

Blue Care Network for State of Michigan

Preventive services	
Health maintenance exam	Covered — \$10 copay
Annual gynecological exam	Covered — \$10 copay
Pap smear screening — laboratory services only	Covered — 100%
Well-baby and well-child care	Covered — \$10 copay
Immunizations	Covered — 100%
Infertility counseling and treatment (excluding in-vitro fertilization)	Covered — \$10 copay
Mammography	
Mammography screening	Covered — 100%
Physician office services	
Office visits	Covered — \$10 copay
Consulting specialist care — when referred	Covered — \$10 copay
Emergency medical care	
Hospital emergency room — approved diagnosis	Covered — \$50 copay (waived if admitted)
Physician's office	Covered — \$10 copay
Urgent care center	Covered — \$10 copay or 50% of treatment cost, whichever is less
Ambulance services — when medically necessary	Covered — 100% ground and air
Diagnostic services	
Laboratory and pathology tests	Covered — 100%
Diagnostic tests and X-rays	Covered — 100%
Radiation therapy	Covered — 100%
Maternity services provided by a physician	
Pre-natal and post-natal care	Covered — \$10 copay per visit
Delivery and nursery care	Covered — 100%
Hospital care	
Semi-private room, inpatient physician care, general nursing care, hospital services and supplies	Covered — 100%, unlimited days
Inpatient consultations	Covered — 100%
Chemotherapy	Covered — 100%
Alternatives to hospital care	
Skilled nursing care	Covered — 100%
Hospice care	Covered — 100% in facility, \$10 office visit for each home visit
Home health care	Covered — 100% in facility, \$10 office visit for each home visit
Surgical services	
Surgery — includes related surgical services and anesthesia	Covered — 100%
Voluntary sterilization	Covered — 100%
Human organ transplants	Covered — 100%, subject to medical criteria



active employees

Mental health care and substance abuse treatment	
Inpatient mental health care and substance abuse care	Covered — 100%, up to 45 days; renewable 60 days after discharge
Outpatient mental health care per calendar year	Covered — 100% for first 20 visits; after 20 visits, \$10 copay for 30-minute visits, \$15 copay for visits longer than 30 minutes
Outpatient substance abuse care	Covered — 100%, up to 35 visits per calendar year
Other services	
Allergy testing and therapy	Covered — 100%
Chiropractic spinal manipulation when referred by PCP	Covered — \$10 copay
Outpatient physical, speech and occupational therapy	Covered — 100%, limited to 60-day treatments/medical episode year, \$10 copay for each visit
Durable medical equipment	Covered — 100%
Prosthetic and orthotic appliances	Covered — 100%
Vision and hearing screenings — when performed in physician's office	Covered — 100%
Prescription drugs — includes contraceptives	\$5 copay for generic prescription drugs/\$10 copay for brand-name prescription drugs (one copay for 90-day supply through mail order)
Deductible, copays and out-of-pocket dollar maximums	
Deductible	None
Copays	<ul style="list-style-type: none"> • \$10 copay for office visits • \$10 copay for urgent care center service • \$50 copay for emergency room service (waived if admitted) • \$5 copay for generic prescription drugs/\$10 copay for brand-name prescription drugs
• Fixed dollar copays	
• Percent copay	None
Copay dollar maximums	
• Fixed dollar copay	None
• Percent copay	None
Dollar maximums	None

Questions?

Contact Blue Care Network Customer Service toll-free at
800-662-6667.

This is intended as an easy-to-read summary. It is not a contract. An official description of benefits is contained in applicable BCN certificates and riders. Payment amounts are based on the BCN-approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into with the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

State Health Plan PPO for active employees and

	In-Network	Out-of-Network
Preventive services		
Health maintenance exam or annual gynecological exam	Covered — 100% one per year	Not covered
Pap Smear screening — laboratory services only	Covered — 100% one per year	Not covered
Well-baby and child care	Covered — 100%	Not covered
Immunizations, annual flu shot and Hepatitis C screening for those at risk	Covered — 100%	Not covered
Fecal occult blood screening	Covered — 100%	Not covered
Flexible Sigmoidoscopy	Covered — 100%	Not covered
Prostate specific antigen screening	Covered — 100% one per year	Not covered
Mammography		
Mammography screening	Covered — 100%	Covered — 90% after deductible
	One per year, no age restrictions	
Colonoscopy		
Colonoscopy	Covered — 100%	Covered — 90% after deductible
Physician office services		
Office visits, consultations and urgent care visits	Covered — \$15 copay (deductible not required)	Covered — 90% after deductible
Outpatient and home visits	Covered — 100% after deductible	Covered — 90% after deductible
Emergency medical care		
Hospital emergency room — for medical emergency or accidental injury	Covered — \$50 (waived if admitted; deductible not required)	
Ambulance services — medically necessary	Covered — 100% after deductible	
Diagnostic services		
Laboratory and pathology tests	Covered — 100% after deductible	Covered — 90% after deductible
Diagnostic tests and X-rays	Covered — 100% after deductible	Covered — 90% after deductible
Radiation therapy	Covered — 100% after deductible	Covered — 90% after deductible
Maternity services — Includes care provided by a certified nurse midwife		
Pre-natal and post-natal care	Covered — 100% after deductible	Covered — 90% after deductible
Delivery and nursery care	Covered — 100% after deductible	Covered — 90% after deductible
Hospital care		
Semi-private room, inpatient physician care, general nursing care, hospital services and supplies	Covered — 100% after deductible, unlimited days	Covered — 90% after deductible, unlimited days
Inpatient consultations	Covered — 100% after deductible	Covered — 90% after deductible
Chemotherapy	Covered — 100% after deductible	Covered — 90% after deductible
Alternatives to hospital care		
Skilled nursing care — up to 120 days per confinement (730 days for UAW and MSPTA)	Covered — 100% after deductible	
Hospice care	Covered — 100% Limited to the lifetime dollar maximum that is adjusted annually by the state	
Home health care	Covered — 100% after deductible, unlimited visits	



non-Medicare eligible retirees

	In-Network	Out-of-Network
Surgical services		
Surgery — includes related surgical services	Covered — 100% after deductible	Covered — 90% after deductible
Voluntary sterilization	Covered — 100% after deductible	Covered — 90% after deductible
Human organ transplants — Contact HOTP at 800-242-3504 for additional information		
Liver, heart, lung, pancreas and other specified human organ transplants — covered in designated facilities only	Covered — 100% Up to \$1 million maximum per transplant type	
Organ and tissue transplants		
Bone marrow — specific criteria apply*	Covered — 100% after deductible	Covered — 90% after deductible
Kidney, cornea and skin	Covered — 100% after deductible	Covered — 90% after deductible
Other services		
Allergy testing and injections	Covered — 100% after deductible	Covered — 90% after deductible
Acupuncture	Covered — 90% after deductible Up to 20 visits per calendar year	
Chiropractic spinal manipulation	Covered — \$15 copay Visit limitations vary according to most recent bargaining outcomes	
Durable medical equipment	SUPPORT Program, 800-321-8074	
Prosthetic and orthotic appliances		
Private duty nursing	Covered — 90% after deductible	
Prescription drugs		
Administered through Express Scripts: 800-505-2324	Retail: \$10 generic; \$20 preferred brand; \$40 non-preferred brand Mail order: \$20 generic; \$40 preferred brand; \$80 non-preferred brand	
Mental health and substance abuse		
Magellan Behavioral of Michigan: 866-503-3158		
Outpatient physical, speech and occupational therapy		
Outpatient physical, speech and occupational therapy — facility and clinic services	Covered — 100% after deductible Visit limitations vary according to most recent bargaining outcomes	
Outpatient physical therapy — physician's office	Covered — 100% after deductible	Covered — 90% after deductible
Deductible, copays and out-of-pocket dollar maximums**		
Deductible	\$300 per member \$600 per family	\$600 per member \$1,200 per family
Copays	<ul style="list-style-type: none"> • \$15 for office visits, office consultations, urgent care visits, osteopathic and chiropractic manipulations and hearing exams (deductible not required) • \$50 emergency care (waived if admitted) • 10% for private duty nursing and acupuncture 	<ul style="list-style-type: none"> • Not applicable • 10% for most services
Annual out-of-pocket dollar maximums	\$1,000 per member \$2,000 per family	\$2,000 per member \$4,000 per family

*Covered in designated facilities only

**Based on current bargaining outcome.
Benefit changes not applicable to MSPTA.

Questions?

Contact BCBSM's State of Michigan Customer Service toll-free at 800-843-4876.

This benefit chart is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the SHP PPO employee handbook. Payment amounts are based on the BCBSM-approved amount, less any applicable deductible and/or copay amount required by the SHP PPO. This coverage is provided pursuant to a contract entered into with the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.



Blue Vision care coverage for State of Michigan

	Participating Provider	Nonparticipating Provider
Vision Testing Examination		
Eye Exam	100% of BCBSM-approved amount minus \$5 copay	75% of BCBSM-approved amount minus \$5 copay
	Once every 12 months	
Frames — Members may obtain either eyeglasses or contact lenses, but not both.		
Frames	Maximum varies based on bargaining unit minus \$7.50 copay*	Maximum of \$14.75; no copay
	Once every 24 months, or once in every 12 months if prescription has changed	
Eyeglass Lenses (glass, plastic, or prism)		
Single vision	100% of BCBSM-approved amount minus \$7.50 copay*	Maximum of \$13 per pair for glass; \$16 per pair for plastic, and \$15 per pair for prism; no copay
	Once every 24 months, or once in every 12 months if prescription has changed	
Bifocal (includes blended)	100% of BCBSM-approved amount minus \$7.50 copay*	Maximum of \$20 per pair for glass; \$23 per pair for plastic, and \$22 per pair for prism; no copay
	Once every 24 months, or once in every 12 months if prescription has changed	
Trifocal	100% of BCBSM-approved amount minus \$7.50 copay*	Maximum of \$24 per pair for glass; \$27 per pair for plastic, and \$26 per pair for prism; no copay
	Once every 24 months, or once in every 12 months if prescription has changed	
Special lenses	100% of BCBSM-approved amount minus \$7.50 copay*	50% or 75% of BCBSM-approved amount for comparable lenses, whichever is less
	Once every 24 months, or once in every 12 months if prescription has changed	
Rose tints #'s 1 and 2	100% of BCBSM-approved amount	Maximum of \$3
	One every 24 months	
Contact Lenses – Members may obtain either eyeglasses or contact lenses, but not both.		
Therapeutic Contact Lenses, medically necessary	100% of BCBSM-approved amount	Maximum of \$40; no copay
	One every 24 months	
Cosmetic Contact Lenses, not medically necessary	Maximum of \$90; no copay	Maximum of \$40; no copay
	One every 24 months	
Copays		
• Eye exam	\$5 copay	\$5 copay
• Frames and/or lenses or therapeutic contact lenses	A combined \$7.50 copay	Member responsible for difference between approved amount and provider's charge

*If member has already made a copay for lenses, no further copay is required.

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Customer Service toll-free at 800-843-4876.**

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