SOLIDARITY HEALTH NETWORK
Experts in Benefit Administration Service Since 1989

2024 COMPARISON LIST

888.338.7677

BlueCross BlueShield

Plan Options

Nationwide insurance plans are provided by Blue Cross Blue Shield of Michigan through a National VEBA Trust Gold, Cobalt, Silver, Bronze and Copper plans are bundled to include medical, prescription drugs and can add dental and vision.

	Gold Plan		Silver Plan		Bronze Plan		Copper Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (per calendar year)	$250 Individual	$500 Individual	$500 Individual	$1,000 Individual	$2,000 Individual	$4,000 Individual	$4,000 Individual	$8,000 Individual
	$500 Family	$1,000 Family	$1,000 Family	$2,000 Family	$4,000 Family	$8,000 Family	$8,000 Family	$16,000 Family
Coinsurance	20%	40%	20%	40%	20%	40%	50%	50%
Out-Of-Pocket Maximum (includes deductible: excludes all copays and penalty amounts)	$1,250 Individual $2,500 Family	$2,250 Individual $4,500 Family	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family	$6,350 Individual $12,700 Family	$12,700 Individual $25,400 Family
Preventive Care Services								
Adult Routine Physical Exam (every 24 months), Annual Routine Mammogram, GYN Exam and PSA.	Covered 100%; no deductible, no copay	Not covered	Covered 100%; no deductible, no copay	Not covered	Covered 100%; no deductible, no copay	Not covered	No Charge	Not Covered
Routine Eye and Hearing Screening (one exam every 24 months)	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Physician Services								
Primary Doctor Office Visit	$10 office visit copay; deductible waived	40% copay, after deductible	$20 office visit copay; deductible waived	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	50% co-insurance after deductible	50% co-insurance after deductible
Specialist Office Visits	$10 office visit copay; deductible waived	40% copay, after deductible	$20 office visit copay; deductible waived	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	50% co-insurance after deductible	50% co-insurance after deductible
X-ray and Lab Services (during office visit)	20% co-insurance after deductible	40% copay, after deductible	20% co- insurance afterdeductible	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	50% co-insurance after deductible	50% co-insurance after deductible
Emergency Services								
Emergency Room (copay waived if admitted)	$50 copay	$50 copay	$150 copay	$150 copay	20% co-insurance after deductible	20% co-insurance after deductible	50% co-insurance	50% co-insurance
Urgent Care								
Immediate Medical Attention	$10 copay	40% copay, after deductible	$20 copay	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	50% co-insurance	50% co-insurance

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Hospital Services								
Hospital Admission	20% co-insurance after deductible	40% copay, after deductible	20% copay, after deductible	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	50% co-insurance after deductible	50% co-insurance after deductible
Outpatient Hospital	20% co-insurance after deductible	40% copay, after deductible	20% copay, after deductible	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	50% co-insurance after deductible	50% co-insurance after deductible
Alternatives to Hospital Care								
Skilled Nursing (max. 120days), this is facility benefit and covered	20% after copay, after deductible	20% after copay, after deductible	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	50% co-insurance after deductible	50% co-insurance after deductible
Home Health (max. 120 days) and Urgent Care	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	20% co-insurance after deductible	50% co-insurance after deductible	50% co-insurance after deductible
Other Services								
Outpatient Short-Term Rehabilitation (includes speech, physical, occupational and spinal manipulation therapy), in office setting.	20% co-insurance after deductible	40% copay, after deductible	20% co-insurance after deductible	40% copay, after deductible	20% after deductible	40% copay, after deductible	50% co- insurance after deductible	Applied behavioral analysis treatment for Autism — by behavioral analyst, up to 18 pre-authorization

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Generic	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drug Plan—Retail Pharmacy								
Generic	$10 copay	$25 after Rx plan $10 copay	$10 copay	25% after Rx plan $10 copay	After deductible, $15 co-pay for retail	After deductible, $30 co-pay for retail	After deductible, 50% co-pay of approved amount	After deductible, co-pay plus 20% of approved amount
Preferred Brand-Name Drugs	$20 copay	$25 after Rx plan $20 copay	$40 copay	25% after Rx plan $40 copay	After deductible/$50 copay for retail or mail order	After deductible, $100 co-pay for retail or mail order	After deductible, 50% co-pay of approved amount	After deductible, co-pay plus 20% of approved amount
Non-Preferred Brand-Name Drugs	$40 copay	$25 after Rx plan $40 copay	$80 copay	25% after Rx plan $80 copay	After deductible/$70 copay or 50% co -insurance of approved amount (whichever is greater) no more than $100 copay	After deductible/$70 copay additional 20% approved amount	After deductible, 50% co-pay of approved amount	After deductible, co-pay plus 20% of approved amount
Prescription Drug Plan—Mail Order (90 Day Supply)								
Generic	$20 copay	N/A	$20 copay	N/A	After deductible/$30 co-pay for 30 day supply	After deductible, co-pay plus additional 20% of approved amount	50% co-pay of amount	Not covered
Preferred Brand	$40 copay	N/A	$80 copay	N/A	$100 co-pay for mail order 90- day supply	After deductible, co-pay plus an additional 20% of approved amount	50% co-pay of amount	Not covered
Non-Preferred Brand	$80 copay	N/A	$160 copay	N/A	$140 or 50% whichever is greater, max of $200 after deductible	After deductible, co-pay plus an additional 20% of approved amount	50% co-pay of amount	Not covered