Insurance Plan Benefit Details and Comparison

4 plans selected for comparison

Finished comparing?

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	Humana Silver 4600/Detroit HMOx ...	Blue Cross® Select Bronze Extra	MyPriority POS Bronze 6000	Aetna Bronze $20 Copay PD
	$1,058.66 Per month	**$1,066.85** Per month	**$1,084.06** Per month	**$1,155.20** Per month
Customer Ratings	Not Yet Rated	Not Yet Rated	Not Yet Rated	Not Yet Rated
Plan Type	HMO	HMO	POS	POS
Metal Level	Silver	Bronze	Bronze	Bronze
Cost Calculator* (based on medical scenarios)	Minor Event (e.g. broken leg) Total Savings: $0 Mid-size Event (e.g. appendectomy) Total Savings: $5,440 Major Event (e.g. heart surgery) Total Savings: $87,400	Minor Event (e.g. broken leg) Total Savings: $0 Mid-size Event (e.g. appendectomy) Total Savings: $2,800 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: $2,800 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: $4,500 Major Event (e.g. heart surgery) Total Savings: $88,500
Office Visit for Primary Doctor	$25 Copay Find Doctors	$40 Copay before deductible Find Doctors	$25 Copay Find Doctors	$20 Copay Find Doctors
Office Visit for Specialist	$35 Copay	Up to four specialist office visits with a $75 copay per visit with no deductible per member per calendar year. After four specialist office visits, additional specialist office visits are subject to the deductible. After the deductible is met, a $75 copay applies to additional specialist office visits. Diagnostic and laboratory services are subject to the deductible and coinsurance.	$50 Copay after deductible	$50 Copay after deductible

Office Visit for Other Practitioner (Nurse, Physician Assistant)	$25 Copay	$40 Copay before deductible	$25 Copay	$20 Copay
Annual Deductible	Family: $9,200 (Any family member who meets his/her **$4,600** individual deductible can start receiving benefits available after deductible. **$9,200** family deductible can be met by two or more family members combined.)	Family: $12,600 NOTE: If your plan is a family plan, the entire 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.	Family: $12,000 You must pay all the costs up to the deductible amount before this plan begins to pay for covered services. The deductible may not apply to all services	Family: $11,500 (Any family member who meets his/her **$5,750** individual deductible can start receiving benefits available after deductible. **$11,500** family deductible can be met by two or more family members combined.)
Coinsurance	20%	40%	40%	0%
Out-of-Pocket Limit	Family: $12,600 Includes deductible	Family: $13,200 Includes deductible	Family: $13,200 Includes deductible	Family: $13,200 Includes deductible
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Health Savings Account (HSA) Eligible	No	No	No	No
Out-of-Network Coverage	No	No	Yes (Details in plan brochure below)	Yes (Details in plan brochure below)
Out-of-Country Coverage	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	Yes. Emergency Care Only	No.
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	$250 Copay after deductible, 40%	$250 Copay after deductible, 40%	$250 Copay after deductible; Exclusions:

		Coinsurance after deductible	Coinsurance after deductible	No coverage for non-emergency care.
Emergency Ambulance Services	20% Coinsurance after deductible	40% Coinsurance after deductible; Exclusions: Transportation for convenience	$250 Copay after deductible, 40% Coinsurance after deductible	$250 Copay after deductible
Urgent Care Facility	$50 Copay	$40 Copay before deductible	$75 Copay	$60 Copay after deductible; Exclusions: No coverage for non-urgent care.
Prescription Drug Coverage				
Retail Prescription Drugs	Generic Drugs: $17 Copay; Preferred Brand Drugs: $50 Copay after deductible; Non-Preferred Brand Drugs: 50% Coinsurance after deductible; Specialty Drugs: 50% Coinsurance after deductible; Off Label Prescription Drugs: 50% Coinsurance after deductible;	Tier 1a - Generic: $4 copay with no deductible Tier 1b - Generic: $20 copay with no 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	Generic Drugs: $20 Copay after deductible; Preferred Brand Drugs: $60 Copay after deductible; Non-Preferred Brand Drugs: $80 Copay after deductible; Specialty Drugs: 20% Coinsurance after deductible;	Generic Drugs: $15 Copay, 0% Coinsurance; Preferred Brand Drugs: $45 Copay after deductible, 0% Coinsurance after deductible; Non-Preferred Brand Drugs: $75 Copay after deductible, 0% Coinsurance after deductible; Specialty Drugs: $0 Copay after deductible, 40% Coinsurance after deductible;
Separate Prescription Drugs Deductible	$1,500 Individual/ $3,000 Family	Medical Plan Deductible Applies	Medical Plan Deductible Applies	Medical Plan Deductible Applies
Outpatient Coverage				
Outpatient Surgery	20% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Outpatient Lab/X-Ray	Outpatient Lab: 20% Coinsurance after deductible; X-rays: 20%	Outpatient Lab: No Charge; X-rays: 40% Coinsurance after deductible	Outpatient Lab: 40% Coinsurance after deductible; X-rays: 40%	Outpatient Lab: 0% Coinsurance after deductible; X-rays: $100 Copay after deductible

	Coinsurance after deductible		Coinsurance after deductible	
Imaging (CT and PET scans, MRIs)	20% Coinsurance after deductible	40% Coinsurance after deductible	$200 Copay after deductible, 40% Coinsurance after deductible	$250 Copay after deductible
Outpatient Mental Health	20% Coinsurance after deductible	40% Coinsurance after deductible	$25 Copay	$50 Copay after deductible
Outpatient Substance Abuse	20% Coinsurance after deductible	40% Coinsurance after deductible	$25 Copay	$50 Copay after deductible
Outpatient Rehabilitation Services (PT, OT, ST)	20% Coinsurance after deductible, limited to 30 Visit(s) per Year	40% 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.	40% Coinsurance after deductible, limited to 90 Visit(s) per Year	$50 Copay after deductible, limited to 30 Visit(s) per Year; Exclusions: Coverage is limited to 30 visits PT/OT/Chiro combined. Benefit limits are shared between rehabilitation and habilitation services.
Inpatient Coverage				
Hospitalization	$0 Copay per Day, 20% Coinsurance after deductible	$0 Copay per Stay, 40% Coinsurance after deductible	$500 Copay per Stay, 40% Coinsurance after deductible	$250 Copay per Stay
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; Exclusions: Custodial Care	$500 Copay per Stay, 40% Coinsurance after deductible, limited to 45 Days per Year	$250 Copay per Stay, limited to 45 Days per Year; Exclusions: Coverage is limited to 45 days per calendar year.
Inpatient Mental Health	20% Coinsurance after deductible	40% Coinsurance after deductible	$500 Copay after deductible, 40% Coinsurance after deductible	$250 Copay after deductible
Inpatient Substance Abuse	20% Coinsurance after deductible	40% Coinsurance after deductible	$500 Copay after deductible, 40% Coinsurance after deductible	$250 Copay after deductible
Home Healthcare	20% Coinsurance after deductible, limited to 45 Days per Year	40% Coinsurance after deductible	40% Coinsurance after deductible	$250 Copay after deductible, limited to 45 Days per Year; Exclusions: Coverage is limited to 45 days per year

Maternity Coverage				
Pre & Postnatal Office Visit	No Charge	Prenatal: Covered 100% with no deductible, copay or coinsurance. Radiology services are subject to plan's deductible and coinsurance. Postnatal: $40 copay per visit after deductible. Radiology services are subject to plan's deductible and coinsurance.	No Charge	0% Coinsurance after deductible; Exclusions: Member cost share based on place and type of service.
Labor & Delivery Hospital Stay	20% Coinsurance after deductible	40% Coinsurance after deductible	$500 Copay after deductible, 40% Coinsurance after deductible	$250 Copay after deductible
Pediatric Services				
Dental Checkup for Children	50% Coinsurance after deductible	Not Covered	Not Covered	$0 Copay, limited to 2 Exam(s) per Year
Basic Dental Care - Child	50% Coinsurance after deductible	Not Covered	Not Covered	30% Coinsurance after deductible
Major Dental Coverage (Pediatric)	50% Coinsurance after deductible	Not Covered	Not Covered	50% Coinsurance after deductible
Orthodontia - Child	20% Coinsurance after deductible	Not Covered	Not Covered	50% Coinsurance after deductible
Routine Eye Exam for Children	50% Coinsurance after deductible, limited to 1 Visit(s) per Year	No Charge, limited to 1 Visit(s) per Year	No Charge, limited to 1 Visit(s) per Year	$0 Copay, limited to 1 Visit(s) per Year; Exclusions: Coverage is limited to 1 exam per calendar year.
Eye Glasses for Children	50% Coinsurance after deductible, limited to 1 Item(s) per Year	No Charge, limited to 1 Item(s) per Year	No Charge, limited to 1 Item(s) per Year	$0 Copay, limited to 1 Item(s) per Year; Exclusions: Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year.
Additional Coverage				
Chiropractic Coverage				$50 Copay after deductible, limited to 30

	20% Coinsurance after deductible, limited to 30 Visit(s) per Year	40% Coinsurance after deductible, limited to 30 Visit(s) per Year	40% Coinsurance after deductible, limited to 30 Visit(s) per Year	Visit(s) per Year; Exclusions: Coverage is limited to 30 visits PT/OT/Chiro combined. Benefit limits are shared between rehabilitation and habilitation services.
Durable Medical Equipment	20% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible	50% Coinsurance after deductible
Hospice	20% Coinsurance after deductible, limited to 45 Days per Year	No Charge after deductible	40% Coinsurance after deductible, limited to 45 Days per Year	$250 Copay after deductible
Diabetes Care Management	Not Covered	Covered	Not Covered	Not Covered
Major Dental Coverage (Adult)	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Network Coverage				
Out-of-Network Annual Deductible	N/A	N/A	$12,000/$24,000	$11,500/$23,000
Out-of-Network Annual Coinsurance	N/A	N/A	60%	50%
Out-of-Network Annual Out-of-Pocket Limit	N/A	N/A	$13,200/$26,400	N/A
Additional Information				
A.M. Best Rating	A- as of 02/28/2014	A- as of 08/07/2013	A- as of 06/11/2014	A as of 06/19/2014
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	View Plan Brochure Summary of Benefits & Coverage (Not available) The carrier has not provided a separate document for Exclusions and Limitations.