Central Care Plan
Medical and Prescription Plan Comparison Grid

Services	PPO 2		Advantage HDHP		Advantage Plus HDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
This benefits summary is intended for use only as a source of reference. Official benefits, conditions, exclusions, and limitations are documented in the certificate and amendments.						
Medical Plan						
Carrier/Network	**Blue Cross Blue Shield Michigan (BCBSM) PPO**					
Annual Deductible (Benefit Plan Year: 7/1-6/30)	$800 per member $1,600 per family	$1,600 per member $3,200 per family **Note**: Out-of- network deductible amounts also count toward the in-network deductible	$2,000 per member $4,000 per family	$4,000 per member $8,000 per family	$5,000 per member $10,000 per family	$10,000 per member $20,000 per family
			Notes: • The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract. • No 4th quarter carry-over. This means claims incurred during the plan's 4th quarter (April – June) will not be applied to the following plan year's deductible.			
Coinsurance (Percent Copays) **Note:** Coinsurance amounts apply once the deductible has been met.	30% of approved amount for private duty nursing care 20% of approved amount for mental health care and substance abuse treatment 20% of approved amount for most other covered services	50% of approved amount for private duty nursing care 40% of approved amount for mental health care and substance abuse treatment 40% of approved amount for most other services	5% of approved amount for most covered services	20% of approved amount for most covered services	10 % of approved amount for most covered services	20% of approved amount for most covered services
Flat Dollar Copays	$30 copay for office visits, office consultations and urgent care $20 copay for chiropractic visits $100 copay for emergency room visits	$100 copay for emergency room visits	None	None	None	None

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Out-of-pocket Maximum (Applies to amounts for all covered services - deductibles, copays, and coinsurance)						
Medical Plan	$6,000 per member $12,000 for two or more members	$12,000 per member $24,000 for two or more members	$4,000 per member $8,000 for two or more members	$8,000 per member $16,000 for two or more members	$7,000 per member $14,000 for two or more members	$14,000 per member $28,000 for two or more members
Prescription Plan	$2,000 per member $4,000 for two or more members	$2,000 per member $4,000 for two or more members				
Total Out-of-Pocket Maximum	**$8,000 per member $16,000 for two or more members**	**$14,000 per member $28,000 for two or more members**	**$4,000 per member $8,000 for two or more members**	**$8,000 per member $16,000 for two or more members**	**$7,000 per member $14,000 for two or more members**	**$14,000 per member $28,000 for two or more members**
Preventive Care Services						
Health Maintenance Exam (Includes chest x-ray, EKG, cholesterol screening & other select lab procedures) **Note**: Additional well-women visits may be allowed based on medical necessity	100% (no deductible or copay / coinsurance), one per member **per calendar year**	Not Covered	100% (no deductible), one per member **per calendar year**	Not Covered	100% (no deductible), one per member **per calendar year**	Not Covered
Gynecological Exam **Note**: Additional well-women visits may be allowed based on medical necessity	100% (no deductible or copay / coinsurance), one per member **per calendar year**	Not Covered	100% (no deductible), one per member **per calendar year**	Not Covered	100% (no deductible), one per member **per calendar year**	Not Covered
Pap Smear Screening (Lab & pathology services)	100% (no deductible or copay / coinsurance), one per member **per calendar year**	Not Covered	100% (no deductible), one per member **per calendar year**	Not Covered	100% (no deductible), one per member **per calendar year**	Not Covered
Voluntary Sterilization for Females	100% (no deductible or copay / coinsurance)	60% after out-of-network deductible	100% (no deductible)	80% after out-of-network deductible	100% (no deductible)	80% after out-of-network deductible
Contraceptive Injections	100% (no deductible or copay / coinsurance)	60% after out-of-network deductible	100% (no deductible)	80% after out-of-network deductible	100% (no deductible)	80% after out-of-network deductible

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Well Baby & Child Care	100% (no deductible or copay / coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member **per calendar year**	Not Covered	100% (no deductible) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member **per calendar year**	Not Covered	100% (no deductible) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member **per calendar year**	Not Covered
Adult & Childhood Preventive Services & 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 / coinsurance)	Not Covered	100% (no deductible)	Not Covered	100% (no deductible)	Not Covered
Fecal Occult Blood Screening	100% (no deductible or copay / coinsurance), one per member **per calendar year**	Not Covered	100% (no deductible), one per member **per calendar year**	Not Covered	100% (no deductible), one per member **per calendar year**	Not Covered
Flexible Sigmoidoscopy Exam	100% (no deductible or copay / coinsurance), one per member **per calendar year**	Not Covered	100% (no deductible), one per member **per calendar year**	Not Covered	100% (no deductible), one per member **per calendar year**	Not Covered
Prostate Specific Antigen (PSA) Screening	100% (no deductible or copay / coinsurance), one **per calendar year**	Not Covered	100% (no deductible), one per member **per calendar year**	Not Covered	100% (no deductible), one per member **per calendar year**	Not Covered

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Routine Mammogram & Related Screening **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to deductible and coinsurance.	100% (no deductible or copay / coinsurance), one per member **per calendar year**	60% after out-of-network deductible **Note:** Out-of-network reading & interpretations are payable only when the screening mammogram itself is performed by an in-network provider.	100% (no deductible), one per member **per calendar year**	80% after out-of-network deductible **Note:** Out-of-network reading & interpretations are payable only when the screening mammogram itself is performed by an in-network provider.	100% (no deductible), one per member **per calendar year**	80% after out-of-network deductible **Note:** Out-of-network reading & interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
Colonoscopy (Routine or medically necessary) **Note:** Subsequent medically necessary colonoscopies are subject to your deductible and coinsurance.	100% (no deductible or copay / coinsurance), one per member **per calendar year**	60% after out-of-network deductible	100% (no deductible), one per member **per calendar year**	80% after out-of-network deductible	100% (no deductible), one per member **per calendar year**	80% after out-of-network deductible
Physician Office Services (Must be medically necessary)						
Office Visits	$30 copay per visit	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Outpatient & Home Medical Care Visits	80% after in-network deductible	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Office Consultations	$30 copay per office consultation	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Urgent Care Visits	$30 copay per urgent care visit	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Online Visits	Medical: $5 copay/visit Behavioral Health: $30 copay/visit	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Emergency Medical Care						
Hospital Emergency Room	$100 copay per visit (copay waived for inpatient hospitalization or accidental injury)		95% after in network deductible		90% after in network deductible	
Ambulance Services (Must be medically necessary)	80% after in-network deductible		95% after in-network deductible		90% after in network deductible	

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic Services						
Laboratory & Pathology Services	80% after in-network deductible	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Diagnostic Tests & X-Rays	80% after in-network deductible	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Therapeutic Radiology	80% after in-network deductible	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Maternity Services						
Pre- and Post-Natal Care Visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible	100% (no deductible)	80% after out-of-network deductible	100% (no deductible)	80% after out-of-network deductible
Postnatal Care	100% (no deductible or copay/coinsurance	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Delivery & Nursery Care	80% after in-network deductible	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Hospital Care						
Inpatient Hospital Care (Semi-private room, inpatient physician care, general nursing care, hospital services & supplies) **Note:** Non-emergency care must be rendered in a **participating** hospital.	80% after in-network deductible	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Inpatient Consultations	80% after in-network deductible	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Alternatives to Hospital Care						
Skilled Nursing Care (Must be in a **participating** skilled nursing facility) **Note:** Limited to a maximum of 120 days per member **per calendar year**	80% after in-network deductible		95% after in-network deductible		90% after in-network deductible	
Hospice Care (Must be in a **participating** hospice program) Note: Limited to 28 pre-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 / coinsurance)		95% after in-network deductible		90% after in-network deductible	
Home Health Care (Must be medically necessary and provided by **participating** home health care agency)	80% after in-network deductible		95% after in-network deductible		90% after in-network deductible	
Infusion Therapy (Must be medically necessary and provided by **participating** Home Infusion Therapy provider or in a **participating** freestanding Ambulatory Infusion Center. May use drugs that require pre- authorization – consult with your doctor.)	80% after in-network deductible		95% after in-network deductible		90% after in-network deductible	

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Surgical Services						
Surgery (Includes related surgical services & medically necessary facility services by a **participating** ambulatory surgery facility)	80 after in-network deductible	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Pre-surgical Consultations	100% (no deductible or copay / coinsurance)	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Voluntary Sterilization for Males	80% after in-network deductible	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Human Organ Transplants						
Specified Human Organ Transplants (Must be in a **designated** facility and coordinated through BCBSM Human Organ Transplant Program 1-800-242-3504)	100% (no deductible or copay / coinsurance) – in designated facilities **only**		95% after in-network deductible – in designated facilities **only**		90% after in-network deductible – in designated facilities **only**	
Bone Marrow Transplant (Must be coordinated through BCBSM Human Organ Transplant Program 1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Specified Oncology Clinical Trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Kidney, Cornea & Skin Transplants	80% after in-network deductible	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Mental Health and Substance Abuse Treatment *Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health and substance abuse service is considered by BCBSM to be comparable to an office visit, you pay only for an office visit.						
Inpatient Mental Health Care & Substance Abuse Treatment (In an approved facility, unlimited days)	80% after in-network deductible	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Residential Psychiatric Treatment Facility (Covered mental health services must be performed in residential psychiatric treatment facility. Treatment must be preauthorized subject to medical criteria)	80% after in-network deductible	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Outpatient Mental Health Care* (In participating facilities **only**)	**Facility and Clinic** 80% after in-network deductible **Physician's Office*** 80% after in-network deductible	**Facility and Clinic** 80% after in-network deductible **Physician's Office*** 60% after out-of-network deductible	**Facility and Clinic** 95% after in-network deductible **Physician's Office*** 95% after in-network deductible	**Facility and Clinic*** 95% after in network deductible **Physician's Office*** 80% after out-of-network deductible	**Facility and Clinic** 90% after in-network deductible **Physician's Office*** 90% after in-network deductible	**Facility and Clinic*** 90% after in network deductible **Physician's Office*** 80% after out-of-network deductible
Outpatient Substance Abuse Treatment* (In an approved facility)	80% after in-network deductible	60% after out-of-network deductible (In-network cost-sharing will apply if there is no PPO network)	95% after in-network deductible	80% after out-of-network deductible (In-network cost-sharing will apply if there is no PPO network)	90% after in-network deductible	80% after out-of-network deductible (In-network cost-sharing will apply if there is no PPO network)
Autism Spectrum Disorders, Diagnoses & Treatment						
Applied Behavioral Analysis (ABA) Treatment (When rendered by an approved board-certified behavioral analyst – is covered through age 18, subject to preauthorization)	80% after in-network deductible		95% after in-network deductible	95% after out-of-network deductible	90% after in-network deductible	90% after out-of-network deductible
			Note: Applied behavioral analyses treatment limited to an annual maximum of $50,000 per member, through age 18 (limit may be waived on an individual consideration basis)			
Outpatient Physical/Speech/ Occupational Therapy, Nutritional Counseling	80% after in-network deductible	60% after out-of-network deductible.	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Other Covered Services Including Mental Health Services	80% after in-network deductible	60% after out-of-network deductible.	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Other Covered Services						
Outpatient Diabetes Management Program **Note**: Screening services required under the provisions of PPACA are covered at 100% of the approved amount with no in network cost-sharing when rendered by a network provider. **Note**: When you purchase diabetic supplies via mail order will lower out of pocket costs	80% after in-network deductible for diabetes medical supplies 100% (no deductible or copay / coinsurance) for diabetes self-management training	60% after out-of-network deductible	95% after in-network deductible for diabetes medical supplies 100% (no deductible) for diabetes self-management training	80% after out-of-network deductible	90% after in-network deductible for diabetes medical supplies 100% (no deductible) for diabetes self-management training	80% after out-of-network deductible
Allergy Testing & Therapy	100% (no deductible or copay / coinsurance)	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Chiropractic Care Chiropractic spinal manipulation & Osteopathic manipulation therapy **Note:** Limited to 36 visits per member **per calendar year**	$20 copay per office visit	60% after out-of-network deductible	95% after in-network deductible	80% after out-of-network deductible	90% after in-network deductible	80% after out-of-network deductible
Outpatient Physical, Speech & Occupational Therapy (Provided for rehabilitation **Note:** Limited to a **combined** 60 maximum visits per member **per calendar year**	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at non-participating outpatient physical therapy facilities are not covered	95% after in-network deductible	80% after out-of-network deductible **Note**: Services at nonparticipating outpatient physical therapy facilities are not covered	90% after in-network deductible	80% after out-of-network deductible **Note**: Services at nonparticipating outpatient physical therapy facilities are not covered
Durable Medical Equipment **Note:** For a list of covered DME items required under the PPACA call BCBSM.	80% after in-network deductible		95% after in-network deductible		90% after in-network deductible	
Prosthetic & Orthotic Appliances	80% after in-network deductible		95% after in-network deductible		90% after in-network deductible	
Private Duty Nursing	70% after in-network deductible		95% after in-network deductible		90% after in-network deductible	

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Hearing Care						
Audiometric Exam (One every 36 months)	100% of approved amount	Not Covered	95% after in-network deductible	Not Covered	90% after in-network deductible	Not Covered
Hearing Aid Evaluation (One every 36 months)	100% of approved amount	Not Covered	95% after in-network deductible	Not Covered	90% after in-network deductible	Not Covered
Ordering & Fitting the Hearing Aid (Monaural hearing aid & binaural hearing aids)	**Monaural hearing aids:** 100% of approved amount up to $1,800 **Binaural hearing aids:** 100% of approved amount up to $3,600	Not Covered	**Monaural hearing aids:** 95% after in-network deductible up to $1,800 **Binaural hearing aids:** 95% after in-network deductible up to $3,600	Not Covered	**Monaural hearing aids:** 90% after in-network deductible up to $1,800 **Binaural hearing aids:** 90% after in-network deductible up to $3,600	Not Covered
Hearing Aid Conformity Test (One every 36 months)	100% of approved amount	Not Covered	95% after in-network deductible	Not Covered	90% after in-network deductible	Not Covered
Prescription						
Carrier/Network	**CVS Caremark**					
Deductible	None		Percent copay applies after deductible		Percent copay applies after deductible	
Annual Out-of-Pocket Maximum	$2,000 per member $4,000 for two or more members		**Notes:** • Included in Medical/Total Out-of-Pocket maximum			
30-Day Supply (Retail)						
Generic Preventive Medication	0% copay	50% copay	0% copay	50% copay	0% copay	50% copay
Generic	10% copay	50% copay	10% copay	50% copay	10% copay	50% copay
Preferred	20% copay	50% copay	20% copay	50% copay	20% copay	50% copay
Non-Preferred	30% copay	50% copay	30% copay	50% copay	30% copay	50% copay
90-Day Supply (Retail & Mail Order)						
Generic	10% copay	Not Covered	10% copay	Not Covered	10% copay	Not Covered
Preferred	20% copay	Not Covered	20% copay	Not Covered	20% copay	Not Covered
Non-Preferred	30% copay	Not Covered	30% copay	Not Covered	30% copay	Not Covered
Prudent RX (coupon program for eligible Specialty medications)						
Specialty drug (in program)	Enrolled: $0	Not Enrolled: 30%	Enrolled: $0 after deductible	Not Enrolled: 30% after deductible	Enrolled: $0 after deductible	Not Enrolled: 30% after deductible