Insurance Plan Benefit Details and Comparison

4 plans selected for comparison Finished comparing? Back to Results	Bronze Copay Select 1 $1,165.64 Per month	MyPriority HMO RxPlus Bronze 3975 $1,205.48 Per month	Humana Gold 2500/Detroit HMOx + ... $1,207.00 Per month	Blue Cross® Select Silver $1,224.52 Per month
Customer Ratings	Not Yet Rated	Not Yet Rated	Not Yet Rated	Not Yet Rated
Plan Type	EPO	HMO	HMO	HMO
Metal Level	Silver	Bronze	Gold	Silver
Cost Calculator* (based on medical scenarios)	Minor Event (e.g. broken leg) Total Savings: $0 Mid-size Event (e.g. appendectomy) Total Savings: $8,800 Major Event (e.g. heart surgery) Total Savings: $86,800	Minor Event (e.g. broken leg) Total Savings: $0 Mid-size Event (e.g. appendectomy) Total Savings: $4,830 Major Event (e.g. heart surgery) Total Savings: $86,800	Minor Event (e.g. broken leg) Total Savings: $0 Mid-size Event (e.g. appendectomy) Total Savings: $9,000 Major Event (e.g. heart surgery) Total Savings: $93,000	Minor Event (e.g. broken leg) Total Savings: $1,190 Mid-size Event (e.g. appendectomy) Total Savings: $8,890 Major Event (e.g. heart surgery) Total Savings: $87,300
Office Visit for Primary Doctor	$50 Copay for first 4 visits then 20% Coinsurance after deductible Find Doctors	$20 Copay before deductible for first 4 visits then 40% Coinsurance after deductible Find Doctors	$25 Copay Find Doctors	$30 Copay before deductible Find Doctors
Office Visit for Specialist	$100 Copay	$20 Copay before deductible for first 4 visits then 40% Coinsurance after deductible	$35 Copay	$50 Copay after deductible
Office Visit for Other Practitioner (Nurse, Physician Assistant)	$50 Copay for first 4 visits then 20% Coinsurance after deductible	$20 Copay before deductible for first 4 visits then 40% Coinsurance after deductible	$25 Copay	$30 Copay before deductible
Annual Deductible	Family: $30,000 (Any family member who meets his/her	Family: $7,950 You must pay all the costs up to the	Family: $5,000 (Any family member who meets his/her	Family: $3,300 NOTE: If your plan is a family plan, the entire

	$5,000 individual deductible can start receiving benefits available after deductible.)	deductible amount before this plan begins to pay for covered services. The deductible may not apply to all services	**$2,500** individual deductible can start receiving benefits available after deductible. **$5,000** family deductible can be met by two or more family members combined.)	family deductible must be met before BCBSM pays for covered services. The family deductible may be met by one or more family members. Medical and drug expenses are combined to meet the integrated deductible.
Coinsurance	20%	40%	20%	30%
Out-of-Pocket Limit	Family: $13,200 Includes deductible	Family: $13,200 Includes deductible	Family: $7,000 Includes deductible	Family: $12,700 Includes deductible
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Health Savings Account (HSA) Eligible	No	No	No	No
Out-of-Network Coverage	No	No	No	No
Out-of-Country Coverage	Yes. Emergency care only	Yes. Emergency Care Only	Yes. Out of Country Coverage is covered for any expense incurred for services received outside of the United States as required by law for emergency care services.	Yes. Emergency Only
Preventive Care Coverage				
Periodic Health Exam	No Charge	No Charge	No Charge	No Charge
Periodic OB-GYN Exam	No Charge	No Charge	No Charge	No Charge
Well Baby Care	No Charge	No Charge	No Charge	No Charge
Emergency and Urgent Care				
Emergency Room	20% Coinsurance after deductible (additional $250 ER deductible for illness if not admitted)	$250 Copay after deductible, 40% Coinsurance after deductible	20% Coinsurance after deductible	$250 Copay after deductible, 30% Coinsurance after deductible
Emergency Ambulance Services	20% Coinsurance after deductible	$250 Copay after deductible, 40% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible; Exclusions: Transportation for convenience

Urgent Care Facility	20% Coinsurance after deductible	$20 Copay before deductible for first 4 visits then 40% Coinsurance after deductible	$50 Copay	$40 Copay before deductible
Prescription Drug Coverage				
Retail Prescription Drugs	Tier 1 - Brand and generic drugs may reside in each tier: $20 Copay; Tier 2 - Brand and generic drugs may reside in each tier: 20% Coinsurance after deductible; Tier 3 - Brand and generic drugs may reside in each tier: 20% Coinsurance after deductible; Tier 4 - Brand and generic drugs may reside in each tier: 20% Coinsurance after deductible;	Generic Drugs: $20 Copay; Preferred Brand Drugs: $75 Copay after deductible; Non-Preferred Brand Drugs: $100 Copay after deductible; Specialty Drugs: 20% Coinsurance after deductible;	Generic Drugs: $8 Copay; Preferred Brand Drugs: $20 Copay after deductible; Non-Preferred Brand Drugs: 35% Coinsurance after deductible; Specialty Drugs: 35% Coinsurance after deductible; Off Label Prescription Drugs: 35% Coinsurance after deductible;	Tier 1a - Generic: $4 copay after integrated deductible Tier 1b - Generic: $20 copay after integrated deductible Tier 2 - Preferred Brand: 25% coinsurance after integrated deductible, $40 minimum and $100 maximum copay Tier 3 - Nonpreferred Brand: 50% coinsurance after integrated deductible, $80 minimum and $100 maximum copay Tier 4 - Preferred Specialty: 20% coinsurance after integrated deductible, no minimum and $200 maximum copay Tier 5 - Nonpreferred Specialty: 25% coinsurance after integrated deductible, no minimum and $300 maximum copay
Separate Prescription Drugs Deductible	Medical Plan Deductible Applies	Medical Plan Deductible Applies	$500 Individual/$1,000 Family	Medical Plan Deductible Applies
Outpatient Coverage				
Outpatient Surgery	20% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible
Outpatient Lab/X-Ray	Outpatient Lab: 20% Coinsurance after deductible; X-rays: 20% Coinsurance after deductible	Outpatient Lab: 40% Coinsurance after deductible; X-rays: 40% Coinsurance after deductible	Outpatient Lab: 20% Coinsurance after deductible; X-rays: 20% Coinsurance after deductible	Outpatient Lab: Covered at 100% with no deductible.; X-rays: 30% Coinsurance after deductible
Imaging (CT and PET scans, MRIs)	20% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	$200 Copay after deductible, 30% Coinsurance after deductible

Outpatient Mental Health	$50 Copay for first 4 visits then 20% Coinsurance after deductible	$20 Copay before deductible for first 4 visits then 40% Coinsurance after deductible	20% Coinsurance after deductible	$30 Copay after deductible
Outpatient Substance Abuse	$50 Copay for first 4 visits then 20% Coinsurance after deductible	$20 Copay before deductible for first 4 visits then 40% Coinsurance after deductible	20% Coinsurance after deductible	$30 Copay after deductible
Outpatient Rehabilitation Services (PT, OT, ST)	20% Coinsurance after deductible	40% Coinsurance after deductible, limited to 90 Visit(s) per Year	20% Coinsurance after deductible, limited to 30 Visit(s) per Year	30% Coinsurance after deductible, PT/ OT have a 30 visit combined per member per year limit, ST needs a separate 30 visit per member per year limit.
Inpatient Coverage				
Hospitalization	$0 Copay per Day, 20% Coinsurance after deductible	$0 Copay per Stay, 40% Coinsurance after deductible	$0 Copay per Day, 20% Coinsurance after deductible	30% coinsurance after deductible then $500 copay
Skilled Nursing Facility	$0 Copay per Day, 20% Coinsurance after deductible, limited to 45 Days per Year	$0 Copay per Stay, 40% Coinsurance after deductible, limited to 45 Days per Year	$0 Copay per Day, 20% Coinsurance after deductible, limited to 45 Days per Year	$500 Copay per Stay, 30% Coinsurance after deductible, limited to 45 Days per year; Exclusions: Custodial Care
Inpatient Mental Health	20% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	$500 Copay after deductible, 30% Coinsurance after deductible
Inpatient Substance Abuse	20% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	$500 Copay after deductible, 30% Coinsurance after deductible
Home Healthcare	20% Coinsurance after deductible, limited to 45 Days per Year	40% Coinsurance after deductible	20% Coinsurance after deductible, limited to 45 Days per Year	30% Coinsurance after deductible
Maternity Coverage				
Pre & Postnatal Office Visit	20% Coinsurance after deductible	No Charge	No Charge	Prenatal: Covered 100% with no deductible, copay or coinsurance. Radiology services are subject to plan's

				deductible and coinsurance. Postnatal: $30 copay per visit after deductible. Radiology services are subject to the plan's deductible and coinsurance.
Labor & Delivery Hospital Stay	20% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	$500 Copay after deductible, 30% Coinsurance after deductible
Pediatric Services				
Dental Checkup for Children	20% Coinsurance after deductible, limited to 1 Visit(s) per 6 Months	Not Covered	50% Coinsurance after deductible	Not Covered
Basic Dental Care - Child	20% Coinsurance after deductible	Not Covered	50% Coinsurance after deductible	Not Covered
Major Dental Coverage (Pediatric)	20% Coinsurance after deductible	Not Covered	50% Coinsurance after deductible	Not Covered
Orthodontia - Child	20% Coinsurance after deductible	Not Covered	20% Coinsurance after deductible	Not Covered
Routine Eye Exam for Children	20% Coinsurance after deductible, limited to 1 Visit(s) per Year	No Charge, limited to 1 Visit(s) per Year	50% Coinsurance after deductible, limited to 1 Visit(s) per Year	No Charge, limited to 1 Visit(s) per Year
Eye Glasses for Children	20% Coinsurance after deductible, limited to 1 Item(s) per Year	No Charge, limited to 1 Item(s) per Year	50% Coinsurance after deductible, limited to 1 Item(s) per Year	No Charge, limited to 1 Item(s) per Year
Additional Coverage				
Chiropractic Coverage	20% Coinsurance after deductible	40% Coinsurance after deductible, limited to 30 Visit(s) per Year	20% Coinsurance after deductible, limited to 30 Visit(s) per Year	30% Coinsurance after deductible, limited to 30 Visit(s) per Year
Durable Medical Equipment	20% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Hospice	20% Coinsurance after deductible, limited to 45 Days per Year	40% Coinsurance after deductible, limited to 45 Days per Year	20% Coinsurance after deductible, limited to 45 Days per Year	No Charge after deductible
Diabetes Care Management	Not Covered	Not Covered	Not Covered	Covered

Major Dental Coverage (Adult)	Not Covered	Not Covered	Not Covered	Not Covered
Additional Information				
A.M. Best Rating	A as of 12/11/2013	A- as of 06/11/2014	A- as of 02/28/2014	A- as of 08/07/2013
Electronic Signature for Application Available	Yes	Yes	Yes	Yes
Details and documents about this plan	View Plan Brochure Summary of Benefits & Coverage (Not available) Exclusions & Limitations	View Plan Brochure Summary of Benefits & Coverage	View Plan Brochure Summary of Benefits & Coverage (Not available) Exclusions & Limitations	View Plan Brochure Summary of Benefits & Coverage