This comparison chart is intended as an easy-to-read summary. Additional limitations, exclusions, or prior authorizations may apply to covered services. Payment amounts are based on the HMO's approved amount, less any applicable deductible and/or copay amounts. Pre-existing conditions are covered with the applicable deductibles and copays for the covered benefit. Carrier contact information and Summary of Benefits can be located on the Plan Information website. Premiums for each benefit plan are located on the Insurance Rates webpage.

2023 State of Michigan Employee
HMO Minimum Required Benefits and Comparison Chart

	Blue Care Network (BCN)[1]	Health Alliance Plan (HAP)[1]	McLaren Health Plan (MHP)[1]	Physicians Health Plan (PHP)[1]
	In-Network	**In-Network**	**In-Network**	**In-Network**
Deductible, Copays, Out-of-Pocket Maximum, and Prescription Drugs				
Deductible[2]	$125/individual[3] $250/family	$125/individual[3] $250/family	$125/individual[3] $250/family	$125/individual[3] $250/family
Out-Of-Pocket Maximum[4]	$2,000/individual $4,000/family	$2,000/individual $4,000/family	$2,000/individual $4,000/family	$2,000/individual $4,000/family
Coinsurance (In-Network)	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Prescription Drug Copays[5]	Retail-$10/$30/$60 (90 day supply available at retail)	Retail-$10/$30/$60	Retail-$10/$30/$60 (90 day supply of most generics available at retail for one copay)	Retail-$10/$30/$60 (90 day supply available at retail)
	Mail Order-$20/$60/$120	Mail Order-$20/$60/$120 (Specialty Drugs limited to 30 day supply)	Mail Order-$20/$60/$120	Mail Order-$20/$60/$120
Preventive Services[6]				
Annual gynecological exam, 1 per plan year	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Childhood Immunization (through age 16)	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Colonoscopy[7]	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Fecal occult blood screening[7]	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Flexible sigmoidoscopy[7]	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Health maintenance exam, 1 per plan year	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Immunizations, annual flu shot, & Hepatitis C screening for those at risk	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Mammography[7]	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Pap smear screening - laboratory services only[7], 1 per plan year	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Prostate specific antigen screening[7], 1 per plan year	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Well-baby and child care	Covered 100%	Covered 100%	Covered 100%	Covered 100%

[1] The State will pay up to 85% of the applicable HMO total premium, capped at the dollar amount which the State pays for the same coverage code under the SHP PPO.

[2] Deductible amounts for all health plans are effective January 1 and renew annually on a calendar basis.

[3] The HMO individual deductible ($125 In-Network) is the maximum amount that applies to any one family member. The family deductible ($250 In-Network) is the combined maximum deductible amount that applies to any combination of family members. One family member is not required to reach the individual deductible before that family deductible can be met. Additionally, one family member cannot contribute in excess of the maximum amount of the individual deductible. Check with your HMO to see if any Out-of-Network services are covered and the applicable Out-of-Network deductible that would apply.

[4] Out-Of-Pocket Maximum amounts for all health plans are effective January 1 and renew annually on a calendar basis. Only In-Network deductibles, fixed-dollar copayments, and prescription drug copayments apply toward the out-of-pocket maximum.

[5] Retail prescriptions must allow at least a 30-day supply for non-specialty medications and Mail Order must allow at least a 90-day supply for non-specialty medications, except where formulary quantity limits are applicable.

[6] Preventive Services are not subject to the deductible.

[7] Patient Protection and Affordable Care Act (PPACA) guidelines apply.

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	In-Network	In-Network	In-Network	In-Network
Physician Office Services				
Office and outpatient hospital visits, consultations, and urgent care visits	$20 Copay	$20 Copay	$20 Copay	$20 Copay (Sparrow FastCare $0 copay)
Outpatient and home visits	$20 Copay	$20 Copay	$20 Copay	$20 Copay
Telemedicine (Medical) - via the Carrier's online vendor	$10 Copay	$10 Copay	$0 Copay	$10 Copay
Telemedicine (Behavioral Health) - via the Carrier's online vendor	$0 Copay	$10 Copay	Not covered	$10 Copay
Telemedicine (Medical) - via the Provider's online tool	$20 Copay	$20 Copay	$20 Copay	$20 Copay
Telemedicine (Behavioral Health) - via the Provider's online tool	$0 Copay	$20 Copay	$10 Copay	$20 Copay
Emergency Medical Care				
Ambulance services - medically necessary	Covered 100% after deductible	Covered 100% after deductible	Covered 100% after deductible	Covered 100% after deductible
Hospital emergency room for medical emergency or accidental injury	$200 copay (Waived if admitted as inpatient)	$200 copay (Waived if admitted as inpatient)	$200 copay (Waived if admitted as inpatient)	$200 copay (Waived if admitted as inpatient)
Worldwide Coverage (Emergency care only)	Covered $200 Copay (Waived if admitted as inpatient; Contact BCN Customer Service for other care in and outside of the United States (e.g. urgent care, follow-up, elective surgeries)).	Covered $200 Copay (Waived if admitted as inpatient)	Covered $200 Copay (Waived if admitted as inpatient)	Covered $200 Copay (Waived if admitted as inpatient)
Diagnostic Services				
Diagnostic tests and x-rays	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Laboratory and pathology tests	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Radiology Examinations & Laboratory Procedures (Non-hospital facility; deductible does not apply to laboratory procedures)	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Radiation therapy	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Maternity Services				
Delivery and nursery care	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Prenatal care[7]	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Postnatal care[7]	Covered 100%	Covered 100%	Covered 100%	Covered 100%

[7] Patient Protection and Affordable Care Act (PPACA) guidelines apply.

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HMO Minimum Required Benefits and Comparison Chart

	Blue Care Network (BCN)[1]	Health Alliance Plan (HAP)[1]	McLaren Health Plan (MHP)[1]	Physicians Health Plan (PHP)[1]
	In-Network	In-Network	In-Network	In-Network
Hospital Care				
Chemotherapy	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Dialysis	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Inpatient consultations	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Semi-private room, inpatient physician care, general nursing care, hospital services, and supplies (unlimited days)	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Alternative to Hospital Care				
Home health care	Covered 100% After Deductible, $20 Copay	Covered 100% After Deductible, $20 Copay (Unlimited visits; excludes PT/OT/ST)	Covered 100% After Deductible, $20 Copay (Limit of 60 visits per plan year)	Covered 100% After Deductible, $20 Copay (Limit of 60 visits per plan year)
Hospice care	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Skilled nursing care (Up to 120 days per confinement)	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible (Unlimited)
Surgical Services				
Anesthesia	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Female voluntary female sterilization[7]	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Inpatient (Includes related surgical services)	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Male vasectomy	Covered 100% after deductible	Covered 100% after deductible	Covered 100% after deductible	Covered 100% after deductible
Outpatient (Includes related surgical services)	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Human Organ Transplant Procedures				
Bone marrow-specific criteria applies	Covered 100% after deductible in designated facilities	Covered 100% after deductible in designated facilities	Covered 100% after deductible in designated facilities	Covered 100% after deductible in designated facilities
Kidney, cornea, and skin	Covered 100% after deductible subject to medical criteria	Covered 100% after deductible subject to medical criteria	Covered 100% after deductible subject to medical criteria	Covered 100% after deductible subject to medical criteria
Liver, heart, lung, pancreas, and other specified organ transplants	Covered 100% after deductible in designated facilities	Covered 100% after deductible in designated facilities	Covered 100% after deductible in designated facilities	Covered 100% after deductible in designated facilities
Other Services				
Acupuncture	Not Covered	Not Covered	Not Covered	Not Covered
Allergy injections	Covered 100%	Covered 100%	Covered 100%	Covered 100%

[7] Patient Protection and Affordable Care Act (PPACA) guidelines apply.

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HMO Minimum Required Benefits and Comparison Chart

	Blue Care Network (BCN)[1]	Health Alliance Plan (HAP)[1]	McLaren Health Plan (MHP)[1]	Physicians Health Plan (PHP)[1]
	In-Network	In-Network	In-Network	In-Network
Other Services (continued)				
Allergy testing and therapy (non-injection)	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Autism - Spectrum Disorder Applied Behavioral Analysis (ABA) treatment	Covered 100% After Deductible	Covered 100%	Covered 100% After Deductible (Requires authorization)	Covered 100% After Deductible
Bariatric Surgery	Covered 100% After Deductible (Limited one per lifetime.)	Bariatric Surgery & Related Services Covered, $1,000 Copay per admission After Deductible; One procedure per lifetime	Covered 100% After Deductible	Bariatric Surgery & Related Services Covered, $1,000 Copay per admission; One procedure per lifetime
Cardiac Rehabilitation & Pulmonary Rehabilitation	Covered, $20 Copay (Limited to 36 visits per plan year)	Covered 100% After Deductible	Covered 100% After Deductible	Covered, $20 Copay (Limited to 90 visits per plan year)
Chiropractic/spinal manipulation	Chiropractic spinal manipulation when referred by PCP, Covered After Deductible, $20 Copay. Deductible applies to x-rays.	Covered $20 Copay (Manipulations only, up to 24 visits per plan year)	Covered After Deductible $20 Copay (Up to 20 visits per plan year)	Covered After Deductible, $20 Copay (Up to 20 visits per plan year)
Durable medical equipment	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Hearing Aids	Covered (for conventional standard hearing aids; Limited to one monaural with a max benefit of $654 or one binaural with a max benefit of $1,177; every 36 months)	Covered, copay based on type of Hearing Aid. Deductible does not apply. Through a NationsHearing provider only. Limit of coverage is one (1) Hearing Aid per ear per plan year.	Covered 100% (Limited to one every 36 months)	Covered 100% - (Limited to either one monaural to max benefit of $880 or one binaural to a max of $1600; every 36 months)
Hearing Care Exam	Covered 100% (Performed in Physician's Office, $20 copay may apply)	Covered 100% $20 Office copay may apply)	Covered $20 Copay	Covered 100% (Preventive for Newborns only)
Infertility Counseling & Treatment	Covered 100% After Deductible (Excludes in-vitro fertilization)	Covered 100% After Deductible; (One attempt of artificial insemination per lifetime)	Covered 100% After Deductible	Covered 100% After Deductible (One attempt of artificial insemination per lifetime)
Nutritional & Health education and counseling	Covered 100%	Covered 100%, limitations apply	Covered 100%	Covered 100%, limitations apply
Orthognathic Surgery	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Oral Surgery	Covered 100% After Deductible for accidental injury. Limitations apply	Covered 100% After Deductible *Limited to emergency oral surgery/dental services for the prompt stabilization of traumatic injury to natural teeth or related body tissue resulting from a non-occupational injury	Covered 100% After Deductible	Covered $20 Copay
Prosthetic and orthotic appliances	Covered 100%	Covered 100%	Covered 100%	Covered 100%

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	In-Network	In-Network	In-Network	In-Network
Other Services (continued)				
Private duty nursing	Covered 100% After Deductible	Covered 100%	Covered 100%	Not Covered
Rabies treatment after initial emergency room visit	Office visit $20 copay; Injections Covered 100%	Office visit $20 copay; Injections Covered 100%	Office visit $20 copay; Injections Covered 100%	Office visit $20 copay; Injections Covered 100%
Temporomandibular Joint Syndrome (TMJS)	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Vision Screening (performed in a physician's office, one exam per plan year)	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Wig, wig stand, adhesives	Covered 100% for hair prosthesis (wig or hair piece) for hair loss due to a medical condition or the treatment of a medical condition. One per calendar year; max benefit $225 per year.	Covered 100% $300 lifetime maximum benefit	Not Covered	Not Covered
Behavioral Health / Substance Use Disorder				
Alcohol & Chemical Dependency Benefits - Inpatient	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Alcohol & Chemical Dependency Benefits - Outpatient	Covered 100%	Covered $20 Copay	Covered $20 Copay	Covered $20 Copay
Behavioral Health Benefit - Inpatient	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Behavioral Health Benefit - Outpatient	Covered 100%	Covered $20 Copay	Covered $20 Copay	Covered $20 Copay
Intensive Outpatient Program (IOP) - Behavioral Health and Substance Use Disorder	Covered 100%	Covered $20 Copay	Covered $20 Copay	Covered $20 Copay
Outpatient Physical, Speech, and Occupational Therapy (Combined maximum of 90 visits per calendar year)				
Outpatient Physical, Speech & Occupational Therapy (Up to combined max of 90 visits per plan year)	Covered, $20 Copay (Unlimited visits for spectrum disorder)	Covered, $20 Copay (Up to combined max of 100 visits per plan year)	Covered, $20 Copay	Covered, $20 Copay