

This is intended as an easy to read summary; it is not a contract. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable BCBSM certificates and riders. Payment amounts are based on the BCBSM approved amount, less any applicable deductible and/or copay amounts required by the plan.

Note: Services from a provider for which there is no 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. If you receive care from a nonparticipating provider, even if referred, you may be billed for the difference between BCBSM's approved amount and the provider's charge.

	90% Plan (with reimbursable in-network deductible)		100% Plan (with zero in-network deductible)	
	In-network	Out-of-network*	In-network	Out-of-network*
Annual deductible	\$1,000 individual, \$2,000 family. Because of the 75% reimbursement provision, the maximum actual deductible is \$250 individual, \$500 family	\$1,000 individual, \$2,000 family per calendar year	\$0 individual, \$0 family	\$500 individual, \$1,000 family per calendar year
Self-funded reimbursement provision	The College's Health Program will reimburse 75% of expenses applied to the in-network deductible; employee may use FSA as secondary reimbursement source	Reimbursement provision does not apply out-of-network; may use FSA	NA	NA
Fixed dollar copays (paid by member)	\$20 for office visits and \$50 for emergency room visits	\$50 for emergency room visits	\$10 for office visits and \$50 for emergency room visits	\$50 for emergency room visits
Percent copays (paid by member)	10% for general services, waived if service is performed in a PPO physician's office , and 50% for private duty nursing	30% for general services, 10% for in-patient mental health care, 50% for private duty nursing.	0% for general services and 50% for private duty nursing	20% for general services, 10% for in-patient mental health care, 50% for private duty nursing.
Copay maximums - fixed dollar copays	None	None	None	None
Copay maximums - percent copays (excludes mental health, substance abuse treatment and private duty nursing)	\$1,000 individual, \$2,000 family	\$2,000 individual, \$4,000 family	Not applicable	\$2,000 individual, \$4,000 family
Dollar maximums	\$1 million lifetime per covered specified human organ transplant type and a separate \$5 million lifetime per member for all other covered services and as noted for individual services			
Preventive care benefits - adults, includes health maintenance exam with chest x-ray, EKG; gynecological exam with pap screening and mammography; fecal occult blood screening, flexible sigmoidoscopy, PSA.	Covered 100%, one per calendar year	Not covered	Covered 100%, one per calendar year	Not covered
Preventive care benefits - well baby and child care children through age 15. Includes childhood immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics.	Covered 100% 6 visits (birth through 12 mo.), 6 visits (13-23 mo), 2 visits 24-35 mo), 2 visits 36-47 mo), 1 visit per birth year (48mo through age 15)	Not covered	Covered 100% 6 visits (birth through 12 mo.), 6 visits (13-23 mo), 2 visits 24-35 mo), 2 visits 36-47 mo), 1 visit per birth year (48mo through age 15)	Not covered
Physician office visit	Covered - \$20 copay	Covered - 70% after deductible	Covered - \$10 copay	Covered - 80% after deductible
Urgent care visits	Covered - \$20 copay	Covered - 70% after deductible	Covered - \$10 copay	Covered - 80% after deductible

	90% Plan	
	(with reimbursable in-network deductible)	
	In-network	Out-of-network*
Emergency care - hospital emergency room	Covered - \$50 copay, waived if admitted or for an accidental injury.	Covered - \$50 copay, waived if admitted or for an accidental injury.
Emergency care - ambulance services - medically necessary	Covered - 90% after deductible	Covered - 90% after deductible
Diagnostic services: laboratory and pathology services, diagnostic tests and x-rays; therapeutic radiology	Covered - 90% after deductible	Covered - 70% after deductible
Hospital care (semi private room, inpatient physician care, general nursing care, hospital services and supplies), inpatient consultations, chemotherapy	Covered - 90% after deductible	Covered - 70% after deductible
Alternatives to hospital care - skilled nursing,	Covered - 90% after deductible, up to 120 days per	
Alternatives to hospital care - hospice care	Covered - 100%, limited to dollar maximum that is reviewed and adjusted periodically	
Alternatives to hospital care - home health care and home infusion therapy, medically necessary	Covered - 90% after deductible	Covered - 70% after deductible
Chiropractic spinal manipulation	Covered - \$20 copay	Covered - 70% after deductible
	Up to 24 visits per calendar year	
Allergy testing and therapy	Covered at 100%	Covered - 70% after deductible
Outpatient physical, speech and occupational therapy	Covered - 90% after deductible	Covered - 70% after deductible
	Combined max. 60 visits per calendar year	
Maternity care- (prenatal and postnatal services provided by a physician or certified nurse midwife).	Covered - 100%	Covered - 70% after deductible
Maternity - delivery and nursery care (includes care by certified nurse midwife)	Covered - 90% after deductible	Covered - 70% after deductible
Inpatient hospital services	Covered - 90% after deductible	Covered - 70% after deductible
Outpatient hospital /alternative facility	Covered - 90% after deductible	Covered - 70% after deductible
Home health care	Covered - 90% after deductible	
Hospice care	Covered - 100%; limited to dollar max reviewed annually after deductible	
Skilled nursing	Covered 90% after deductible, up to 120 days/yr	
Surgery - includes related surgical services and voluntary sterilizations	Covered - 90% after deductible	Covered - 70% after deductible
Presurgical consultations	Covered - 100%	Covered - 70% after deductible
Private duty nursing	Covered - 50% after deductible	Covered - 50% after deductible
Durable medical equipment; prosthetic and orthotic appliances	Covered - 90% after deductible	Covered - 90% after deductible
Mental health - inpatient.	Covered - 90%, deductible waived	Covered - 70%, deductible waived
	Limit 60 days per year	
Mental health - outpatient.	Covered - \$20 copay, deductible waived	Covered - \$20 copay, deductible waived
	50 visit per year limit; no lifetime limit	
Prescription drugs (Rx) Contraceptives are covered. Elective drugs (used to treat sexual impotency, infertility, weight loss, smoking cessation) are not covered.	\$10 / \$20 / \$40	\$10/\$20/\$40 plus 25% of BCBSM approved amount.
Mail order Rx for 35- to 90-day supply	\$20 / \$40 / \$80	No coverage

	100% Plan	
	(with zero in-network deductible)	
	In-network	Out-of-network*
Emergency care - hospital emergency room	Covered - \$50 copay, waived if admitted or for an accidental injury.	Covered - \$50 copay, waived if admitted or for an accidental injury.
Emergency care - ambulance services - medically necessary	Covered - 100%	Covered - 100%
Diagnostic services: laboratory and pathology services, diagnostic tests and x-rays; therapeutic radiology	Covered - 100%	Covered - 80% after deductible
Hospital care (semi private room, inpatient physician care, general nursing care, hospital services and supplies), inpatient consultations, chemotherapy	Covered - 100%	Covered - 80% after deductible
Alternatives to hospital care - skilled nursing,	Covered 100%, up to 120 days per calendar year	
Alternatives to hospital care - hospice care	Covered - 100%, limited to dollar maximum that is reviewed and adjusted periodically	
Alternatives to hospital care - home health care and home infusion therapy, medically necessary	Covered - 100%	Covered - 80% after deductible
Chiropractic spinal manipulation	Covered - \$10 copay	Covered - 80% after deductible
	Up to 24 visits per calendar year	
Allergy testing and therapy	Covered - 100%	Covered - 80% after deductible
Outpatient physical, speech and occupational therapy	Covered - 100%	Covered - 80% after deductible
	Combined max. 60 visits per calendar year	
Maternity care- (prenatal and postnatal services provided by a physician or certified nurse midwife).	Covered - 100%	Covered - 80% after deductible
Maternity - delivery and nursery care (includes care by certified nurse midwife)	Covered - 100%	Covered - 80% after deductible
Inpatient hospital services	Covered - 100%	Covered - 80% after deductible
Outpatient hospital /alternative facility	Covered - 100%	Covered - 80% after deductible
Home health care	Covered 100%	
Hospice care	Covered - 100%; limited to dollar max reviewed annually after deductible	
Skilled nursing	Covered 100% after deductible, up to 120 days/yr	
Surgery - includes related surgical services and voluntary sterilizations	Covered - 100%	Covered - 80% after deductible
Presurgical consultations	Covered - 100%	Covered - 80% after deductible
Private duty nursing	Covered - 50% after deductible	Covered - 50% after deductible
Durable medical equipment; prosthetic and orthotic appliances	Covered - 100%	Covered - 100%
Mental health - inpatient.	Covered - 100%	Covered - 80%, deductible waived
	Limit 60 days per year	
Mental health - outpatient.	Covered - \$10 copay, deductible waived	Covered - \$10 copay, deductible waived
	50 visit per year limit; no lifetime limit	
Prescription drugs (Rx) Contraceptives are covered. Elective drugs (used to treat sexual impotency, infertility, weight loss, smoking cessation) are not covered.	\$10 / \$15 or \$20 / \$30	\$10/\$20/\$30 plus 25% of BCBSM approved amount.
Mail order Rx for 35- to 90-day supply	\$20 / \$40 / \$60	No coverage