LIVINGSTON EDUCATIONAL SERVICE AGENCY
COMPARISON OF BCBSM PLANS
In-Network Only

	BCN HMO (NO H.S.A.)	BCN HMO - High Deductible H.S.A.	Simply Blue PPO- H.S.A.	Community Blue 4 - PPO

Deductible, Copays and Dollar Maximums

Note: The **Deductible** will apply to certain services as defined below.

Deductible	$500 individual/$1,000 family per calendar year	$1,350 individual/$2,700 family per calendar year Deductible - The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract	$1,350 for a one-person contract $2,700 for a family contract (2 or more members) each calendar year **(no 4th quarter carry-over);** Your deductible combines deductible amounts paid under your Simply Blue HSA medical coverage and your Simply Blue prescription drug coverage. The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract.	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in- network physician's office.
Fixed Dollar Copays	$5 for allergy injections $20 for office visits $35 for urgent care visits $150 for emergency room visits $25 for ambulance $30 for referral physician visits	None	See "Prescription Drugs" section	$30 copay for office visits and office consultations $30 copay for medical online visits $30 copay for chiropractic and osteopathic manipulative therapy $150 copay for emergency room visits $30 copay for urgent care visits

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Coinsurance Note: Where applicable, Coinsurance amounts apply once the deductible has been met.	50% for select services as noted below	50% for select services as noted below	None	50% of approved amount for private duty nursing care 20% of approved amount for mental health care and substance use disorder treatment 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)
Annual Coinsurance Maximum (ACM)	N/A - Included in OOPM	N/A - Included in OOPM	N/A - Included in OOPM	N/A - Included in OOPM
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$1,000 per individual/$2,000 per family (includes pharmacy cost sharing)	$2,350 per member, $4,700 per contract per calendar year. Out of pocket maximum applies to deductibles.	$2,250 for a one-person contract $4,500 for a family contract (2 or more members) each calendar year	$2,000 for one member, $4,000 for the family (when two or more members are covered under your contract) each calendar year
Lifetime Maximums	None	None	None	None

Preventive Services

Health Maintenance Exam	100%	100%	100% (no deductible or copay/coinsurance), one per member per calendar year. Includes chest x-ray, EKG, cholesterol screening and 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 **Note:** Additional well-women visits may be allowed based on medical necessity. Includes chest x-ray, EKG, cholesterol screening and other select lab procedures
Annual Gynecological Exam	100%	100%	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.

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Pap Smear Screening	100%	100%	100% (no deductible or copay/coinsurance), one per member per calendar year	100% (no deductible or copay/coinsurance), one per member per calendar year
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100%	100%	100% (no deductible or copay/coinsurance); includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance);includes insertion and removal of an intrauterine device by a licensed physician
Contraceptive injections	100%	100%	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Well-Baby and Child Care	100%	100%	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 under the health maintenance exam benefit	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 under the health maintenance exam benefit
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%	100%	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Fecal occult blood screening	100%	100%	100% (no deductible or copay/coinsurance), one per member per calendar year	100% (no deductible or copay/coinsurance), one per member per calendar year
Flexible sigmoidoscopy exam	100%	100%	100% (no deductible or copay/coinsurance), one per member per calendar year	100% (no deductible or copay/coinsurance), one per member per calendar year

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Prostate Specific Antigen (PSA) Screening	100%	100%	100% (no deductible or copay/coinsurance), one per member per calendar year	100% (no deductible or copay/coinsurance), one per member per calendar year
Routine screening colonoscopy	100%	100%	100% (no deductible or copay/coinsurance) for routine colonoscopy **Note:** Medically necessary colonoscopies performed during the **same** calendar year are subject to your deductible and coinsurance. One routine colonoscopy per member per year.	100% (no deductible or copay/coinsurance), for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.One routine colonoscopy per member per year.
Routine mammogram and related reading	100%	100%	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the **same** calendar year are subject to your deductible and coinsurance. One per member per calendar year.	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.One per member per calendar year.
Voluntary Female Sterilization	100%	100%	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Breast Pumps (DME guidelines apply.)	100%	100%	100% after in-network deductible	100% after in-network deductible
Maternity Pre-Natal care	100%	100%	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

Physician Office Services

PCP Office Visits	$20 Copay	100% after deductible. Deductible does not apply to preventive services and routine maternity care	100% after in-network deductible	$30 copay per office visit
Online Visits	$20 Copay	100% after deductible. Deductible does not apply to preventive services and routine maternity care	100% after in-network deductible	$30 copay per online visit ;**Note**: Online visits by a non-BCBSM selected vendor are not covered

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Consulting Specialist Care	$30 Copay	100% after deductible. Deductible does not apply to preventive services and routine maternity care	100% after in-network deductible	$30 copay per office consultation
Emergency Medical Care				
Hospital Emergency Room - Copay waived if admitted	$150 Copay after deductible	100% after deductible	100% after in-network deductible	$150 copay per visit (copay waived if admitted or for an accidental injury)
Urgent Care Center	$35 Copay	100% after deductible	100% after in-network deductible	$30 copay per urgent care visit
Ambulance Services	$25 copay for ground and air services after deductible	100% after deductible	100% after in-network deductible	80% after in-network deductible
Diagnostic Services				
Laboratory and Pathology Tests	100%	100% after deductible	100% after in-network deductible	80% after in-network deductible
Diagnostic Tests and X-rays	100% after deductible	100% after deductible	100% after in-network deductible	80% after in-network deductible
Theraputic Radiology	100% after deductible	100% after deductible	100% after in-network deductible	80% after in-network deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	$150 copay after deductible	100% after deductible	100% after in-network deductible	100% after in-network deductible
Radiation Therapy	100% after deductible	100% after deductible	100% after in-network deductible	100% after in-network deductible
Maternity Services Provided by a Physician				
Post-Natal and Non-routine Pre-Natal Care (See Preventive Services section for routine Pre-Natal Care)	$20 Copay	100% (Deductible applies for non-routine maternity care)	100% after in-network deductible	100% (no deductible or copay/coinsurance)
Delivery and Nursery Care	100% For professional services. (See Hospital Care for facility charges) after deductible	100% after deductible	100% after in-network deductible	80% after in-network deductible
Hospital Care				
General Nursing Care, Hospital Services and Supplies; SemiPrivate Room	100% after deductible	100% after deductible	100% after in-network deductible; unlimited days. Non-emergency services must be rendered in a participating hospital.	100% after in-network deductible; unlimited days. Non-emergency services must be rendered in a participating hospital.
Outpatient Surgery - included all related surgical services and anesthesia - see member certificate for specific surgical copays.	100% after deductible	100% after deductible	100% after in-network deductible	100% after in-network deductible
Inpatient Consultations	100% after deductible	100% after deductible	100% after in-network deductible	80% after in-network deductible
Chemotherapy	100% after deductible	100% after deductible	100% after in-network deductible	80% after in-network deductible

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Alternatives to Hospital Care				
Skilled Nursing Care	100% after deductible	100% after deductible	100% after in-network deductible	80% after in-network deductible
	Up to 45 days per member per calendar year	Up to 45 days per calendar year	Limited to a maximum of 120 days per member per calendar year	Limited to a maximum of 120 days per member per calendar year

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Hospice Care	100% (When authorized) after deductible	100% after deductible	100% after in-network deductible; Up to 28 pre-hospice counseling visits before electing hospice services;when elected, four 90-day periods - provided through a participating hospice programonly; 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); Up to 28 pre-hospice counseling visits before electing hospice services;when elected, four 90-day periods - provided through a participating hospice programonly; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)
Home Health Care	$30 Copay after deductible	100% after deductible	100% after in-network deductible; must be medically necessary; must be provided by a participating home health care agency.	80% after in-network deductible; must be medically necessary; must be provided by a participating home health care agency.
Infusion Therapy	100% after deductible	100% after deductible	100% after in-network deductible * Must be medically necessary; Must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center IAIC); may use drugs that require preauthorization - consult with your doctor.	80% after in-network deductible * Must be medically necessary; Must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center IAIC); may use drugs that require preauthorization - consult with your doctor.
Surgical Services				
Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	100% after deductible	100% after deductible	100% after in-network deductible ; includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility. Includes pre-surgical consultations.	80% after in-network deductible; includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility. Includes pre-surgical consultations.

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Pre-Surgical Consultations	100% after deductible	100% after deductible	100% after in-network deductible	100% (no deductible or copay/coinsurance)
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	50% after deductible	Male - 50% after deductible	100% after in-network deductible	80% after in-network deductible
Elective Abortion	Not Covered	Not Covered	Not Covered	Not Covered
Human Organ Transplants	100% after deductible	100% after deductible	100% after in-network deductible; must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance); must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)
Bone Marrow Transplants	100% after deductible	100% after deductible	100% after in-network deductible; Must be coordinated through BCBSM Human Organ Transplant Program (1-800-242-3504).	80% after in-network deductible10/23/2017 Must be coordinated through BCBSM Human Organ Transplant Program (1-800-242-3504).
Specified Oncology Clinical Trials	100% after deductible	100% after deductible	100% after in-network deductible; BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible; BCBSM covers clinical trials in compliance with PPACA.
Kidney, cornea and skin transplants	100% after deductible	100% after deductible	100% after in-network deductible	80% after in-network deductible
Reduction Mammoplasty	50% after deductible	50% after deductible	100% after in-network deductible	80% of approved amount for the most other covered services (coinsuranced waived for covered services performed in an in-network physician's office).
Male Mastectomy	50% after deductible	50% after deductible	100% after in-network deductible	80% of approved amount for the most other covered services (coinsuranced waived for covered services performed in an in-network physician's office).
Temporomandibular Joint Syndrome	50% after deductible	50% after deductible	Not Covered	Not Covered
Orthognathic Surgery	50% after deductible	50% after deductible	Not Covered	Not Covered

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Weight Reduction Procedures (Limited to one procedure per lifetime)	50% after deductible	50% after deductible	100% after in-network deductible	80% of approved amount for the most other covered services (coinsuranced waived for covered services performed in an in-network physician's office).
Mental Health Care and Substance Use Disorder Treatment				
Inpatient Mental Health Care	100% after deductible -Unlimited Days	100% after deductible- Unlimited Days	100% after in-network deductible- Unlimited Days	80% after in-network deductible - Unlimited Days
Inpatient Substance Use Disorder	100% after deductible -Unlimited Days	100% after deductible -Unlimited Days	100% after deductible -Unlimited Days	80% after in-network deductible - Unlimited Days
Residential psychiatric treatment facility	100% after deductible	100% after deductible	100% after in-network deductible; covered mental health services must be performed in a residential psychiatric treatment facility; treatment must be preauthorized; subject to medical criteria.	80% after in-network deductible; covered mental health services must be performed in a residential psychiatric treatment facility; treatment must be preauthorized; subject to medical criteria.
Outpatient Mental Health Care includes facility, clinic, physician's offices and online visits Note: For diagnostic and therapeutic services, the medical benefit applies.	$20 Copay	100% after deductible	100% after in-network deductible; facility, clinic and physician's office.	80% after in-network deductible; facility and clinic and physician's office; 90% after in-network deductible for online visits.
Outpatient Substance Use Disorder	$20 Copay	100% after deductible	100% after in-network deductible- in approved facillities only.	80% after in-network deductible- in approved facillities only.

Autism Spectrum Disorders, Diagnoses and Treatment

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Applied behavioral analyses (ABA) treatment	$20 Copay	100% after deductible	100% after in-network deductible; Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization.Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	80% after in-network deductible; Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization.Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	$30 Copay after deductible	100% after deductible	100% after in-network deductible; includes nutritional counseling	80% after in-network deductible; includes nutritional counseling
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visit and preventive benefit.	See your outpatient mental health, medical office visit and preventive benefit.	100% after in-network deductible	80% after in-network deductible

Other Services

Allergy Testing and Therapy	50% after deductible	100% after deductible	100% after in-network deductible	100% (no deductible or copay/coinsurance)
Allergy Injections	$5 copay	100% after deductible	100% after in-network deductible	100% after in-network deductible
Chiropractic Spinal Manipulation - when referred	$30 Copay	100% after deductible	100% after in-network deductible; includes osteopathic manipulative	$30 Copay; includes osteopathic manipulative therapy
	(up to 30 visits per calendar year)	(up to 30 visits per calendar year)	(up to 12 visites per calendar year)	(up to 24 visites per calendar year)
Outpatient Physical, Speech and Occupational Therapy	$30 Copay after deductible	100% after deductible	100% after in-network deductible	80% after in-network deductible - when provided for rehabilitation
	60 visits per calendar year for any combination of therapies	60 visits per calendar year for any combination of therapies	30 visits per calendar year for any combination of therapies	60 visits per calendar year for any combination of therapies

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Outpatient Diabetes Management Program (ODMP) Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	100% after deductible	100% after deductible	100% after in-network deductible	80% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay/coinsurance) for diabetes self-management training
Infertility Counseling and Treatment (Excludes In- vitro fertilization)	50% after deductible	50% after deductible	Only covered if a medical condition exists. Would not cover for infertility.	Only covered if a medical condition exists.
Durable Medical Equipment (DME)	50%	50% after deductible	100% after in-network deductible; DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM	80% after in-network deductible; DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM
Prosthetic and Orthotic Appliances (P&O)	50%	50% after deductible	100% after in-network deductible	80% after in-network deductible
Diabetic Supplies	100%	50% after deductible	100% - When Dispensed with insulin	100% - When Dispensed with insulin
Private duty nursing care	100% after deductible	100% after deductible	100% after in-network deductible	50% after in-network deductible
Prescription Drugs				
Prescription Drugs	Tier 1A - $10, Tier 1B - $30, T2- $60, T3- $80, T4- 20 coinsurance (max $200), T5- 20% coinsurance (max $300) 30 day supply	Tier 1A - $10 after deductible, Tier 1B - $30 after deductible, T2- $60 after deductible, T3- $80 after deductible, T4- 20% coinsurance after deductible (max $200), T5- 20% coinsurance after deductible (max $300); 30 day supply	Tier 1 - $10; Tier 2 - $40; Tier 3-$80	Tier 1 - $10; Tier 2 - $40; Tier 3-$80
	Sexual Dysfunction Drugs - 50% coinsurance	Sexual Dysfunction drugs - 50% coinsurance after deductible	Covered as above (in regular Rx Rider)	Covered as above (in regular Rx Rider)

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	Contraceptives – T1A- 100%, Tier 1B - $30, T2 - $60, T3-$80; 30 day supply	Contraceptives – T1A- 100% (deductible does not apply), Tier 1B - $30 after deductible, T2 - $60 after deductible, T3-$80 after deductible; 30 day supply	Covered as above (in regular Rx Rider)	Covered as above (in regular Rx Rider)
Mail Order Prescription Drugs	30 day supply or less - applicable tiered copay / coinsurance; 31-90 day supply - 3x's the 30 day copay/coinsurance minus $10 ; All 90 day Rx must go through Mail Order.	30 day supply or less - applicable tiered copay/coinsurance, 31-90 day supply - 3x's the 30 day copay/coinsurance minus $10 after deductible; All 90 day Rx must go through Mail Order.	30 day supply or less - applicable tiered copay/coinsurance, 31-90 day supply - 2x's the 30 day copay after deductible; NOTE: 90-day maintenance perscriptions are can be filled through mail order or retail pharmacy.	30 day supply or less - applicable tiered copay/coinsurance, 31-90 day supply - 2x's the 30 day copay after deductible; NOTE: 90-day maintenance perscriptions can be filled at retail or through mail order.
Prescription Drug Deductible	None	Prescription drug deductible integrated with the medical deductible	Prescription drug deductible integrated with the medical deductible	Prescription drug deductible integrated with the medical deductible
Hearing Aid	Not Covered	Not covered	Not covered	Not covered