Benefit comparison for AC/AP/CC/FA/PT/VF

This is not a full description of coverage. It is a comparison intended to highlight the coverages of the health plans. For a summary of the covered services for each plan, you must refer to Blue Cross Blue Shield's Benefits at a Glance Summary for EMU. If you have questions before making a plan selection, you may contact any of the plans' Member Services Departments.

Blue Cross Blue Shield of Michigan: 877-257-9703 • 800-637-2227 • 248-486-8666 • **bcbsm.com** | Vision Service Plan: 800-877-7195 • **vsp.com**

Priority Health (Care Choices) HMO: 1-800-852-9780 • **priorityhealth.com**

	Community Blue PPO Option 1 **AC/AP/CC/FA/PT/VF**		*Community Blue PPO Option 2* **AC/AP/CC/FA/PT/VF**		*BCBSM Traditional* **FA**	*Priority Health* **FA**
Benefits	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*		
Hospital Services						
Number of Days of Care	Unlimited	Unlimited	Unlimited	Unlimited	365 days for general care and 45 days for pulmonary TB, 60-day renewal; additional days under Master Medical (MM), after deductible	Unlimited
Semi-Private Room or Intensive Care	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible	Covered – 100%	Covered in full
Surgery and All Related Surgical Services	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible	Covered – 100%	Covered in full
Anesthesia	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible	Covered – 100%	Covered in full
Laboratory Tests and X-rays	Covered – 90% after deductible, with limitations[1]	Covered – 70% after deductible, with limitations[1]	Covered – 100%, with limitations[1]	Covered – 80% after deductible, with limitations[1]	Covered – 100%	Covered in full
Medicines and Drugs	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible	Covered – 100%	Covered in full
In Hospital Physician Care	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible	Unlimited days for general care and 45 days for pulmonary TB	Covered in full
Outpatient Services						
Office Visit (for illness or injury)	Covered – $15 copay	Covered – 70% after deductible, must be medically necessary	Covered – $10 copay	Covered – 80% after deductible, must be medically necessary	Covered – 90% under MM after deductible	Covered – $10 copay
Specialist Office Visit	Covered – $15 copay	Covered – 70% after deductible, must be medically necessary	Covered – $10 copay	Covered – 80% after deductible, must be medically necessary	Covered – 90% under MM after deductible	Covered – $10 copay upon approved referral
Routine Physical Examination	Covered – 100%, one per calendar year	Not covered	Covered – 100%, one per calendar year	Not covered	Not covered	Covered – included in office visit
Dermatology Services	Covered – $15 copay	Covered – 70% after deductible	Covered – $10 copay	Covered – 80% after deductible	Covered – with limitations[1]	Covered – included in office visit
Allergy Services	Covered – with limitations[1]	Covered – 70% after deductible, with limitations[1]	Covered – with limitations[1]	Covered – 80% after deductible, with limitations[1]	Covered – 90% under MM after deductible	Covered – included in office visit
Chiropractic Services	Covered – 100%, up to 24 visits per calendar year	Covered – 70% after deductible,up to 24 visits per calendar year	Covered – 100%, up to 24 visits per calendar year	Covered – 80% after deductible, up to 24 visits per calendar year	Covered – 90% under MM after deductible	Not covered
Immunizations	Covered – 100% (through age 16)	Not covered	Covered – 100% (through age 16)	Not covered	Not covered	Covered – included in office visit
Outpatient Surgery	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible	Covered – 100%	Covered in full
Occupational Therapy, Physical Therapy, Speech Therapy	Covered – 90%, up to 60 visits per calendar year	Covered – 70 % after deductible, up to 60 visits per calendar year	Covered – 100%, up to 60 visits per calendar year	Covered – 80 % after deductible, up to 60 visits per calendar year	Covered – 60 combined days per calendar year; additional MM benefits, 90% after deductible	Covered in full – up to 60 combined visits per year
Voluntary Family Planning Services	Covered – 90% after deductible, with limitations[1]	Not covered	Covered – with limitations[1]	Not covered	Not covered	Covered – included in office visit
Infertility Treatment and Procedures	Covered – 90% after deductible, with limitations[1]	Not covered	Covered – with limitations[1]	Not covered	Not covered	Covered – with limitations

	Community Blue PPO Option 1 AC/AP/CC/FA/PT/VF		Community Blue PPO Option 2 AC/AP/CC/FA/PT/VF		BCBSM Traditional FA	Priority Health FA
Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**		
Outpatient Services continued						
Voluntary Sterilization	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible	Not covered	Not covered
Pregnancy Termination	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible	Covered – 100%	Not covered
Diagnostic and Therapeutic Procedures						
Laboratory Tests	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible	Covered – 100%	Covered in full
Radiation Therapy	Covered – 90% after deductible	Covered – 70% after deductible	Covered –100%	Covered – 80% after deductible	Covered – 100%	Covered in full
Diagnostic X-rays and Tests	Covered – 90% after deductible, with limitations[1]	Covered – 70% after deductible, with limitations[1]	Covered – with limitations[1]	Covered – 80% after deductible, with limitations[1]	Covered – 100%	Covered in full
Chemotherapy	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible	Covered – 100%	Covered in full
Routine Pap Smear Test	Covered – 100%, one per calendar year (lab test only)	Not covered	Covered – 100%, one per calendar year (lab test only)	Not covered	Covered – 100%	Covered in full
Mammogram	Covered – 100%, one per calendar year, no age restriction	Covered – 70% after deductible, one per calendar year, no age restriction	Covered – 100%, one per calendar year, no age restriction	Covered – 80% after deductible, one per calendar year, no age restriction	Covered – 100%, baseline 35-40 years, annual 40+ years	Covered in full
Hospital Emergency Room Services						
At participating Hospitals	Covered – $50 copay, waived if admitted or for an accidental injury	Covered – $50 copay, waived if admitted or for an accidental injury	Covered – $50 copay, waived if admitted or for an accidental injury	Covered – $50 copay, waived if admitted or for an accidental injury	Covered – 100% with approved diagnosis	Covered – subject to $25 copay for emergency treatment or when authorized (copay waived if admitted)
At Non Participating Hospitals in Plan Service Area	Covered – $50 copay, waived if admitted or for an accidental injury	Covered – $50 copay, waived if admitted or for an accidental injury	Covered – $50 copay, waived if admitted or for an accidental injury	Covered – $50 copay, waived if admitted or for an accidental injury	Covered – $25 maximum per visit for non-participating hospitals	Covered – subject to $25 copay for emergency treatment or when authorized (copay waived if admitted)
Ambulance Service	Covered – 100%, must be medically necessary	Covered – 100%, must be medically necessary	Covered – 100%, must be medically necessary	Covered – 100%, must be medically necessary	Covered – 90% under MM after deductible	Covered in full for emergencies or when approved by the Plan
Maternity Services						
Prenatal and Post Partum Care	Covered – 100%	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible	Covered – 90% under MM after deductible[4]	Covered in full, $10 copay first visit
Delivery in Hospital	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible	Covered – 100%	Covered in full
Newborn Examination(Inpatient)	Covered – 90% after deductible	Not covered	Covered – 100%	Not covered	Covered – 100%	Covered in full
Well-Baby Care (Outpatient)	Covered – 100%	Not covered	Covered – 100%	Not covered	Not covered	Covered, $10 copay per visit
Other Medical Services						
Durable Medical Equipment	Covered – 90% after deductible, with limitations[1]	Covered – 70% after deductible, with limitations[1]	Covered – with limitations[1]	Covered – with limitations[1]	Covered – 90% under MM after deductible	Covered in full
Prosthetic/Orthotic Devices	Covered – 90% after deductible, with limitations[1]	Covered – 70% after deductible, with limitations[1]	Covered – with limitations[1]	Covered – with limitations[1]	Covered – 90% under MM after deductible	Covered in full
Home Health Care (Professional Services only)	Covered – 90% after deductible	Covered – 90% after deductible	Covered – 100%	Covered – 100%	Covered – 100%	Covered in full
Hospice Care	Covered – 100%, limited to lifetime dollar maximum which is adjusted annually by the State	Covered – 100%, limited to lifetime dollar maximum which is adjusted annually by the State	Covered – 100%, limited to lifetime dollar maximum which is adjusted annually by the State	Covered – 100%, limited to lifetime dollar maximum which is adjusted annually by the State	Covered – 100%	Covered in full with authorization
Skilled Nursing Facility	Covered – 100%, limited to 120 days per calendar year	Covered – 100%, limited to 120 days per calendar year	Covered – 100%, limited to 120 days per calendar year	Covered – 100%, limited to 120 days per calendar year	Not covered	Covered in full, up to 730 days
Hearing Services	Covered – $15 copay per visit (exams, tests, hearing aid once every 36 months when provided by participating providers)	Not covered	Covered – $10 copay per visit (exams, tests, hearing aid once every 36 months when provided by participating providers)	Not covered	Not covered	Covered for exams, tests; hearing aids not covered

	Community Blue PPO Option 1 AC/AP/CC/FA/PT/VF		Community Blue PPO Option 2 AC/AP/CC/FA/PT/VF		BCBSM Traditional FA	Priority Health FA
Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**		
Vision Services						
Eye Exam	Covered – $5 copay up to $35. Once every 24 months, covers a complete eye exam including refraction, glaucoma testing and other test necessary to determine the overall visual health of the patient	Covered – $5 copay, up to $35. Once every 24 months, covers a complete eye exam including refraction, glaucoma testing and other test necessary to determine the overall visual health of the patient	Covered – $5 copay, up to $35. Once every 24 months, covers a complete eye exam including refraction, glaucoma testing and other test necessary to determine the overall visual health of the patient	Covered – $5 copay, up to $35. Once every 24 months, covers a complete eye exam including refraction, glaucoma testing and other test necessary to determine the overall visual health of the patient	Not covered	Not covered
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.)	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.)	Not covered	Not covered
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.	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.	Not covered	Not covered
Contacts	Covered – $120 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 – $120 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 – $120 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 – $120 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.	Not covered	Not covered
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)	Not covered	Not covered
Prescriptions						
Retail Prescription Drugs	Covered – $10 for generic, $20 for Preferred brand-name drugs listed on the BCBSM Custom Formulary, $30 for Nonpreferred brand-name drugs not listed on the BCBSM Custom Formulary	Covered – 75% of approved amount less copay	Covered – $10 for generic, $20 for Preferred brand-name drugs listed on the BCBSM Custom Formulary, $30 for Nonpreferred brand-name drugs not listed on the BCBSM Custom Formulary	Covered – 75% of approved amount less copay	Covered – $10 for generic, $20 for Preferred brand-name drugs listed on the BCBSM Custom Formulary, $30 for Nonpreferred brand-name drugs not listed on the BCBSM Custom Formulary	Covered – $15 for generic; $25 for brand-name, up to 34-day supply.
Mail Order Drugs[2]	Covered – 90 day supply, $20 for generic, $40 for Preferred brand-name drugs listed on the BCBSM Custom Formulary, $60 for Nonpreferred brand-name drugs not listed on the BCBSM Custom Formulary. Mandatory mail order for maintenance drugs after third refill is strongly recommended.	N/A	Covered – 90 day supply, $20 for generic, $40 for Preferred brand-name drugs listed on the BCBSM Custom Formulary, $60 for Nonpreferred brand-name drugs not listed on the BCBSM Custom Formulary. Mandatory mail order for maintenance drugs after third refill is strongly recommended.	N/A	Covered – 90 day supply, $20 for generic, $40 for Preferred brand-name drugs listed on the BCBSM Custom Formulary, $60 for Nonpreferred brandname drugs not listed on the BCBSM Custom Formulary. Mandatory mail order for maintenance drugs after third refill is strongly recommended.	$30 copay generic; $50 copay brand-name; up to a maximum of 90-day supply.[3] Certain maintenance drugs are available by mail order through Express Scripts, Inc. Two (2) times copay for up to a 90-day supply.
Birth Control Pills	Covered – $10 for generic, $20 for Preferred brand-name drugs listed on the BCBSM Custom Formulary, $30 for Nonpreferred brand-name drugs not listed on the BCBSM Custom Formulary	Covered – 75% of amount billed then copay	Covered – $10 for generic, $20 for Preferred brand-name drugs listed on the BCBSM Custom Formulary, $30 for Nonpreferred brand-name drugs not listed on the BCBSM Custom Formulary	Covered – 75% of amount billed then copay	Not covered	Not covered
Birth Control Devices	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible	Not covered	Not covered

	Community Blue PPO Option 1 AC/AP/CC/FA/PT/VF		Community Blue PPO Option 2 AC/AP/CC/FA/PT/VF		BCBSM Traditional FA	Priority Health FA
Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network		
Mental Health Care						
Inpatient Psychiatric Services	Covered – 80%, limited to 60 days annually, 120 days lifetime	Covered – 80% after deductible, limited to 60 days annually, 120 days lifetime	Covered – 80%, limited to 60 days annually, 120 days lifetime	Covered – 80% after deductible, limited to 60 days annually, 120 days lifetime	Covered – 60 days, 120 days lifetime MM benefits, 75% after deductible	Covered in full, up to 45 days/year
Outpatient Visits	Covered – 80%, facility and clinic; Covered – 80%, physician's office	Covered – 80%, facility and clinic; Covered – 80%, physician's office, after deductible	Covered – 80%, facility and clinic; Covered – 80%, physician's office	Covered – 80%, facility and clinic; Covered – 80%, physician's office, after deductible	Covered – 50 annual visits, 120 lifetime visits, 75% under MM after deductible	Up to 20 visits/year, $10 copay/visit
Alcoholism and Substance Abuse						
Inpatient Services	Covered – 80%, limited to 60 days annually, 120 days lifetime	Covered – 80% after deductible, limited to 60 days annually, 120 days lifetime	Covered – 80%, limited to 60 days annually, 120 days lifetime	Covered – 80% after deductible, limited to 60 days annually, 120 days lifetime	Covered – up to the unused portion of inpatient psychiatric days (no MM coverage)	Covered in full, up to 30 days/year
Detoxification	Included in inpatient services above	Included in inpatient services above	Included in inpatient services above	Included in inpatient services above	Covered – up to 5 days	Included in inpatient services above
Outpatient Services	Covered – 80%, facility and clinic; Covered – 80%, physician's office	Covered – 80%, facility and clinic; Covered – 80%, physician's office, after deductible	Covered – 80%, facility and clinic; Covered – 80%, physician's office	Covered – 80%, facility and clinic; Covered – 80%, physician's office, after deductible	Covered – up to annual maximum determined by the state	Subject to prior evaluation; covered up to 35 visits/year; 50% copay
Miscellaneous						
Deductible	Covered – $250 per member, $500 per family	Covered – $500 per member, $1,000 per family	None	Covered – $250 per member, $500 per family	Basic Plan: no deductible copays as noted; Master Medical Deductible: $100 per person, $200 per family each calendar year	None; copays as noted
Coinsurance	Covered – 10% in-network; maximum: $500 per member, $1,000 per family	Covered – 30% out-of-network; maximum: $2,500 per member, $5,000 per family	None	Covered – 20% out-of-network; maximum: $2,000 per member, $4,000 per family	Covered – 10% general services, 25% mental health care and private duty nursing; maximums: $1 million per member	None; copays as noted
Claim Forms	None	Nonparticipating providers only	None	Nonparticipating providers only	On **bcbsm.com** Web site	None
Conversion Option	Yes	Yes	Yes	Yes	Yes	Yes
Pre-Existing Condition	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%	Covered in full
Dependent Coverage	Covered – up to age 19. Family Continuation Rider ages 19-25, unmarried, and IRS dependent. Sponsored Dependent at least 19 years of age or older, related by blood or marriage, IRS dependent. No vision or hearing coverage.	Covered – up to age 19. Family Continuation Rider ages 19-25, unmarried, and IRS dependent. Sponsored Dependent at least 19 years of age or older, related by blood or marriage, IRS dependent. No vision or hearing coverage.	Covered – up to age 19. Family Continuation Rider ages 19-25, unmarried, and IRS dependent. Sponsored Dependent at least 19 years of age or older, related by blood or marriage, IRS dependent. No vision or hearing coverage.	Covered – up to age 19. Family Continuation Rider ages 19-25, unmarried, and IRS dependent. Sponsored Dependent at least 19 years of age or older, related by blood or marriage, IRS dependent. No vision or hearing coverage.	Covered – up to age 19. Family Continuation Rider ages 19-25, unmarried, and IRS dependent. Sponsored Dependent at least 19 years of age or older, related by blood or marriage, IRS dependent. No Master Medical coverage.	Covered – up to age 19. Family Continuation Rider ages 19-25, unmarried, and IRS dependent. Sponsored Dependent at least 19 years of age or older, related by blood or marriage, IRS dependent.

Footnotes

[1] Contact Customer Service for additional information at 800-637-2227 (8:30 a.m.–12:00 p.m., 1:00 p.m. - 5:00 p.m., Monday – Friday).

[2] When a member obtains a brand-name drug (preferred or nonpreferred), the copay for Tier 2 or 3 still applies even if the prescription indicates “Dispense as Written” (DAW) or the brand name medication has no generic equivalent.

[3] Certain maintenance drugs are available by mail order through Express Scripts, Inc. Two (2) times copay for up to a 90-day supply.

[4] Prenatal and postpartum care visits are considered a basic benefit, without a copay.