Michigan Catholic Conference Health Plan Benefits Comparison

Plan Year: 2021

The information contained in this comparison tool is not the official statement of benefits. Before making your final health plan selection, please refer to the individual plan descriptions. Your employer establishes the amount, if any, of employee contribution towards cost of plan.

	BCN Blue Elect Plus		BCBSM PPO1		BCBSM PPO2		BCBSM PPOHD	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductibles/Maximums								
Deductible Single/Family	$100/$300	$500/$1500	$250/$500	$500/$1,000	$1,500/$3,000	$3,000/$6,000	$5,000/10,000	$10,000/$20,000
Annual Out of Pocket Max - Medical (single/family)	$1,000/$3,000	$3,000/$9,000	$1,250 / $2,500	$3,500 / $7, 000	$4,000 / $9,000	$8,000 / $16,000	$6,350/$12,700	$12,700/$25,400
Annual Out of Pocket Max - Rx (single/family)			$5,100 / $10,700	$10,200 / $21,400	$2,350 / $4,200	$4,700 / $8,400		
Coinsurance (Plan Share/Member share)	80% / 20%	80% / 20%	80% / 20%	60% / 40%	70% / 30%	60% / 40%	70% / 30%	60% / 40%
Office Visits								
Primary Care Office Visit	$20 copay	80% after deductible	$25 copay	60% after deductible	70% after deductible	60% after deductible	70% after deductible	60% after deductible
Specialist Visit	$35 copay	80% after deductible	$25 copay	60% after deductible	70% after deductible	60% after deductible	70% after deductible	60% after deductible
Preventive Services								
Health Maintenance Exam	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
Well-Baby & Child Care	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
Immunizations - pediatric & adult	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
Pre-Natal Care	100%	Not Covered	100%	60% after deductible	100%	60% after deductible	100%	Not Covered
Annual Gynecological Exam GYN Exams	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
Pap Smear Screening	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
Mammography Screening	100%	80% after deductible	100%	60% after deductible	100%	60% after deductible	100%	60% after deductible
Routine Colonoscopy	100%	80% after deductible	100%	60% after deductible	100%	60% after deductible	100%	Not Covered
Prostate Specific Antigen (PSA) Screening	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
Contraception Methods & Counseling	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Emergency Medical Care								
Hospital Emergency Room*	$150 copay	$150 copay	$100 copay	$100 copay	$100 copay	$100 copay	70% after deductible	60% after deductible
Urgent Care	$35 copay	$35 copay	$50 copay	60% after deductible	$50 copay	60% after deductible	70% after deductible	60% after deductible
Ambulance Services	$50 copay	$50 copay	80% after deductible	80% after deductible	70% after deductible	70% after deductible	70% after deductible	60% after deductible
Hospital Services								
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	80% after deductible	80% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible	70% after deductible	60% after deductible
Inpatient Medical Care	80% after deductible	80% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible	70% after deductible	60% after deductible
Surgical Services	80% after deductible	80% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible	70% after deductible	60% after deductible
Outpatient Surgery	80% after deductible	80% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible	70% after deductible	60% after deductible
Behavioral Health & Substance Abuse Inpatient	80% after deductible	80% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible	70% after deductible	60% after deductible
Behavioral Health & Substance Abuse Outpatient	$20 copay	80% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible	70% after deductible	60% after deductible
Diagnostic Services								
Laboratory & Pathology	100%	100% of allowed amount	80% after deductible	60% after deductible	70% after deductible	60% after deductible	70% after deductible	60% after deductible
MRI, MRA, PET and CAT Scans and Nuclear Medicine	80% after deductible	80% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible	70% after deductible	60% after deductible

	BCN Blue Elect Plus		BCBSM PPO1		BCBSM PPO2		BCBSM PPOHD	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic Tests and X-rays	80% after deductible	80% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible	70% after deductible	60% after deductible
Radiation Therapy and Chemotherapy	80% after deductible	80% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible	70% after deductible	60% after deductible
Maternity Services								
Pre-Natal Care - routine	100%	80% after deductible	100%	60% after deductible	100%	Not Covered	100%	60% after deductible
Postnatal Care Visits	$20 copay	80% after deductible	100%	60% after deductible	100%	Not Covered	100% after deductible	60% after deductible
Delivery and Nursery Care	80% after deductible	80% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible	70% after deductible	60% after deductible
Other Services								
Allergy Testing and Therapy	100%	50% after deductible	100%	60% after deductible	100%	60% after deductible	70% after deductible	60% after deductible
Chiropractic Spinal Manipulation	$35 copay limited to 24 visits/year	Not Covered	$25 copay limited to 24 visits/year	60% after deductible limited to 24 visits/year	70% after deductible	60% after deductible	70% after deductible	60% after deductible
Physical, Occupational and Speech Therapy	$35 copay limited to 60 visits/year	80% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible	70% after deductible	60% after deductible
Cardiac Rehabilitation	$35 copay	80% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible	70% after deductible	60% after deductible
Durable Medical Equipment (DME)	100%	Not Covered	80% after deductible	80% after deductible	70% after deductible	70% after deductible	70% after deductible	60% after deductible
Prosthetic and Orthotic Appliances (P&O)	100%	Not Covered	80% after deductible	80% after deductible	70% after deductible	70% after deductible	70% after deductible	60% after deductible
Hearing Exam/Aid	Binaural hearing aids and exam covered every 36 months- 100%		Binaural hearing aids and exam covered every 36 months- 100%		Binaural hearing aids and exam covered every 36 months- 100%		70% after deductible	60% after deductible
Hospice Care	100% after deductible	80% after deductible	100%	100%	100%	100%	70% after deductible	60% after deductible
Home Health Care	100% after deductible	80% after deductible	80% after deductible	80% after deductible	70% after deductible	70% after deductible	70% after deductible	60% after deductible
Skilled Nursing Limited to max of 120 days per calendar year	80% after deductible	80% after deductible	80% after deductible	80% after deductible	70% after deductible	70% after deductible	70% after deductible	60% after deductible
Vision Exams	Not Covered	Not Covered	$25 copay	Reimburse up too $35 less $25 copay	70% after deductible	Reimburse up too $35 less $25 copay	70% after deductible	Not Covered
Prescription Drugs	**Retail 30/Mail Order 90**		**Retail 30/Mail Order 90**		**Retail 30/Mail Order 90**		**Retail 30/Mail Order 90**	
Generic	$10/$20	Not Covered	$7/$14	Not Covered	$15/$30	Not Covered	70% after deductible	Not Covered
Preferred Formulary	$30/$60		$30/$60		$50/$100			
Non-Preferred Formulary	$50/$100		$50/$100		$100/$200			

* Emergency Room copay waived if admitted. This does not apply to PPOHD.
Out-of-Network benefits are typically paid based on allowed amount.
Please refer to the Benefit section of Michigan Catholic Conference website at www.micatholic.org/benefits for more plan information.
This is a summary of coverage. If there is discrepancy between this and the BCBSM/BCN Benefit Design Document (BDD, the BDD is the ruling document.

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