Michigan Catholic Conference Medical Plan Benefits Comparison

Plan Year: 2024

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 Benefits At A Glance.
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 Annual Out of Pocket Max - Rx (single/family)	$1,000/$3,000	$3,000/$9,000	$1,250 / $2,500 $5,100 / $10,700	$3,500 / $7, 000 $10,200 / $21,400	$4,000 / $9,000 $2,350 / $4,200	$8,000 / $16,000 $4,700 / $8,400	$6,350/$12,700	$12,700/$25,400
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
Telemedicine Visits	$20 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
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% of allowed amount after deductible	100%	60% after deductible	100%	60% after deductible	100%	60% after deductible
Routine Colonoscopy	100%	80% of allowed amount 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% of allowed amount 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% of allowed amount 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% of allowed amount 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% of allowed amount 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% of allowed amount after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible	70% after deductible	60% after deductible
Diagnostic Tests and X-rays	80% after deductible	80% of allowed amount 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% of allowed amount 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
Maternity Services								
Pre-Natal Care - routine	100%	80% of allowed amount after deductible	100%	60% after deductible	100%	Not Covered	100%	Not Covered
Postnatal Care Visits	100%	80% of allowed amount after deductible	100%	60% after deductible	100%	Not Covered	70% after deductible	60% after deductible
Delivery and Nursery Care	80% after deductible	80% of allowed amount after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible	100%	Not Covered
Behaviorl Health Services (Mental Health and Substance Use Disorder)								
Inpatient Behavioral Health & Substance Abuse Treatment	80% after deductible	80% of allowed amount after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible	70% after deductible	60% after deductible
Outpatient Behavioral Health & Substance Abuse Treatment	$20 copay	80% of allowed amount after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible	70% after deductible	60% after deductible
Telemedicine Mental Health Care Visits	$20 copay	80% of allowed amount after deductible	$25 copay	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 *Maximum amount allowed for hearing aids*	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.

This is a summary of coverage. Please refer to the Benefit section of Michigan Catholic Conference website at www.micatholic.org/benefits for more plan information.

9/14/2023