2019

# EMU Benefits Comparison

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Blue Cross Blue Shield of Michigan: 877-354-2583 • **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** | $1,350 for a one-person contract or $2,700 for a family contract (2 or more members) each calendar year **(no 4th quarter carry-over)** | $2,100 for a one-person contract or $5,200 for a family contract (2 or more members) each calendar year **(no 4th quarter carry-over)** | $250 for one member, $500 for two person, $750 for the family<br>**Note:** Deductible may be waived if service is performed in a PPO physician's office. | $1,000 for one member, $1,500 for the family (when two or more members are covered under your contract) each calendar year<br>**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<br>• $50 copay for emergency room visits | $50 copay for emergency room visits |
| **Percent coinsurance**<br>**Note:** Copays apply once the deductible has been met. | 20% of approved amount | 40% of approved amount | • 50% of approved amount for private duty nursing<br>• 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<br>• 30% of approved amount for most other covered services |
| **Annual Coinsurance Maximums (ACM)** | $1,250 for a one-person contract or $2,500 for a family contract (2 or more members) each calendar year | $2,500 for a one-person contract or $5,000 for a family contract (2 or more members) each calendar year | $1,000 for one member, $2,000 for two or more members each calendar year | $2,500 for one member, $5,000 for two or more members each calendar year<br>**Note:** Out-of-network copays also apply toward the in-network maximum. |
| | 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 | | | |
| **Annual out-of-pocket maximums** – includes deductible, fixed dollar medical and Rx copays, and coinsurance. | $2,500 for one member<br>$5,000 for two or more members each calendar year | $5,000 for one member<br>$10,000 for two or more members each calendar year<br>**Note**: Out-of-network cost-sharing does not count toward the in-network out-of-pocket maximum. | $6,600 for one member<br>$13,200 for two or more members each calendar year | $13,200 for one member<br>$26,400 for two or more members each calendar year<br>**Note**: Out-of-network cost-sharing does not count toward the in-network out-of-pocket maximum. |
| **Lifetime dollar maximum** | None | | None | |

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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|---|---|---|---|---|
| **Benefits** | **In-Network** | **Out-of-Network*** | **In-Network** | **Out-of-Network*** |
| **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 |
| Well-baby and child care visits | 100% (no deductible or copay)<br>• 8 visits for first 12 months<br>• 6 visits from 13 months to 23 months<br>• 6 visits from 24 to 35 months<br>• 2 visits per 12 months age 36 to 47 months<br>• 1 visit per 12 months age 48 months to adult<br>If older than age restrictions or subsequent tests, services should process according to current group specific benefits. | Not covered | 100% (no deductible or copay)<br>• 8 visits for first 12 months<br>• 6 visits from 13 months to 23 months<br>• 6 visits from 24 to 35 months<br>• 2 visits per 12 months age 36 to 47 months<br>• 1 visit per 12 months age 48 months to adult<br>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)<br>**Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay. | 60% after out-of-network deductible<br>**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)<br>**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<br>**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<br>**Note:** Medically necessary colonoscopies are subject to your deductible and percent copay. | 60% after out-of-network deductible | 100% (no deductible or copay) for the first billed colonoscopy<br>**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) | 60% 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) | 60% after out-of-network deductible | 100% (no deductible or copay/ coinsurance) | 70% after out-of-network deductible |

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| **Physician office services** | | | | |
| Office visits – must be medically necessary | 80% after in-network deductible | 60% 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 | 80% after in-network deductible | 60% after out-of-network deductible | 90% after in-network deductible | 70% after out-of-network deductible, must be medically necessary |
| Office consultations – must be medically necessary | 80% after in-network deductible | 60% 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 | 80% after in-network deductible | 60% after out-of-network deductible | $20 copay per office visit | 70% after out-of-network deductible, must be medically necessary |
| **Emergency medical care** | | | | |
| Hospital emergency room | 80% after in-network deductible | 80% after in-network deductible | $50 copay per visit (copay waived if admitted or for an accidental injury) | $50 copay per visit (copay waived if admitted or for an accidental injury) |
| Ambulance services – must be medically necessary | 80% after in-network deductible | 80% after in-network deductible | 100% if medically necessary | 100% if medically necessary |
| **Diagnostic services** | | | | |
| Laboratory and pathology services | 80% after in-network deductible | 60% after out-of-network deductible | 90% after in-network deductible | 70% after out-of-network deductible |
| Diagnostic tests and x-rays | 80% after in-network deductible | 60% after out-of-network deductible | 90% after in-network deductible | 70% after out-of-network deductible |
| Therapeutic radiology | 80% after in-network deductible | 60% after out-of-network deductible | 90% after in-network deductible | 70% after out-of-network deductible |
| **Maternity services provided by a physician** | | | | |
| Prenatal and postnatal care visits | 80% after in-network deductible | 60% after out-of-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 | |
| Delivery and nursery care | 80% after in-network deductible | 60% 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<br>**Note:** Nonemergency services must be rendered in a **participating** hospital. | 80% after in-network deductible | 60% after out-of-network deductible | 90% after in-network deductible | 70% after out-of-network deductible |
| | Unlimited days | | Unlimited days | |
| Inpatient consultations | 80% after in-network deductible | 60% after out-of-network deductible | 90% after in-network deductible | 70% after out-of-network deductible |
| Chemotherapy | 80% after in-network deductible | 60% after out-of-network deductible | 90% after in-network deductible | 70% after out-of-network deductible |

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| **Alternatives to hospital care** | | | | |
| Skilled nursing care – must be in a **participating** skilled nursing facility | 80% after in-network deductible<br>Limited to a maximum of 90 days per member per calendar year | 80% after in-network deductible | 100%<br>Limited to a maximum of 120 days per member per calendar year | 100% |
| Hospice care | 80% after in-network deductible<br>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) | 80% after in-network deductible | 100% (no deductible or copay)<br>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) | 100% (no deductible or copay) |
| Home health care – must be medically necessary and provided by a **participating** home health care agency | 80% after in-network deductible | 80% after in-network deductible | 100% (professional services only) | 100% (professional services only) |
| Home infusion therapy – must be medically necessary and given by **participating** home infusion therapy providers | 80% after in-network deductible | 80% 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 | 80% after in-network deductible | 60% after out-of-network deductible | 90% after in-network deductible | 70% after out-of-network deductible |
| Presurgical consultations | 80% after in-network deductible | 60% 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) | 80% after in-network deductible | 80% 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) | 80% after in-network deductible | 60% after out-of-network deductible | 90% after in-network deductible | 70% after out-of-network deductible |
| Specified oncology clinical trials | 80% after in-network deductible | 60% after out-of-network deductible | 90% after in-network deductible | 70% after out-of-network deductible |
| Kidney, cornea and skin transplants | 80% after in-network deductible | 60% after out-of-network deductible | 90% after in-network deductible | 70% after out-of-network deductible |

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|---|---|---|---|---|
| **Benefits** | **In-Network** | **Out-of-Network*** | **In-Network** | **Out-of-Network*** |
| **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 | 80% after in-network deductible | 60% after out-of-network deductible | 90% after in-network deductible | 70% after out-of-network deductible |
| | Unlimited days | | Unlimited days | |
| • Outpatient clinic | 80% after in-network deductible | 80% after in-network deductible, in participating facilities only | 100% (no deductible or copay) | 70% after out-of-network deductible, must be medically necessary |
| • Outpatient physician's office | 80% after in-network deductible | 60% after out-of-network deductible | 100% (no deductible or copay) | 70% after out-of-network deductible |
| Outpatient substance abuse treatment – in approved facilities only | 80% after in-network deductible | 60% 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% (no deductible or copay) | 60% 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. | 80% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay) for diabetes self-management training | 60% 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 | 80% after in-network deductible | 60% 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 | 80% after in-network deductible | 60% 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 | 80% after in-network deductible | 80% after in-network deductible | 90% after in-network deductible | 90% after in-network deductible |
| Prosthetic and orthotic appliances | 80% after in-network deductible | 80% after in-network deductible | 90% after in-network deductible | 90% after in-network deductible |
| Private duty nursing | 80% after in-network deductible | 80% after in-network deductible | 50% 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 | 80% after in-network deductible, but limited to 24 visits | 60% 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 |

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| **Other covered services (continued)** | | | | |
| Prescription drugs<br><br>For the Simply Blue (HSA), you must pay full cost (copays and coinsurance) until the deductible is met. | **Note: If you seek prescriptions drugs through Snow Pharmacy, you can fill Tier I drugs at a $3 copay or $7 for 90-day supply (applies to all three plans)** | | | |
| SNOW PHARMACY | 34-day supply:<br>Tier 1 – $3 copay<br>Tier 2 – $30 copay<br>Tier 3 – $60 copay<br>Tier 4 – $75 copay<br>90-day supply:<br>Tier 1 – $7 copay<br>Tier 2 – $60 copay<br>Tier 3 – $120 copay<br>Tier 4 – N/A | Not Applicable | 34-day supply:<br>Tier 1 – $3 copay<br>Tier 2 – $30 copay<br>Tier 3 – $60 copay<br>Tier 4 – $75 copay<br>90-day supply:<br>Tier 1 – $7 copay<br>Tier 2 – $60 copay<br>Tier 3 – $120 copay<br>Tier 4 – N/A | Not Applicable |
| | Tier 1 – $10 copay<br>Tier 2 – $30 copay<br>Tier 3 – $60 copay<br>Tier 4 – $75 copay | | Tier 1 – $10 copay<br>Tier 2 – $30 copay<br>Tier 3 – $60 copay<br>Tier 4 – $75 copay | |
| | Mail order:<br>Tier 1 – $10 (35 to 90 day, $25)<br>Tier 2 – $30 (35 to 90 day, $75)<br>Tier 3 – $60 (35 to 90 day, $150) | | Mail order:<br>Tier 1 – $10 (35 to 90 day, $25)<br>Tier 2 – $30 (35 to 90 day, $75)<br>Tier 3 – $60 (35 to 90 day, $150) | |
| **Vision services** | | | | |
| 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 $35, 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 | 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 | 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 $35, 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.) | 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 $45, 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 $45, 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) |

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.

# Benefit Comparison for Healthy *Blue* Living℠

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)**<br>**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**<br>**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 and Post-Natal 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*

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)** |
| **Autism Spectrum Disorders, Diagnoses and Treatment** | | |
| Applied behavioral analyses (ABA) treatment | $20 Copay | $35 Copay |
| Outpatient physical, speech and occupational therapy, nutronal counseling for autism spectrum disorder through age 18 | $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<br>Up to 30 visits per calendar year | $45 Copay<br>Up to 30 visits per calendar year |
| Outpatient Physical, Speech and Occupational Therapy | $20 Copay<br>One period of treatment for any combined therapies within 60 consecutive days per calendar year. | $45 Copay<br>One period of treatment for any combined therapies within 60 consecutive days per calendar year. |
| 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 4 – $75 copay; with contraceptives, 30 day supply | Tier 1 – $20 copay, Tier 2 – $45 copay, Tier 3 – $85 copay; Tier 4 – $100 copay; with contraceptives, 30 day supply |
| | Women's Contraceptives – Tier 1 – 100%,<br>Tier 2 – Tier 2 Copayment/Coinsurance above applies,<br>Tier 3 – Tier 3 Copayment/Coinsurance above applies | Women's Contraceptives – Tier 1 – 100%,<br>Tier 2 – Tier 2 Copayment/Coinsurance above applies,<br>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** | | |
| 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 $35, 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 $35, 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 $45, 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 $45, 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.

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