Saginaw Valley State University
BCBSM Medical Plan Comparison
(In Network-For out of Network, see Carrier Benefit Guides)

The information in this document is based on BCBSM current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This BAAG is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

This is intended as an easy-to read summary and provides only a general overview of your benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the State of Michigan and will be construed under the jurisdiction of and according to the laws of the State of Michigan. See BCBS Benefit Guides for out of network benefits.

Saginaw Valley State University	Simply Blue PPO HSA In-Network	Community Blue PPO1 - Plan 2 007000536-0011 In-Network	Community Blue PPO3 Plan 007000536-0009 In-Network
Member's responsibility (deductibles, copays, and dollar maximums) Note: Services from a provider for which there is no PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.			
Deductible	$1,650 individual/$3,300 Family **Note:** your deductible combines deductible amounts paid under your SB HSA medical coverage and your SB prescription drug coverage **Note:** The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract	None	$250 Individual/$500 Family
Copays			
• Fixed Dollar Copays (no maximum)	None	$5 online visit, $20 for office visit, $100 for emergency room visits	$5 online visit, $25 for office visits and $150 dollars for emergency room visits.
	After deductible is met, you pay: $15/$50/$70 or 50% for prescription drugs with maximum of $100	$15/$50/$70 or 50% for prescription drugs with maximum of $100	$15/$50/$70 or 50% for prescription drugs with maximum of $100
• Percent Copays (up to annual copay dollar maximum)	None	30% for private duty nursing	30% for private duty nursing, 20% of approved amount for most other covered services (copay waived if service is performed in a PPO physician's office)
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if applicable	$2,250 for one member; $4,500 for two or more members each calendar year.	$600 for one member; $1,200 for two or more members each calendar year.	$1,250 for one member; $2,500 for two or more members each calendar year.
Lifetime dollar maximum	None	None	None
Preventive care services - *No Annual Maximum - Age Restrictions May Apply			
Health maintenance exam - includes chest x-ray, EKG, and select lab procedures	100% (no deductible or copay), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity	100% (no deductible or copay), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity	100% (no deductible or copay), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity
Gynecological exam	100% (no deductible or copay), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity	100% (no deductible or copay), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity	100% (no deductible or copay), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity
Pap smear screening - laboratory and pathology services	100% (no deductible or copay), one per member per calendar year	100% (no deductible or copay), one per member per calendar year	100% (no deductible or copay), one per member per calendar year
Well-baby and child care	100% (no deductible or copay) • 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) • 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) • 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

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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% (no deductible or copay)	100% (no deductible or copay)	100% (no deductible or copay)
Fecal occult blood screening	100% (no deductible or copay), one per member per calendar year	100% (no deductible or copay), one per member per calendar year	100% (no deductible or copay), one per member per calendar year
Flexible sigmoidoscopy exam	100% (no deductible or copay), one per member per calendar year	100% (no deductible or copay), one per member per calendar year	100% (no deductible or copay), one per member per calendar year
Prostate specific antigen (PSA) screening	100% (no deductible or copay), one per member per calendar year	100% (no deductible or copay), one per member per calendar year	100% (no deductible or copay), one per member per calendar year
Routine mammogram and related reading	100% (no deductible or copay) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	100% (no deductible or copay) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	100% (no deductible or copay) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.
	One per member per calendar year		
Routine screening colonoscopy	100% (no deductible or copay) for routine colonoscopy **Note:** Medically necessary colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	100% (no deductible or copay) for routine colonoscopy **Note:** Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	100% (no deductible or copay) for routine colonoscopy **Note:** Subsequent medically necessary colonoscopies performed during the same calendar year are subject to your deductible and percent copay.
	One routine colonoscopy per member per calendar year		
Physician Office Services			
Office Visits	Covered 100% after in-network deductible	Covered - $20 copay per office visit	Covered - $25 copay
Online Visits - by physician or BCBSM selected vendor	Covered 100% after in-network deductible	Covered - $5 copay per online visit	Covered - $5 copay per online visit
Outpatient and Home Visits	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Office Consultations	Covered 100% after in-network deductible	Covered - $20 copay per office visit	Covered - $25 copay
Urgent Care Visits	Covered 100% after in-network deductible	Covered - $20 copay per office visit	Covered - $25 copay
Emergency Medical Care			
Hospital Emergency Room	Covered 100% after in-network deductible	Covered - $100 copay per visit, waived if admitted or for an accidental injury	Covered - $150 copay per visit, waived if admitted or for an accidental injury
Ambulance Services – must medically necessary	Covered 100% after in-network deductible	Covered - 100%	Covered - 80% after in-network deductible
Diagnostic Services			
Laboratory and Pathology Services	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Diagnostic Tests and X-rays	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Therapeutic radiology	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Maternity Services Provided by a Physician			
Prenatal and Postnatal Care (includes care provided by a certified nurse midwife)	Pre-natal: covered at 100% (no deductible or copay/coinsurance) Post-natal: covered at 100% after in-network deductible	Covered -100% (no deductible or copay/coinsurance), includes care provided by a certified nurse midwife	Covered -100% (no deductible or copay/coinsurance), includes care provided by a certified nurse midwife
Delivery and Nursery Care (includes care provided by a certified nurse midwife)	Covered 100% after in-network deductible	Covered -100% (no deductible or copay/coinsurance), includes care provided by a certified nurse midwife	Covered - 80% after in-network deductible, includes delivery provided by a certified nurse midwife
Hospital Care			
Semiprivate Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies. (Unlimited days)	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible, unlimited days

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Inpatient Consultations	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Chemotherapy	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Alternatives to Hospital Care			
Skilled Nursing Care	Covered 100% after in-network deductible (up to 90 days per member per calendar year)	Covered - 100% (no deductible or copay/coinsurance) (up to 120 days per member per calendar year)	Covered - 80% after in-network deductible (up to 120 days per member per calendar year)
Hospice Care	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 100% (no deductible or copay)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management.		
Home health care - medically necessary	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Home infusion therapy - medically necessary	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Surgical Services			
Surgery – includes related surgical services	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Presurgical consultations	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 100% (no deductible or copay)
Colonoscopy	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Voluntary Sterilization	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Human Organ Transplants			
Specified Organ Transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 100% (no deductible or copay)
	No Lifetime Dollar Maximum take off	No Lifetime Dollar Maximum	No Lifetime Dollar Maximum
Bone Marrow – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Specified oncology clinical trials	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Kidney, Cornea and Skin	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Mental Health & Substance Abuse			
Inpatient mental health care (unlimited days)	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Inpatient Substance Abuse Treatment (unlimited days)	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Outpatient mental health care • Facility and clinic	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
• Physician's office	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Outpatient substance abuse treatment - in approved facilities	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
	Mental health and substance abuse procedures that are the equivalent of an office visit (consultative services rendered in the physician's office) will be treated and processed like an office visit, subject to the fixed dollar office visit copay.		
Other Services			
Outpatient Diabetes Management Program (ODMP)	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance) for diabetes medical supplies Covered - 100% (no deductible or copay/coinsurance) for diabetes self-management training	Covered - 80% after in-network deductible for diabetes medical supplies Covered - 100% (no deductible or copay/coinsurance) for diabetes self-management training
Allergy Testing and Therapy	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 100% (no deductible or copay)
Chiropractic manipulation and osteopathic manipulation treatment	Covered 100% after in-network deductible (Limited to a combined 12-visit maximum per member per year)	$20 copay per office visit (Limited to a combined 24-visit maximum per member per year)	$25 copay per office visit (Limited to a combined 24-visit maximum per member per year)

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Outpatient Physical, Speech and Occupational Therapy • Facility and Clinic • Physician's office -**excludes speech and occupational therapy**	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
	A **combined** maximum of 30 visits per member per calendar year	A **combined** maximum of 60 visits per member per calendar year	
Durable Medical Equipment	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Prosthetic and Orthotic Appliances	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Private Duty Nursing	Covered 100% after in-network deductible	Covered - 70% (no deductible)	Covered - 70% after in-network deductible
Hearing Care	No Coverage	No Coverage	No Coverage
Autism spectrum disorders, diagnoses and treatment			
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 treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited		
Other covered services, including mental health services, for autism spectrum disorder	Covered 100% after in-network deductible	Covered - 100% (no deductible or copay/coinsurance)	Covered - 80% after in-network deductible
Prescription Drugs			
At Retail Using Mail Order	AFTER DEDUCTIBLE IS MET, you pay: $15/$50/$70 or 50% of the approved amount (whichever is greater), but no more than $100, 1 month supply $30/$100/$140 or 50% of the approved amount (whichever is greater), but no more than $200, 90 days supply	$15/$50/$70 or 50% of the approved amount (whichever is greater), but no more than $100, 1 month supply $30/$100/$140 or 50% of the approved amount (whichever is greater), but no more than $200, 90 days supply	$15/$50/$70 or 50% of the approved amount (whichever is greater), but no more than $100, 1 month supply $30/$100/$140 or 50% of the approved amount (whichever is greater), but no more than $200, 90 days supply