $60 (35 to 90 day, $150)	

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	Simply Blue℠ (HSA)		Community Blue℠ PPO Option 5	
Benefits	**In-Network**	**Out-of-Network***	**In-Network**	**Out-of-Network***
Vision Services Plan				
Frames	Covered – $10 copay. One frame every 24 months. (A wide selection of quality frames is fully covered by VSP frame allowance. Members should ask which frames are covered in full. Members may select a more expensive frame and pay a cost controlled price difference.)	Covered – $10 copay, up to predetermined amount. One frame every 24 months. (A wide selection of quality frames is fully covered by VSP frame allowance. Members should ask which frames are covered in full. Members may select a more expensive frame and pay a cost controlled price difference.) Reimbursed up to $70, less $10 copay.	Covered – $10 copay. One frame every 24 months. (A wide selection of quality frames is fully covered by VSP frame allowance. Members should ask which frames are covered in full. Members may select a more expensive frame and pay a cost controlled price difference.)	Covered – $10 copay, up to predetermined amount. One frame every 24 months. (A wide selection of quality frames is fully covered by VSP frame allowance. Members should ask which frames are covered in full. Members may select a more expensive frame and pay a cost controlled price difference.) Reimbursed up to $70, less $10 copay.
Lenses	Covered – $10 copay. One pair every 24 months. Single vision, bifocal and lenticular lenses are covered in full by the plan. Patients can choose glass or plastic lenses, as well as oversized lenses up to 61 mm. Pink lens tint (for glare reduction) are also covered in full.	Covered – $10 copay, up to predetermined amount. One pair every 24 months. Single vision, bifocal and lenticular lenses are covered in full by the plan. Patients can choose glass or plastic lenses, as well as oversized lenses up to 61 mm. Pink lens tint (for glare reduction) are also covered in full. Single vision lenses reimbursed up to $25 less $10 copay. Bi-focal lenses reimbursed up to $40 less $10 copay. Tri-focal lenses reimbursed up to $55 less $10 copay. Elective contact lenses, $105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses. Medically necessary contact lenses, reimbursed up to $210 less $10 copay.	Covered – $10 copay. One pair every 24 months. Single vision, bifocal and lenticular lenses are covered in full by the plan. Patients can choose glass or plastic lenses, as well as oversized lenses up to 61 mm. Pink lens tint (for glare reduction) are also covered in full.	Covered – $10 copay, up to predetermined amount. One pair every 24 months. Single vision, bifocal and lenticular lenses are covered in full by the plan. Patients can choose glass or plastic lenses, as well as oversized lenses up to 61 mm. Pink lens tint (for glare reduction) are also covered in full. Single vision lenses reimbursed up to $25 less $10 copay. Bi-focal lenses reimbursed up to $40 less $10 copay. Tri-focal lenses reimbursed up to $55 less $10 copay. Elective contact lenses, $105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses. Medically necessary contact lenses, reimbursed up to $210 less $10 copay.
Contacts	Covered – $130 applied toward contact lens fitting, evaluation and materials, member responsible for difference. Once every 24 months. Members may obtain either eyeglasses or contact lenses, but not both.	Covered – $105 applied toward contact lens fitting, evaluation and material, member responsible for difference. Once every 24 months. Members may obtain either eyeglasses or contact lenses, but not both.	Covered – $130 applied toward contact lens fitting, evaluation and materials, member responsible for difference. Once every 24 months. Members may obtain either eyeglasses or contact lenses, but not both.	Covered – $105 applied toward contact lens fitting, evaluation and material, member responsible for difference. Once every 24 months. Members may obtain either eyeglasses or contact lenses, but not both.
Therapeutic Contact Lenses	Covered – 100% after $10 copay, must be medically necessary and VSP Providers must receive prior approval	Covered – $210 maximum, member responsible for difference (must be medically necessary)	Covered – 100% after $10 copay, must be medically necessary and VSP Providers must receive prior approval	Covered – $210 maximum, member responsible for difference (must be medically necessary)

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Benefit Comparison for Healthy *Blue* Living℠

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	PCP Focus Network (HMO) Blue Care Network is a Michigan-based health care network. Primary Care Physicians must be chosen from the seven county Focus Network in southeast Michigan.	
Benefits	**Enhanced Benefits (BCN10)**	**Standard Benefits (BCN10)**
Deductible, Copays and Dollar Maximums **Note: The Deductible will apply to certain services as defined below.**		
Deductible	$500 per member/$1,000 per family per calendar year	$1,500 per member/$3,000 per family per calendar year
Fixed Dollar Copays	$5 for allergy injections	$5 for allergy injections
	$20 for office visits and online visits	$35 for office visits and online visits
	$20 for urgent care visits	$50 for urgent care visits
	$100 for emergency room visits	$100 for emergency room visits
	No fixed dollar copay for ambulance services. See below for applicable coinsurance.	No fixed dollar copay for ambulance services. See below for applicable coinsurance.
	$20 for referral physician visits	$45 for referral physician visits
Coinsurance	50% for select services as noted below	50% for select services as noted below
	20% for select services as noted below	30% for select services as noted below
Annual Coinsurance Maximum (ACM)	$1,000 per member/$2,000 per family per calendar year	$1,500 per member/$3,000 per family per calendar year
	Services that DO NOT apply to the ACM: Deductible, Flat Dollar Copays, Infertility, Male Mastectomy, Reduction Mammoplasty, Male Sterilization, Elective Abortion, TMJ, Orthognathic Surgery, Weight Reduction, DME, P&O, Diabetic Supplies, Prescription Drugs	
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$6,600 per member/$13,200 per family	$6,600 per member/$13,200 per family
Preventive Services		
Health Maintenance Exam	100%	100%
Annual Gynecological Exam	100%	100%
Pap Smear Screening	100%	100%
Well-Baby and Child Care	100%	100%
Immunizations – pediatric and adult	100%	100%
Prostate Specific Antigen (PSA) Screening	100%	100%
Mammography		
Mammography Screening	100%	100%
Physician Office Services		
Office Visits	$20 Copay	$35 Copay
Consulting Specialist Care – when referred	$20 Copay	$45 Copay
Emergency Medical Care		
Hospital Emergency Room (copay waived if admitted, if applicable)	$100 Copay	$100 Copay
Urgent Care Center	$20 Copay	$50 Copay
Ambulance Services – medically necessary	80% after deductible	70% after deductible

Enhanced Benefit: CLSSLG, 6600PM, CI20%, CO20, D500, ER100, UR20, WDEDFC, FOCUS, VACR50, 1KECM, HA2, VSP BV-12/24/24, 13675P, MOPD20, 6600PM

Standard Benefit: CLSSLG, 6600PM, C130%, CO35, D1500, ER100, UR50, WDEDFC, FOCUS, 45RP, VACR50, 1SECM, 20455P, 6600PM, MOPD20, HA2, VSP BV 12/24/24

Benefit Comparison – Healthy *Blue* Living *continued*

This is not a full description of coverage. It is a comparison intended to highlight the coverages of the health plans. Every effort has been made to ensure the accuracy of the information in this booklet. However, if statements in this booklet differ from applicable contracts, certificates and riders, then the terms and conditions of these contracts, certificates and riders will prevail.

	PCP Focus Network (HMO) Blue Care Network is a Michigan-based health care network. Primary Care Physicians must be chosen from the seven county Focus Network in southeast Michigan.	
Benefits	**Enhanced Benefits (BCN10)**	**Standard Benefits (BCN10)**
Diagnostic Services		
Laboratory and Pathology Tests	Office visit copay may apply per member, per visit	Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	80% after deductible	70% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	80% after deductible	70% after deductible
Radiation Therapy	80% after deductible	70% after deductible
Maternity Services Provided by a Physician		
Pre-Natal Care	100%	100%
Post-Nata Care	$20 Copay	$35 Copay
Delivery and Nursery Care	100% (For professional services. See Hospital Care for facility charges) after deductible	100% (For professional services. See Hospital Care for facility charges) after deductible
Hospital Care		
General Nursing Care, Hospital Services and Supplies (unlimited days)	80%, after deductible	70% after deductible
Outpatient Surgery	80%, after deductible	70% after deductible
Outpatient Facility Visits – Non-Surgical	$10 Copay	$10 Copay
Alternatives to Hospital Care		
Skilled Nursing Care	80%, after deductible	70% after deductible
	Up to 45 days per member per calendar year	Up to 45 days per member per calendar year
Hospice Care	100% when authorized after deductible	100% when authorized after deductible
Home Health Care	$20 Copay	$45 Copay
Surgical Services		
Surgery – included all related surgical services and anesthesia	See Hospital Care for inpatient and outpatient copay	See Hospital Care for inpatient and outpatient copay
Voluntary Sterilization	Male – 50% after deductible	Male – 50% after deductible
	Female – 100%	Female – 100%
Human Organ Transplants (subject to medical criteria)	80%, after deductible	70% after deductible
Reduction Mammoplasty (subject to medical criteria)	50% after deductible	50% after deductible
Male Mastectomy (subject to medical criteria)	50% after deductible	50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	50% after deductible	50% after deductible
Orthognathic Surgery (subject to medical criteria)	50% after deductible	50% after deductible
Mental Health Care and Substance Abuse Treatment		
Inpatient Mental Health Care	80% after deductible	70% after deductible
Inpatient Substance Abuse Care	80% after deductible	70% after deductible
Outpatient Mental Health Care	$20 Copay	$35 Copay
Outpatient Substance Abuse	$20 Copay	$35 Copay

Enhanced Benefit: CLSSLG, 6600PM, CI20%, CO20, D500, ER100, UR20, WDEDFC, FOCUS, VACR50, 1KECM, HA2, VSP BV-12/24/24, 13675P, MOPD20, 6600PM

Standard Benefit: CLSSLG, 6600PM, C130%, CO35, D1500, ER100, UR50, WDEDFC, FOCUS, 45RP, VACR50, 1SECM, 20455P, 6600PM, MOPD20, HA2, VSP BV 12/24/24

Benefit Comparison – Healthy *Blue* Living *continued*

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	PCP Focus Network (HMO) Blue Care Network is a Michigan-based health care network. Primary Care Physicians must be chosen from the seven county Focus Network in southeast Michigan.	
Benefits	**Enhanced Benefits (BCN10)**	**Standard Benefits (BCN10)**
Autism Spectrum Disorders, Diagnoses and Treatment		
Applied behavioral analyses (ABA) treatment	$20 Copay	$35 Copay
Outpatient physical, speech and occupational therapy, nutrional counseling for autism spectrum disorder	$20 Copay	$45 Copay
Other covered services, including mental health services for autism spectrum disorder	See your outpatient mental health benefit and medical office visit benefit	See your outpatient mental health benefit and medical office visit benefit
Other Services		
Allergy Care	50% after deductible	50% after deductible
Allergy Injections	$5 Copay	$5 Copay
Chiropractic Spinal Manipulation – when referred	$20 Copay Up to 30 visits per calendar year	$45 Copay Up to 30 visits per calendar year
Outpatient Physical, Speech and Occupational Therapy	$20 Copay 60 visits per benefit year for any combination of outpatient rehabilitation therapies.	$45 Copay 60 visits per benefit year for any combination of outpatient rehabilitation therapies.
Infertility Counseling and Treatment (excludes In-vitro Fertilization)	50% on all associated costs after deductible	50% on all associated costs after deductible
Durable Medical Equipment	50%	50%
Breast Pumps (DME guidelines apply. Limited to no more than one per 24-month period)	100%	100%
Prosthetic and Orthotic Appliances	50%	50%
Weight Reduction Procedures	50% after deductible	50% after deductible
Prescription Drugs	Tier 1 – $10 copay, Tier 2 – $30 copay, Tier 3 – $60 copay	Tier 1 – $20 copay, Tier 2 – $45 copay, Tier 3 – $85 copay
	Women's Contraceptives – Tier 1 – 100%, Tier 2 – Tier 2 Copayment/Coinsurance above applies, Tier 3 – Tier 3 Copayment/Coinsurance above applies	Women's Contraceptives – Tier 1 – 100%, Tier 2 – Tier 2 Copayment/Coinsurance above applies, Tier 3 – Tier 3 Copayment/Coinsurance above applies
	Sexual Dysfunction drugs – 50% coinsurance	Sexual Dysfunction Drugs – 50% coinsurance
Mail Order Prescription Drugs	Two times the applicable copay up to a 90 day supply	Two times the applicable copay up to a 90 day supply
Prescription Drug Deductible	None	None
Hearing Aid	Covers two hearing aids and exams every 36 months	Covers two hearing aids and exams every 36 months

Enhanced Benefit: CLSSLG, 6600PM, CI20%, CO20, D500, ER100, UR20, WDEDFC, FOCUS, VACR50, 1KECM, HA2, VSP BV-12/24/24, 13675P, MOPD20, 6600PM

Standard Benefit: CLSSLG, 6600PM, C130%, CO35, D1500, ER100, UR50, WDEDFC, FOCUS, 45RP, VACR50, 1SECM, 20455P, 6600PM, MOPD20, HA2, VSP BV 12/24/24

Benefit Comparison – Healthy *Blue* Living *continued*

This is not a full description of coverage. It is a comparison intended to highlight the coverages of the health plans. Every effort has been made to ensure the accuracy of the information in this booklet. However, if statements in this booklet differ from applicable contracts, certificates and riders, then the terms and conditions of these contracts, certificates and riders will prevail.

	PCP Focus Network (HMO) Blue Care Network is a Michigan-based health care network. Primary Care Physicians must be chosen from the seven county Focus Network in southeast Michigan.	
Benefits	**Enhanced Benefits (BCN10)**	**Standard Benefits (BCN10)**
Vision Services Plan		
Eye Exam	Covered – $5 copay up to $35. Once every 12 months, covers a complete eye exam including refraction, glaucoma testing and other test necessary to determine the overall visual health of the patient. Reimbursed up to $50, less $5 copay.	Covered – $5 copay, up to $35. Once every 12 months, covers a complete eye exam including refraction, glaucoma testing and other test necessary to determine the overall visual health of the patient. Reimbursed up to $50, less $5 copay.
Frames	Covered – $10 copay. One frame every 24 months. (A wide selection of quality frames is fully covered by VSP frame allowance. Members should ask which frames are covered in full. Members may select a more expensive frame and pay a cost controlled price difference.) Reimbursed up to $70, less $10 copay.	Covered – $10 copay, up to predetermined amount. One frame every 24 months. (A wide selection of quality frames is fully covered by VSP frame allowance. Members should ask which frames are covered in full. Members may select a more expensive frame and pay a cost controlled price difference.) Reimbursed up to $70, less $10 copay.
Lenses	Covered – $10 copay. One pair every 24 months. Single vision, bifocal and lenticular lenses are covered in full by the plan. Patients can choose glass or plastic lenses, as well as oversized lenses up to 61 mm. Pink lens tint (for glare reduction) are also covered in full. Single vision lenses reimbursed up to $25 less $10 copay. Bi-focal lenses reimbursed up to $40 less $10 copay. Tri-focal lenses reimbursed up to $55 less $10 copay. Elective contact lenses, $105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses. Medically necessary contact lenses, reimbursed up to $210 less $10 copay.	Covered – $10 copay, up to predetermined amount. One pair every 24 months. Single vision, bifocal and lenticular lenses are covered in full by the plan. Patients can choose glass or plastic lenses, as well as oversized lenses up to 61 mm. Pink lens tint (for glare reduction) are also covered in full. Single vision lenses reimbursed up to $25 less $10 copay. Bi-focal lenses reimbursed up to $40 less $10 copay. Tri-focal lenses reimbursed up to $55 less $10 copay. Elective contact lenses, $105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses. Medically necessary contact lenses, reimbursed up to $210 less $10 copay.
Contacts	Covered – $130 applied toward contact lens fitting, evaluation and materials, member responsible for difference. Once every 24 months. Members may obtain either eyeglasses or contact lenses, but not both.	Covered – $105 applied toward contact lens fitting, evaluation and material, member responsible for difference. Once every 24 months. Members may obtain either eyeglasses or contact lenses, but not both.
Therapeutic Contact Lenses	Covered – 100% after $10 copay, must be medically necessary and VSP Providers must receive prior approval	Covered – $210 maximum, member responsible for difference (must be medically necessary)

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 and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

Healthy *Blue* Living members (subscribers) must complete program requirements within the first 90 days of enrollment or re-enrollment. To qualify for or maintain enhanced benefits, members need to complete a health assessment and qualification form during the first 90 days and follow their primary care physician's recommendations for a healthy lifestyle. Members who use tobacco must enroll in BCN's smoking cessation program within 120 days of enrollment or re-enrollment. Members with a BMI of 30 or above must choose one of two BCN-sponsored weight management programs (Weight Watchers or Walkingspree pedometer plan) within 120 days of enrollment or re-enrollment.

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Standard Benefit: CLSSLG, 6600PM, C130%, CO35, D1500, ER100, UR50, WDEDFC, FOCUS, 45RP, VACR50, 1SECM, 20455P, 6600PM, MOPD20, HA2, VSP BV 12/24/24