Benefit	Health Alliance Plan In-Network Only	Blue Care Network In-Network Only	Total Health Care In-Network Only
Inpatient Hospital			
Hospital Services	Covered in full	Covered in full	Covered in full
Medical Care			
Office Visits: In Person Telemedicine/Virtual Visits	$20 copay $20 copay	$20 copay $20 copay	$20 copay Covered in full
Preventive Services — Routine Physical, Well-Baby Care, Pediatric Exams, Childhood Immunizations	Covered in full	Covered in full	Covered in full
Vision and Hearing Examinations	$20 copay	Vision exam not covered Hearing exam covered	Vision exam not covered Hearing exam covered
Emergency Room Services	$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies. Must notify medical plan within 48 hours of admission.	$100 copay (waived if admitted). Covers life-threatening or accidental medical emergencies. Must notify medical plan within 48 hours of admission.	$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies. Must notify medical plan within 48 hours of admission.
Laboratory, Pathology and Radiology (X-Ray) Services	Covered in full	Covered in full	Covered in full
Allergy Testing and Injections	Covered in full	Covered in full	$20 Copay
Outpatient Physical, Speech and Occupational Therapy	Covered in full (up to 60 combined visits per year)	Office visit copay applies (up to 60 visits per medical episode per year)	Covered in full (up to 30 visits per year)
Durable Medical Equipment	Covered in full for approved equipment	Covered in full	Covered in full for approved equipment
Chiropractic Services/ Spinal Manipulation	Not covered	Office visit copay applies (referral required)	Office visit copay applies (up to 30 visits per year; combined with physical and occupational therapy)
Reproductive Care			
Pre-Natal Care	Covered in full	Covered in full	Covered in full
Delivery and Routine Nursery Care	Covered in full	Covered in full	Covered in full
Infertility Services	Covered with limitations	Covered with limitations	Covered with limitations
Voluntary Sterilization	Covered in full	Covered in full	Covered in full

Benefit	Traditional BCBSM	Community Blue PPO	
		In-Network	Out-of-Network
Inpatient Hospital			
Hospital Services	Plan pays 90% after deductible (non-emergency services must be rendered in a **participating** hospital)	Covered in full (non-emergency services must be rendered in a **participating** hospital)	80% after out-of-network deductible (non-emergency services must be rendered in a **participating** hospital)
Medical Care			
Office Visits: In Person Telemedicine/Virtual Visits	$20 copay $20 copay	$20 copay $20 copay	80% after out-of-network deductible Not covered
Preventive Services — Routine Physical, Well-Baby Care, Pediatric Exams, Childhood Immunizations	Covered in full	Covered in full	Not covered
Vision and Hearing Examinations	Not covered	Vision exam not covered Hearing exam covered	Vision exam not covered Hearing exam covered at **participating** providers
Emergency Room Services	$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies.	$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies.	$100 copay (waived if admitted or for an accidental injury). Covers life-threatening or accidental medical emergencies.
Laboratory, Pathology and Radiology (X-Ray) Services	Plan pays 90% after deductible (preventive services excluded)	Covered in full	80% after out-of-network deductible
Allergy Testing and Injections	$20 copay	Covered in full	80% after out-of-network deductible
Outpatient Physical, Speech and Occupational Therapy	Plan pays 90% after deductible	Covered in full (up to 60 visits per year)	80% after out-of-network deductible at **participating** providers
Durable Medical Equipment	Plan pays 90% after deductible	Covered in full	Covered in full
Chiropractic Services/ Spinal Manipulation	Plan pays 90% after deductible (up to 38 visits per year)	Covered in full (up to 24 visits per year)	80% after out-of-network deductible (up to 24 visits per year)
Reproductive Care			
Pre-Natal Care	Covered in full	Covered in full	80% after out-of-network deductible
Delivery and Routine Nursery Care	Plan pays 90% after deductible	Covered in full	80% after out-of-network deductible
Infertility Services	Not covered	Not covered	Not covered
Voluntary Sterilization	Covered in full (female only)	Covered in full	80% after out-of-network deductible

Benefit	Health Alliance Plan In-Network Only	Blue Care Network In-Network Only	Total Health Care In-Network Only
Mental Health and Substance Abuse			
Outpatient Care: In Person Telemedicine/Virtual Visits	Office visit copay applies Not covered	Office visit copay applies $20 copay	Covered in full Not covered
Inpatient Care	Covered in full	Covered in full	Covered in full (intermediate care only)
Prescription Drugs			
Prescription Drugs	$5 generic drugs $20 preferred brand drugs $45 non-preferred brand drugs (copay waived for generic oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mai-order prescriptions (90-day supply) are available.	$5 generic drugs $20 preferred brand drugs $45 non-preferred brand drugs (copay waived for generic oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available.	$5 generic drugs $20 preferred brand drugs $45 non-preferred brand drugs (copay waived for generic oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available.
Other Services			
Autism Spectrum Disorder	Covered — contact carrier for details	Covered — contact carrier for details	Covered — contact carrier for details
Eyeglasses and Contact Lenses	Covered following cataract or intra-ocular surgery	Not covered	Not covered
Hearing Aids	Covered for authorized conventional hearing aids	Covered (one hearing aid every 36 months)	Covered (one hearing aid per ear every three (3) years)
Skilled Nursing Care Facility (excluding custodial care)	Covered in full (730 days, renewable after 60 days)	Covered in full (730 days in a lifetime)	Covered in full (120 days per calendar year)
Deductibles, Copays, and Limitations			
Annual Deductible	No deductible	No deductible	No deductible
Annual Coinsurance Maximum	N/A	N/A	N/A
Annual Out-of-Pocket Maximum (includes deductible, coinsurance & copays)	$6,350 per individual $12,700 per family	$6,350 per individual $12,700 per family	$6,350 per individual $12,700 per family
Hospital Precertification	Required for admission in a non-participating hospital within 48 hours	Required for admission in a non-participating hospital within 48 hours	Required for admission in a non-participating hospital within 48 hours

Benefit	Traditional BCBSM	Community Blue PPO	
		In-Network	Out-of-Network
Mental Health and Substance Abuse			
Outpatient Care: In Person Telemedicine/Virtual Visits	Plan pays 90% after deductible Plan pays 90% after deductible	Covered in full (approved facilities) Covered in full	80% after out-of-network deductible Not covered
Inpatient Care	Plan pays 90% after deductible	Covered in full	80% after out-of-network deductible
Prescription Drugs			
Prescription Drugs	$5 generic drugs $20 preferred brand drugs $45 non-preferred brand drugs (copay waived for generic oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available.	$5 generic drugs $20 preferred brand drugs $45 non-preferred brand drugs (copay waived for generic oral contraceptives) Limited to one month supply. Includes contraceptive medications. Mail-order prescriptions (90-day supply) are available.	75% of approved amount less plan copay. Limited to one month supply. Includes contraceptive medications.
Other Services			
Autism Spectrum Disorder	Covered — contact carrier for details	Covered — contact carrier for details	Covered — contact carrier for details
Eyeglasses and Contact Lenses	Covered following cataract or intra-ocular surgery, accidental injury, or certain non-routine diagnoses. Plan pays 90% after deductible.	Not covered	Not covered
Hearing Aids	Not covered	Covered (one hearing aid every 36 months)	Not covered
Skilled Nursing Care Facility (excluding custodial care)	Not covered	Covered in full (120 days per calendar year)	Covered in full (120 days per calendar year)
Deductibles, Copays, and Limitations			
Annual Deductible	$100 per individual $200 maximum per family	No deductible	$250 per individual $500 per family
Annual Coinsurance Maximum	$500 per individual $1,000 per family	N/A	$2,000 per individual $4,000 per family
Annual Out-of-Pocket Maximum (includes deductible, coinsurance & copays)	$600 per individual $1,200 per family	$600 per individual $1,200 per family	$2,250 per individual $4,500 per family
Hospital Precertification	Required — provider responsibility	Required — provider responsibility	Required — provider responsibility