

## Benefit comparison chart for members of the State Police Enlisted Unit

**Effective October 2, 2011**

**Disclaimer:** This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable entered into with the State of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.

### Preventive services

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Health maintenance exam	Covered 100% one per calendar year	Not covered	Covered 100% after \$10 office visit copay
Annual gynecological exam	Covered 100% one per calendar year		
Pap smear screening – laboratory services only*	Covered 100% one per calendar year		
Well-baby and child care	Covered 100% <ul style="list-style-type: none"> <li>• 6 visits per year through age 1</li> <li>• 2 visits per year, age 2 – 3</li> <li>• 1 visit per year, age 4 – 15</li> </ul>		
Immunizations and annual flu shot (age 17 and older)	Covered 100%		
Hepatitis C screening (for those at risk)	Covered 100%		
Fecal occult blood screening*	Covered 100% one per calendar year		
Flexible sigmoidoscopy*	Covered 100% one every 5 years		
Prostate specific antigen screening*	Covered 100% one per calendar year		
Childhood immunizations (children through age 16)	Covered 100%		
Colonoscopy exam*	Covered 100%	Covered 90% after deductible	Check with your HMO
	Beginning at age 50. One every 10 years.		
Mammography screening*	Covered 100%	Covered 90% after deductible	Covered 100%
	One per calendar year.		

### Physician office services

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Office visits, office consultations, chiropractic office visits and manipulations, medical hearing exams, medical eye exams and urgent care visits	Covered \$15 copay	Covered 90% after deductible	Covered after \$10 copay
Outpatient and home visits	Covered 100% after deductible		

\*American Cancer Society guidelines apply

**Emergency medical care**

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Hospital emergency room	Covered for medical emergency or accidental injury \$50 copay (waived if admitted)		\$50 copay (waived if admitted)
Ambulance services – medically necessary	Covered 100% after deductible		Covered 100%

**Diagnostic services**

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Laboratory and pathology tests	Covered 100% after deductible	Covered 90% after deductible	Covered 100%
Diagnostic tests and x-rays			
Radiation therapy			

**Maternity services**

*(State Health Plan PPO includes care by a certified nurse midwife)*

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Pre-natal and post-natal care	Covered 100% after deductible	Covered 90% after deductible	Office visit: \$10 copay
Delivery and nursery care			Covered 100%

**Hospital care**

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Semi-private room, inpatient physician care, general nursing care, hospital services, blood storage and supplies	Covered 100% after deductible	Covered 90% after deductible	Covered 100%
Inpatient consultations	Covered 100% after deductible	Covered 90% after deductible	Covered 100%
Chemotherapy			

**Alternatives to hospital care**

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Skilled nursing care	Covered 100% after deductible up to 120 days per confinement		Covered 100%
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		Covered \$10 for each home visit

**Surgical services**

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Surgery – includes related surgical services	Covered 100% after deductible	Covered 90% after deductible	Covered 100%
Voluntary sterilization			

**Human organ transplants**

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Liver, heart, lung, pancreas and other specified organ transplants – covered in designated facilities only. Preauthorization is required.	Covered 100% in designated facilities only Up to \$1 million maximum per transplant type		Covered 100% in designated facilities
Bone marrow – specific criteria apply	Covered 100% in designated facilities only		
Kidney, cornea and skin	Covered 100% after deductible	Covered 90% after deductible	Covered 100% subject to medical criteria

**Other services**

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Allergy testing and therapy	Covered 100% after deductible	Covered 90% after deductible	Covered 100% Office visit copay may apply
Acupuncture	Covered 90% after deductible if performed by or under the supervision of a M.D. or D.O. – 20 visit limit.		Check with HMO
Rabies treatment after initial emergency room visit	Covered 100% after deductible	Covered 90% after deductible	Office visit: \$10 copay Injections: Covered 100%
Hearing care program	\$15 office visits; more frequent than 36 months if standards met		Check with HMO
Chiropractic spinal manipulation	Covered - \$15 copay	Covered 90% after deductible	Check with HMO
Durable medical equipment, prosthetic and orthotic appliances (Covered by SUPPORT program)	Covered 100%	Covered 80% plus the difference allowed amount and charge	Covered 100%
Private duty nursing	Covered 90% after deductible		Covered 100%
Wig, wig stand, adhesives (Covered by SUPPORT program)	Upon meeting medical conditions, eligible for a lifetime maximum reimbursement of \$300. Additional wigs covered for children due to growth		Check with HMO

**Outpatient physical, speech and occupational therapy**

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Outpatient physical, speech and occupational therapy – facility and clinic services	Covered 100% after deductible	Covered 90% after deductible	Covered 100%
	Combined maximum of 90 visits per calendar year		
Outpatient physical therapy – physician's office	Covered 100% after deductible	Covered 90% after deductible	Office visit: \$10 copay

**Mental health/substance abuse services**

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Inpatient substance abuse	Covered 100% - 28 days with a 60-day renewal and only 2 admissions per calendar year. No dollar maximum.		Check with HMO
Inpatient psychiatric	Covered 100% No dollar maximum.		
Outpatient substance abuse	Covered 90% for services rendered by a participating BCBS provider. Covered at 90% of BCBS's approved amount for services rendered by a non-participating BCBS provider. Subject to a \$3,500 maximum per member per calendar year.		
Outpatient (office) psychiatric	Covered 90% for services rendered by a participating BCBS provider. Covered at 90% of BCBS's approved amount for services rendered by a non-participating BCBS provider.		
Residential care facility	Covered 100% for the standard length of treatment program		
Acute care hospital (using acute care beds)	Covered 67% of semi-private room and board charges and 100% of covered miscellaneous fees for the standard length of treatment program.		
Detoxification	Covered 100% for semi-private room and board and miscellaneous fees.		

**Deductible, copays and out-of-pocket dollar maximums**

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Deductible	\$300 per member \$600 per family	\$600 per member \$1,200 per family	None
Copays <ul style="list-style-type: none"> <li>Fixed dollar copays (does not apply toward deductible)</li> </ul>	\$15 for office visits, office consultations, chiropractic office visits and manipulations, medical hearing exams, medical eye exams and urgent care visits	Not applicable	\$10 office visits and urgent care visits \$50 emergency room visits, if not admitted
Copays <ul style="list-style-type: none"> <li>Percent copays</li> </ul>	10% for private duty nursing and acupuncture	10% for most services	None
Annual dollar maximums <ul style="list-style-type: none"> <li>Fixed dollar copays (does not apply toward out-of-pocket maximum)</li> </ul>	Not applicable	None	None
Annual dollar maximums <ul style="list-style-type: none"> <li>Percent copays (private duty nursing copays do not apply toward out-of-pocket maximum)</li> </ul>	\$1,000 per member \$2,000 per family	\$2,000 per member \$4,000 per family	
Annual dollar maximum	\$5 million lifetime per member for all covered services as noted above for individual services		

**Mental health copay**

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Deductible	Not applicable	Not applicable	
Percent copay	10% for outpatient psychiatric and outpatient substance abuse	10% for outpatient psychiatric and outpatient substance abuse. Non-participating providers are reimbursed according to BCBS's allowed amount minus the 10%	Check with HMO

**Prescription drug copay**

	State Health Plan PPO		HMO Benefits	
	Prescription drugs	Generic \$ 10 Brand Name Preferred \$ 20 Brand Name Non-Preferred \$ 40  All maintenance drugs filled at a participating pharmacy may only be approved for up to a 34-day supply. Members will still be able to pay a 1-month co-pay and receive up to a 90-day supply by mail order.		Generic \$ 5 Brand Name \$ 10