

Medical Plan Comparison Chart

This chart is a general outline of employee costs for covered benefits and does not include all of the benefits, limitations and exclusions of the benefit programs. If there are any discrepancies between the information contained therein and the benefit proposals or official benefit plan documents, the benefit proposals or official benefit plan documents prevail. Rates vary based on enrollment coverage level. Provider network also impacts rates.

For rates, visit: <https://hr.wayne.edu/tcw/health-welfare/medical-rates>

Plan 1	Health Alliance Plan In-Network Only	Blue Care Network In-Network Only	Priority Health		Traditional BCBSM	BCBSM PPO	
			Tier 1 In-Network Only	Tier 2 In-Network Only		In-Network	Out-of-Network
What's Covered	Coverage summary	Coverage summary	Coverage summary		Coverage summary	Coverage summary	
Provider Network	Arenac, Bay, Genesee, Hillsdale, Huron, Iosco, Jackson, Lapeer, Lenawee, Livingston, Macomb, Monroe, Oakland, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola, Washtenaw, and Wayne Counties	All lower peninsula counties	Wayne, Oakland, Macomb, Livingston, Washtenaw and St. Clair Counties		Nationwide	Nationwide	N/A
Deductibles & Coinsurance							
Deductible <i>The individual deductible will apply for each family member until the family deductible has been met.</i>	No deductible	No deductible	No deductible	\$2,000 per individual \$4,000 per family	\$100 per individual \$200 per family	No deductible	\$250 per individual \$500 per family
Coinsurance	No coinsurance	No coinsurance	No coinsurance	20% coinsurance after deductible	10% coinsurance after deductible	No coinsurance	20% coinsurance after deductible
Coinsurance Maximum	N/A	N/A	N/A	No maximum	N/A	N/A	\$2,000 per individual \$4,000 per family
Total Out-of-Pocket Maximum <i>Includes deductible, coinsurance and copays</i>	\$6,350 per individual \$12,700 per family	\$6,350 per individual \$12,700 per family	\$6,350 per individual \$12,700 per family		\$600 per individual \$1,200 per family	\$600 per individual \$1,200 per family	\$2,250 per individual \$4,500 per family
Visit Copays							
Primary Care	\$20	\$20	\$20	\$40	\$20	\$20	20% coinsurance after deductible
Virtual Doctor Visits	\$20	\$20	\$0		\$20	\$20	Not covered
Specialist	\$20	\$20	\$20	\$40	\$20	\$20	20% coinsurance after deductible
Chiropractic Care	Not covered	\$20	\$20 copay <i>Up to 30 visits per year, combined Tier 1 & Tier 2.</i>	\$40 copay <i>Up to 30 visits per year, combined Tier 1 & Tier 2.</i>	10% coinsurance <i>Up to 38 visits per year.</i>	\$0 <i>Up to 24 visits per year.</i>	20% coinsurance after deductible <i>Up to 24 visits per year.</i>
Urgent Care	\$20	\$20	\$20	\$40	\$20	\$20	20% coinsurance after deductible
Emergency Room	\$100 copay <i>Waived if admitted or for an accidental injury. Covers life-threatening or accidental medical emergencies. Must notify medical plan within 48 hours of admission.</i>	\$100 copay <i>Waived if admitted. Covers life-threatening or accidental medical emergencies. Must notify medical plan within 48 hours of admission.</i>	\$100 copay <i>Waived if admitted.</i>		\$100 copay <i>Waived if admitted or for an accidental injury. Covers life-threatening or accidental medical emergencies.</i>	\$100 copay <i>Waived if admitted or for an accidental injury. Covers life-threatening or accidental medical emergencies.</i>	
Prescription Copays (30-day retail)							
Generic	\$5	\$5	\$5		\$5	\$5	25% of approved amount plus \$5 copay
Preferred Brand	\$20	\$20	\$20		\$20	\$20	25% of approved amount plus \$20 copay
Non-preferred brand	\$45	\$45	\$45		\$45	\$45	25% of approved amount plus \$45 copay
90-day mail order supply	Same as copays above	Same as copays above	2 times copays above		Same as copays above	Same as copays above	Not covered