Michigan Catholic Conference Medical Plan Benefits Comparison

Plan Year: 2026

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Your employer establishes the amount, if any, of employee contribution towards cost of plan.

	BCN Blue Elect Plus		BCBSM PPO1		BCBSM PPO2 (HDHP PPO2)		BCBSM PPOHD	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
MCC Health Savings Account	Not Eligible		Not Eligible		Eligible		Eligible	
Deductibles/Maximums /Coinsurance								
Annual Deductible Single/Family	$100/$300	$500/$1500	$800/$1,600	$1,500/$3,000	$2,000/$4,000	$4,000/$8,000	$5,000/10,000	$10,000/$20,000
Annual Out of Pocket Max - Medical (single/family)	$1,000/$3,000	$3,000/$9,000	$2,800/$5,600	$5,000/$10,000	$4,000 / $8,000	$8,000 / $16,000	$7,000/$14,000	$14,000/$28,000
Coinsurance (Plan Share/Member share)	80% / 20%	80% / 20%	80% / 20%	60% / 40%	80% / 20%	60% / 40%	70% / 30%	60% / 40%
Office Visits								
Primary Care Office Visit	$20 copay	80% after deductible	$30 copay	60% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible
Specialist Visit	$35 copay	80% after deductible	$50 copay	60% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible
Telemedicine Visits	$20 copay	80% after deductible	$30 copay	60% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible
Virtual Care- Online Medical Visits	$20 copay	Not Covered	$30 copay	Not Covered	80% after deductible	Not Covered	70% after deductible	Not Covered
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
Routine Physical Related Test X-Rays, EKG and lab procedures as part of the health maintenance	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 (includes 3D)	100%	80% after deductible	100%	60% after deductible	100%	60% after deductible	100%	60% after deductible
Endoscopic Exam	100%	80% after deductible	100%	60% after deductible	100%	60% after deductible	100%	60% after deductible
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	$150 copay*	$150 copay	80% after deductible	80% after deductible	70% after deductible	70% after deductible
Urgent Care	$35 copay	$35 copay	$50 copay	60% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible
Ambulance Services	$50 copay	$50 copay	80% after deductible	80% after deductible	80% after deductible	80% after deductible	70% after deductible	70% after deductible
Hospital Services								
Semi-Private Room, Inpatient Physician Care, General Nursing Care. Hospital Services and	80% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible
Inpatient Medical Care	80% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible
Surgical Services	80% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible
Outpatient Surgery	80% after deductible	80% after deductible	80% after deductible	60% after deductible	80% 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	80% after deductible	60% after deductible	70% after deductible	60% after deductible
MRI, MRA, PET and CAT Scans and Nuclear Medicine	80% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible
Diagnostic Tests and X-rays	80% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible
Radiation Therapy and Chemotherapy	80% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible

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	BCN Blue Elect Plus		BCBSM PPO1		BCBSM PPO2 (HDHP 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								
Prenatal Care and Postnatal Care Visits	100%	80% after deductible	100%	60% after deductible	100%	60% after deductible	100%	60% after deductible
Delivery and Nursery Care	80% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible
Behaviorl Health Services (Mental Health and Substance Use Disorder)								
Inpatient Behavioral Health & Substance Abuse Treatment	80% after deductible	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible
Outpatient Behavioral Health & Substance Abuse Treatment	$20 copay	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible
Telemedicine Mental Health Care Visits	$20 copay	80% after deductible	$30 copay	60% after deductible	80% 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	80% after deductible	60% after deductible	70% after deductible	60% after deductible
Chiropractic Spinal Manipulation	$35 copay limited to 24 visits/year	Not Covered	$30 copay limited to 24 visits/year	60% after deductible limited to 24 visits/year	80% 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	80% after deductible	60% after deductible	70% after deductible	60% after deductible
Cardiac Rehabilitation	$35 copay	80% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	70% after deductible	60% after deductible
Durable Medical Equipment (DME)	100%	Not Covered	80% after deductible	80% after deductible	80% after deductible	80% after deductible	70% after deductible	70% after deductible
Prosthetic and Orthotic Appliances (P&O)	100%	Not Covered	80% after deductible	80% after deductible	80% after deductible	80% after deductible	70% after deductible	70% after deductible
Hearing Exam/Aid *Maximum amount allowed for hearing aids*	Binaural hearing aids and exam covered every 36 months- 100%	Not Covered	Binaural hearing aids and exam covered every 36 months- 100%	Not Covered	Binaural hearing aids and exam covered every 36 months- 100%	Not Covered	Binaural hearing aids and exam covered every 36 months- 100%	Not Covered
Hospice Care	100% after deductible	80% after deductible	100%	100%	100% after deductible	100% after deductible	100% after deductible	100% after deductible
Home Health Care	100% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible	70% after deductible	70% 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	80% after deductible	80% after deductible	70% after deductible	70% after deductible
Diabetic Supplies	See Benefits At A Glance							
Vision Exams	Not Covered	Not Covered	$25 copay	Reimburse up to $35 less $25 copay	$25 copay	Reimburse up to $35 less $25 copay	$25 copay	Reimburse up to $35 less $25 copay
Prescription Drugs**	**Retail 30/90**		**Retail 30/90**		**Retail 30/90**		**Retail 30/90**	
Generic	$10/$20		$15/30		10%		20%	
Preferred Formulary	$30/$60		$40/$80		20%		30%	
Non-Preferred Formulary	$50/$100		$75/$150		30%		40%	

Out-of-Network benefits are typically paid based on allowed amount.

* Emergency Room copay waived if admitted.

** BCBSM Custom Formulary. All medical plans have Saver90 Program for Prescription Drugs.

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