

# Eastern Michigan University Community Blue Benefit Summary

This is not a full description of coverage. It is a comparison intended to highlight the coverage of the health plans. If you have questions before making a plan selection, you may contact the plan's Member Services Department.

Blue Cross Blue Shield: 1-877-257-9703 or 1-800-637-2227 or [www.bcbsm.com](http://www.bcbsm.com)

## Community Blue Option 1

## Community Blue Option 2

<b>Benefits</b>	<b>PPO In-Network</b>	<b>PPO Out-of-Network</b>	<b>PPO In-Network</b>	<b>PPO Out-of-Network</b>
<b>Hospital Services</b>				
<b>Hospital Services</b>	Unlimited	Unlimited	Unlimited	Unlimited
<b>Number of Days of Care</b>				
<b>Semi-Private Room or Intensive Care</b>	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
<b>Surgery and All Related Surgical Services</b>	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
<b>Anesthesia</b>	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
<b>Laboratory Tests and X-rays</b>	Covered – 90% after deductible, with limitations <sup>1</sup>	Covered – 70% after deductible, with limitations <sup>1</sup>	Covered – 100%, with limitations <sup>1</sup>	Covered – 80% after deductible, with limitations <sup>1</sup>
<b>Medicines and Drugs</b>	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
<b>In Hospital Physician Care</b>	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible

<b>Benefits</b>	<b>PPO In-Network</b>	<b>PPO Out-of-Network</b>	<b>PPO In-Network</b>	<b>PPO Out-of-Network</b>
<b>Outpatient Services</b>				
<b>Office Visit (for illness or injury)</b>	Covered – \$15 copay	Covered – 70% after deductible, must be medically necessary	Covered – \$10 copay	Covered – 80% after deductible, must be medically necessary
<b>Specialist Office Visit</b>	Covered – \$15 copay	Covered – 70% after deductible, must be medically necessary	Covered – \$10 copay	Covered – 80% after deductible, must be medically necessary
<b>Routine Physical Examination</b>	Covered – 100%, one per calendar year	Not covered	Covered – 100%, one per calendar year	Not covered
<b>Dermatology Services</b>	Covered – \$15 copay	Covered – 70% after deductible	Covered – \$10 copay	Covered – 80% after deductible
<b>Allergy Services</b>	Covered – with limitations <sup>6</sup>	Covered – 70% after deductible, with limitations <sup>6</sup>	Covered – with limitations <sup>6</sup>	Covered – 80% after deductible, with limitations <sup>6</sup>
<b>Chiropractic Services</b>	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
<b>Immunizations</b>	Covered – 100% (through age 16)	Not covered	Covered – 100% (through age 16)	Not covered
<b>Outpatient Surgery</b>	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
<b>Occupational Therapy, Physical Therapy, Speech Therapy</b>	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
<b>Voluntary Family Planning Services</b>	Covered – 90% after deductible, with limitations <sup>6</sup>	Not covered	Covered – with limitations <sup>6</sup>	Not covered
<b>Infertility Treatment and Procedures</b>	Covered – 90% after deductible, with limitations <sup>6</sup>	Not covered	Covered – with limitations <sup>6</sup>	Not covered
<b>Voluntary Sterilization</b>	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
<b>Pregnancy Termination</b>	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible

**Community Blue Option 1**

**Community Blue Option 2**

<b>Benefits</b>	<b>PPO In-Network</b>	<b>PPO Out-of-Network</b>	<b>PPO In-Network</b>	<b>PPO Out-of-Network</b>
<b>Diagnostic and Therapeutic Procedures</b>				
<b>Laboratory Tests</b>	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
<b>Radiation Therapy</b>	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
<b>Diagnostic X-rays and Tests</b>	Covered – 90% after deductible, with limitations <sup>6</sup>	Covered – 70% after deductible, with limitations <sup>6</sup>	Covered – with limitations <sup>6</sup>	Covered – 80% after deductible, with limitations <sup>6</sup>
<b>Chemotherapy</b>	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
<b>Routine Pap Smear Test</b>	Covered – 100%, one per calendar year (lab test only)	Not covered	Covered – 100%, one per calendar year (lab test only)	Not covered
<b>Mammogram</b>	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
<b>Hospital Emergency Room Services</b>				
<b>At participating Hospitals</b>	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
<b>At Non Participating Hospitals in Plan Service Area</b>	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
<b>Ambulance Service</b>	Covered – 100%, must be medically necessary	Covered – 100%, must be medically necessary	Covered – 100%, must be medically necessary	Covered – 100%, must be medically necessary

<b>Benefits</b>	<b>PPO In-Network</b>	<b>PPO Out-of-Network</b>	<b>PPO In-Network</b>	<b>PPO Out-of-Network</b>
<b>Maternity Services</b>				
<b>Prenatal and Post Partum Care</b>	Covered – 100%	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
<b>Delivery in Hospital</b>	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
<b>Newborn Examination (Inpatient)</b>	Covered – 90% after deductible	Not covered	Covered – 100%	Not covered
<b>Well-Baby Care (Outpatient)</b>	Covered – 100%	Not covered	Covered – 100%	Not covered
<b>Other Medical Services</b>				
<b>Durable Medical Equipment</b>	Covered – 90% after deductible, with limitations <sup>6</sup>	Covered – 70% after deductible, with limitations <sup>6</sup>	Covered – with limitations <sup>6</sup>	Covered – with limitations <sup>6</sup>
<b>Prosthetic/Orthotic Devices</b>	Covered – 90% after deductible, with limitations <sup>6</sup>	Covered – 70% after deductible, with limitations <sup>6</sup>	Covered – with limitations <sup>6</sup>	Covered – with limitations <sup>6</sup>
<b>Home Healthcare (Professional Services only)</b>	Covered – 90% after deductible	Covered – 90% after deductible	Covered – 100%	Covered – 100%
<b>Hospice Care</b>	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
<b>Skilled Nursing Facility</b>	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
<b>Hearing Services</b>	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

<b>Benefits</b>	<b>PPO In-Network</b>	<b>PPO Out-of-Network</b>	<b>PPO In-Network</b>	<b>PPO Out-of-Network</b>
<b>Vision Services</b>				
<b>Eye Exam</b>	Covered – \$5 copay up to \$35 <sup>7</sup> . 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
<b>Frames</b>	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.)
<b>Lenses</b>	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.
<b>Contacts</b>	Covered – \$105 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 – \$105 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.
<b>Therapeutic Contact Lenses</b>	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)

**Community Blue Option 1**

**Community Blue Option 2**

<b>Benefits</b>	<b>PPO In-Network</b>	<b>PPO Out-of-Network</b>	<b>PPO In-Network</b>	<b>PPO Out-of-Network</b>
<b>Alcoholism and Substance Abuse</b>				
<b>Inpatient Services</b>	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
<b>Detoxification</b>	Included in inpatient services above	Included in inpatient services above	Included in inpatient services above	Included in inpatient services above
<b>Outpatient Services</b>	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
<b>Miscellaneous</b>				
<b>Deductible</b>	Covered – \$250 per member, \$500 per family	Covered – \$500 per member, \$1,000 per family	None	Covered – \$250 per member, \$500 per family
<b>Coinsurance</b>	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
<b>Claim Forms</b>	None	Nonparticipating providers only	None	Nonparticipating providers only
<b>Conversion Option</b>	Yes	Yes	Yes	Yes
<b>Pre-Existing Condition</b>	Covered – 100%	Covered – 100%	Covered – 100%	Covered – 100%

<b>Benefits</b>	<b>PPO In-Network</b>	<b>PPO Out-of-Network</b>	<b>PPO In-Network</b>	<b>PPO Out-of-Network</b>
<b>Prescriptions</b>				
<b>Retail Prescription Drugs</b>	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	N/A	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	N/A
<b>Mail Order Drugs<sup>8</sup></b>	Covered – 90 day supply, \$30 for generic, \$60 for Preferred brand-name drugs listed on the BCBSM Custom Formulary, \$90 for Nonpreferred brand-name drugs not listed on the BCBSM Custom Formulary. Mandatory mail order for maintenance drugs after third refill	N/A	Covered – 90 day supply, \$30 for generic, \$60 for Preferred brand-name drugs listed on the BCBSM Custom Formulary, \$90 for Nonpreferred brand-name drugs not listed on the BCBSM Custom Formulary. Mandatory mail order for maintenance drugs after third refill	N/A
<b>Birth Control Pills</b>	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
<b>Birth Control Devices</b>	Covered – 90% after deductible	Covered – 70% after deductible	Covered – 100%	Covered – 80% after deductible
<b>Mental Healthcare</b>				
<b>Inpatient Psychiatric Services</b>	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
<b>Outpatient Visits</b>	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

## Special Footnotes

<sup>6</sup> Contact Customer Service for additional information at 1-800-637-2227.(8:30 a.m. – 12:00 p.m., 1:00 p.m. – 5:00 p.m., Monday – Friday.)

<sup>7</sup> VSP — Vision Services Plan 1-800-877-7195: [www.VSP.com](http://www.VSP.com)

<sup>8</sup> 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.