Washtenaw Community College
Benefits at a Glance
2008

Blue Care Network (BCN) HMO
Blue Cross Blue Shield of Michigan (BCBSM) PPO

This chart is a summary of services comparing the BCN HMO to the BCBSM PPO. Detailed information including exclusions or limitation will be available in the Plan Certificate or Rider.

HMO (Health Maintenance Organization) *– An HMO sets guidelines on how physicians can operate. Members receive health care services from their primary care physicians, however, if specialized care is needed, the member will be referred by their primary care physician to a specialist. Most services are pre-paid and no claim forms are needed. There is no deductible, however, a member must see an HMO contracted physician or hospital/facility for the service to be covered.*

PPO (Preferred Provider Organization) *– A PPO is designed to supply health care services at a discounted cost by providing incentives to use designated health care providers, but also provides coverage for providers outside the network. This plan is ideal for members with dependents outside of the state or coverage area. While the member must meet a deductible, they have the ability to "self refer" themselves to doctors and specialists of their choice, inside and outside the network.*

Summary of Services

Preventive Services	**BCN HMO Coverage**	**BCBSM PPO Coverage**	
		In network	Out of Network
Health Maintenance Exam	Covered - $5 copay	Covered – 100% One per calendar year	Not Covered
Annual Gynecological Exam	Covered - $5 copay	Covered - 100% One per calendar year	Not Covered
Pap Smear Screening- laboratory services only	Covered - 100%	Covered – 100% One per calendar year	Not Covered
Well-Baby and Child Care	Covered - $0 copay for well child visits through age 6; over age 6, $5 copay per visit	Covered – 100% Up to 6 visits / year through age 1 Up to 2 visits / year; age 2 -3 One visit / year; age 4 - 15	Not Covered
Immunizations- pediatric and adult	Covered - 100%	Covered – 100% through age 16	Not Covered
Prostate Specific Antigen (PSA) Screening-laboratory services only	Covered – 100%	Covered – 100% One per calendar year	Not Covered
Preventive Colonoscopy	Covered – 100%	Covered – 100% One per calendar year	Not Covered

Mammography

Mammography Screening	Covered – 100%	Covered – 90% after deductible One per calendar year	Covered – 70% after deductible One per calendar year

	BCN HMO Coverage	BCBSM PPO Coverage	
Physician Office Services		In Network	Out of Network
Office Visits	Covered - $5 copay	Covered - $10 copay	Covered – 70 % after deductible
Consulting Specialist Care- when referred	Covered - $5 copay	Covered - $10 copay	Covered – 70% after deductible

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered - $25 copay	Covered - $50 copay	Covered - $50 copay
Urgent Care Center	Covered - $10 copay	Covered - $10 copay	Covered – 70% after deductible
Ambulance Services – medically necessary	Covered – 100%	Covered - 90% after deductible	Covered - 90% after deductible

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100%	Covered – 90% after deductible	Covered – 70% after deductible
Diagnostic Tests and X-Rays	Covered – 100%	Covered – 90% after deductible	Covered – 70% after deductible
Radiation Therapy	Covered – 100%	Covered – 90% after deductible	Covered – 70% after deductible

Maternity Services Provided by a Physician

Pre-natal and Post-Natal Care	Covered – 100%	Covered – 100%	Covered – 70% after deductible
Delivery and Nursery Care	Covered – 100%	Covered – 90% after deductible	Covered – 70% after deductible

Hospital Care

Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 100%	Covered – 90% after deductible	Covered – 70% after deductible
Outpatient Surgery	Covered – 100%	Covered – 90% after deductible	Covered – 70% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100%, up to 45 days per member, per calendar year	Covered – 90% after deductible Up to 120 days / calendar year	Covered – 90% after deductible Up to 120 days / calendar year
Hospice Care	Covered – 100%	Covered – 100%	Covered – 100%
Home Health Care	Covered – 100%	Covered – 90% after deductible	Covered – 90% after deductible

	BCN HMO Coverage	BCBSM PPO Coverage	
		In Network	Out of Network

Surgical Services

Service	BCN HMO Coverage	BCBSM PPO In Network	BCBSM PPO Out of Network
Surgery – includes all related surgical services and anesthesia	Covered – 100%	Covered – 90% after deductible	Covered – 70% after deductible
Voluntary Sterilization	Covered – 100%	Covered – 90% after deductible	Covered – 70% after deductible
Human Organ Transplant	Covered- 100%, subject to medical criteria	Covered – 100% for liver, lung, heart, pancreas and heart-lung. (Up to $1 million max. per transplant). Other transplants covered 90% after deductible	Covered – 100% for liver, lung, heart, pancreas and heart-lung. (Up to $1 million max. per transplant). Other transplants covered 70% after deductible

Mental Health Care and Substance Abuse Treatment

Service	BCN HMO Coverage	BCBSM PPO In Network	BCBSM PPO Out of Network
Inpatient Mental Health Care and Substance Abuse Care	Mental Health Care: Covered - 100% up to 45 days per calendar year, renewable after 60 days	Mental Health Care: Covered – 100% after deductible Unlimited days	Mental Health Care: Covered – 100% after deductible Unlimited days
	Substance Abuse Care: Covered – 100%, one program per 12-month period	Substance Abuse Care: Covered – 50% after deductible Up to $15,000 annually / $30,000 lifetime / member	Substance Abuse Care: Covered – 50% after deductible Up to $15,000 annually / $30,000 lifetime / member
Outpatient Mental Health Care	Covered - $15 copay per visit, up to 20 visits per calendar year	Covered – 100% after deductible	Covered – 100% after deductible
Outpatient Substance Abuse Care	Covered - $15 copay per visit, up to 20 visits per calendar year	Covered – 50% after deductible up to state dollar amount	Covered – 50% after deductible up to state dollar amount

Other Services

Service	BCN HMO Coverage	BCBSM PPO In Network	BCBSM PPO Out of Network
Allergy Testing and Therapy	Covered – $5 copay	Covered – 100%	Covered – 70% after deductible
Chiropractic Spinal Manipulation	Covered - $5 copay (when referred)	Covered – 100% up to 24 visits per year / per member	Covered – 70% after deductible up to 24 visits per year / per member
Outpatient Physical, Speech and Occupational Therapy	Covered – 100%, limited to 60 consecutive days per episode, per year for a combination of therapies; subject to significant improvement within 60 days	Covered – 90% after deductible. Excludes speech and occupational therapy	Covered – 90% after deductible Excludes speech and occupational therapy
Durable Medical Equipment	Covered – 100%	Covered – 90% after deductible	Covered – 90% after deductible
Prosthetic and Orthotic Appliances	Covered – 100%	Covered – 90% after deductible	Covered – 90% after deductible
Hearing Aid	Covered – 100% ,Binaural hearing aids and one exam every 36 months	None	None
Prescription Drugs	Covered – 100% after copay- $5 generic, $10 brand name and non - formulary. Includes contraceptives. Health Habit covered 50%, Mail Order -$10 generic, $20 brand	Covered – 100% after copay - $10 generic, $20 brand name. Mail order (90 day supply) - $20 generic, $40 brand name	Covered – 75% after copay - $10 generic, $20 brand name. Mail order (90 day supply) - $20 generic, $40 brand name

Vision Care	BCN HMO Coverage	BCBSM PPO Coverage In Network	Out of Network
Vision Care Program	Not Covered	Exam - $5 copay Lenses, frames, contact lenses - $7.50 copay Covered every 24 months	Exam - $5 copay Lenses, frames, contact lenses - $7.50 copay Covered every 24 months

Deductible, Copays and Dollar Maximums

Deductible	None	$100 / Member $200 / Family Deductible is waived if service is performed in PPO physicians office	$250 / Member $500 / Family Out of Network deductible amounts also apply toward In Network deductible
Fixed Dollar Copay	$5 for office visits, $15 for outpatient mental health and outpatient substance abuse; $10 for urgent care visits, $25 for emergency room visits, and $1,000 for weight reduction procedures	$10 for office visits, $10 for urgent care visits, $50 for emergency room visits	None
Percent Copay	50% for infertility services	10% for general services 50% for substance abuse & private duty nursing	30% for general services 50% for substance abuse & private duty nursing
Copay Dollar Maximums - Fixed Dollar Copay	None	$500 / Member $1,000 / Family (per calendar year)	$1,500 / Member $3,000 / Family (per calendar year) Out of Network copays also apply toward the In Network maximum