

# Eligibility



**Blue Care Network (BCN)**



**Health Alliance Plan (HAP)**



**McLaren Health Plan**



**Physicians Health Plan (PHP)**



**Priority Health**

All State of Michigan Employees who reside in the coverage area determined by zip code.

All State of Michigan Employees who reside in the coverage area determined by zip code.

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All State of Michigan Employees who reside in the coverage area determined by zip code.

2016-2017 Plan Year

# Deductibles, Copayments, & Maximums



**Blue Care Network (BCN)**



**Health Alliance Plan (HAP)**



**McLaren Health Plan**



**Physicians Health Plan (PHP)**



**Priority Health**

**Service**

**Deductible**

\$125 Individual  
\$250 Family

**Out-of-Pocket Maximum (OOPM)**

\$2,000 Individual  
\$4,000 Family

**Fixed-Dollar Copays**  
(Office, referral, specialist, and urgent care visits)

**\$20**

**\$20**

**\$20**

**\$20**  
(No copay for FastCare visits)

**\$20**

**Emergency Room Visit Copay**  
(Waived if admitted)

**\$200**

**\$200**

**\$200**

**\$200**

**\$200**

2016-2017 Plan Year

# Preventive Services



**Blue Care Network (BCN)**



**Health Alliance Plan (HAP)**



**McLaren Health Plan**



**Physicians Health Plan (PHP)**



**Priority Health**

**Health Maintenance Exam**

Covered  
100%

Covered  
100%

Covered  
100%

Covered  
100%

Covered  
100%

**Annual Gynecological Exam**

Covered  
100%

Covered  
100%

Covered  
100%

Covered  
100%

Covered  
100%

**Pap Smear Screening**

Covered  
100%

Covered  
100%

Covered  
100%

Covered  
100%

Covered  
100%

**Immunizations**

Covered  
100%

Covered  
100%

Covered  
100%

Covered  
100%

Covered  
100%

**Well-Baby and Well-Child Care**

Covered  
100%

Covered  
100%

Covered  
100%

Covered  
100%

Covered  
100%

2016-2017 Plan Year

## Services In-Hospital



**Blue Care Network (BCN)**



**Health Alliance Plan (HAP)**



**McLaren Health Plan**



**Physicians Health Plan (PHP)**



**Priority Health**

**Service**

**Number of Days in Care**

Covered 100%  
After Deductible

**Semi-private room, intensive care, surgery, general nursing, hospital services/supplies**

Covered 100%  
After Deductible

**Surgery & all related surgical services**

Covered 100%  
After Deductible

**Anaesthesia**

Covered 100%  
After Deductible

**Laboratory tests & X-Rays**

Covered 100%  
After Deductible

**Inpatient Consultation**

Covered 100%  
After Deductible

**Chemotherapy**

Covered 100%  
After Deductible

**Radiation Therapy**

Covered 100%  
After Deductible

**Hemodialysis**

Covered 100%  
After Deductible

# Surgical Services



**Blue Care Network (BCN)**



**Health Alliance Plan (HAP)**



**McLaren Health Plan**



**Physicians Health Plan (PHP)**



**Priority Health**

**Service**

<p><b>Inpatient</b> Includes related surgical services</p>	<p>Covered 100% After Deductible</p>	<p>Covered 100% After Deductible</p>	<p>Covered 100% After Deductible</p>	<p>Covered 100% After Deductible</p>	<p>Covered 100% After Deductible</p>
<p><b>Outpatient</b> Includes related surgical services</p>	<p>Covered 100% After Deductible</p>	<p>Covered 100% After Deductible</p>	<p>Covered 100% After Deductible</p>	<p>Covered 100% After Deductible</p>	<p>Covered 100% After Deductible Prior approval required for certain radiology exams.</p>
<p><b>Certain Surgeries &amp; Treatments</b></p>	<p>Covered 100% After Deductible</p>	<p>Covered \$1,000 Copay Bariatric Surgery &amp; Related Services. One procedure per lifetime.</p>	<p>Covered 100% After Deductible See plan outline for approved procedures.</p>	<p>Bariatric Surgery Covered 10% co-insurance up to \$1,000 copay</p>	<p>Covered 100% After Deductible See plan outline for approved procedures.</p>
<p><b>Sterilization</b> Female</p>	<p>Covered 100%</p>	<p>Covered 100%</p>	<p>Covered 100%</p>	<p>Covered 100%</p>	<p>Covered 100%</p>
<p><b>Sterilization</b> Male</p>	<p>Covered 100% After Deductible</p>	<p>Covered 100% After Deductible</p>	<p>Covered 100% After Deductible</p>	<p>Covered 100% After Deductible</p>	<p>Covered 100% After Deductible</p>
<p><b>Human Organ Transplant Procedures</b> Liver, heart, lung, pancreas, &amp; other specified organs. Bone marrow - specific criteria applies</p>	<p>Covered 100% After Deductible In Designated Facilities</p>	<p>Covered 100% After Deductible In Designated Facilities</p>	<p>Covered 100% After Deductible In Designated Facilities</p>	<p>Covered 100% After Deductible In Designated Facilities</p>	<p>Covered 100% After Deductible In Designated Facilities</p>
<p><b>Human Organ Transplant Procedures</b> Kidney, cornea, &amp; skin</p>	<p>Covered 100% After Deductible Subject to Medical Criteria</p>	<p>Covered 100% After Deductible Subject to Medical Criteria</p>	<p>Covered 100% After Deductible Subject to Medical Criteria</p>	<p>Covered 100% After Deductible Subject to Medical Criteria</p>	<p>Covered 100% After Deductible Subject to Medical Criteria</p>

2016-2017 Plan Year

# Emergency Medical Care: Medical & Accidental Injury



**Blue Care Network (BCN)**



**Health Alliance Plan (HAP)**



**McLaren Health Plan**



**Physicians Health Plan (PHP)**



**Priority Health**

**Service**

**Hospital Emergency Room Visit**  
(Copay waived if admitted)

Covered  
\$200 Copay

**Physician's Office Visit**

Covered  
\$20 Copay

**Urgent Care Visit**

Covered  
\$20 Copay

Covered  
\$20 Copay

Covered  
\$20 Copay

Covered  
\$20 Copay  
(FastCare Downtown visits covered no copay)

Covered  
\$20 Copay

**Ambulance**  
(Medically necessary)

Covered 100%  
After Deductible

2016-2017 Plan Year

# Maternity Services



**Blue Care Network (BCN)**



**Health Alliance Plan (HAP)**



**McLaren Health Plan**



**Physicians Health Plan (PHP)**



**Priority Health**

**Service**

**Prenatal Care**

Covered  
100%

Covered  
100%

Covered  
100%

Covered  
100%

Covered  
100%

**Postnatal Care**

Covered  
\$20 Copay

Covered  
\$20 Copay

Covered  
\$20 Copay

Covered  
\$20 Copay

Covered  
100%

**Delivery in Hospital**

Covered 100%  
After Deductible

**Newborn Care in Hospital**

Covered 100%  
After Deductible

2016-2017 Plan Year

## Diagnostic Services

Service	 <b>Blue Care Network (BCN)</b>	 <b>Health Alliance Plan (HAP)</b>	 <b>McLaren Health Plan</b>	 <b>Physicians Health Plan (PHP)</b>	 <b>Priority Health</b>
<b>Laboratory and Pathology Tests</b>	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
<b>Radiology Examinations &amp; Laboratory Procedures</b> (Non-hospital facility)	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible (Prior approval required for certain radiology exams)
<b>Diagnostic tests and X-rays</b>	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible

2016-2017 Plan Year

## Prescription Drugs



**Blue Care Network (BCN)**



**Health Alliance Plan (HAP)**



**McLaren Health Plan**



**Physicians Health Plan (PHP)**



**Priority Health**

**Service**

**Retail Pharmacy**  
(30-Day Supply)

\$10 Generic  
\$30 Brand-Name Preferred  
\$60 Brand-Name Non-Preferred

**Mail Order Pharmacy**  
(90-Day Supply)

\$20 Generic  
\$30 Brand-Name Preferred  
\$120 Brand-Name Non-Preferred

2016-2017 Plan Year

# Alternatives to Hospital Care



**Blue Care Network (BCN)**



**Health Alliance Plan (HAP)**



**McLaren Health Plan**



**Physicians Health Plan (PHP)**



**Priority Health**

**Service**

**Skilled Nursing Care in a Nursing Home**

Covered 100% After Deductible (Up to 120 visits per benefit period) Please see Certificate of Coverage.

Covered 100% After Deductible (Up to 120 days per confinement) Please see Certificate of Coverage.

Covered 100% After Deductible Please see Certificate of Coverage.

Covered 100% After Deductible Please see Certificate of Coverage.

Covered 100% After Deductible (Up to 120 days per confinement) Please see Certificate of Coverage.

**Home Health Care**

Covered 100% After Deductible \$20 Copay

Covered 100% (Does not include PT/OT/ST) Up to 60 visits per benefit period.

Covered 100% After Deductible \$20 Copay

Covered 100% After Deductible \$20 Copay Limit of 60 visits per plan year.

Covered 100% After Deductible \$20 Copay Includes Hospice; excludes rehab services.

**Hospice Care**

Covered 100% After Deductible

Covered 100% After Deductible (Limited to 210 days lifetime)

Covered 100% After Deductible

Covered 100% After Deductible

Covered 100% After Deductible (Up to 120 days per confinement)

2016-2017 Plan Year

# Mental Health Care



**Blue Care Network (BCN)**



**Health Alliance Plan (HAP)**



**McLaren Health Plan**



**Physicians Health Plan (PHP)**



**Priority Health**

**Service**

**Outpatient Psychiatric Services**

Covered 100%  
After Deductible

Covered  
\$20 Copay

Covered  
\$20 Copay

Covered  
\$20 Copay

Covered  
\$20 Copay

**Inpatient Psychiatric Hospital Services**

Covered 100%  
After Deductible

Covered 100%  
After Deductible

Covered 100%  
After Deductible

Covered 100%  
After Deductible

Covered 100%  
After Deductible  
(Prior approval  
required)

2016-2017 Plan Year

## Substance Abuse (Alcohol and Drug Use)

Service



**Blue Care Network (BCN)**



**Health Alliance Plan (HAP)**



**McLaren Health Plan**



**Physicians Health Plan (PHP)**



**Priority Health**

**Outpatient Substance Abuse Care**

Covered  
\$20 Copay

**Inpatient Alcoholism and Drug Abuse Care**

Covered 100%  
After Deductible

Covered 100%  
After Deductible

Covered 100%  
After Deductible

Covered 100%  
After Deductible

Covered 100%  
After Deductible  
(Prior approval  
required)

2016-2017 Plan Year

## Applicances & Prosthetics (Leg Braces, Artificial Limbs, etc.)



**Blue Care Network (BCN)**



**Health Alliance Plan (HAP)**



**McLaren Health Plan**



**Physicians Health Plan (PHP)**



**Priority Health**

**Service**

**Prosthetics & Orthotics**

**Covered  
100%**

**Covered  
100%**

**Covered  
100%**

**Covered  
100%**

**Covered  
100%**

**Durable Medical Equipment (Wheelchairs, hospital beds, crutches, etc.)**

**Covered  
100%**

**Covered  
100%**

**Covered  
100%**

**Covered  
100%**

**Covered  
100%**

2016-2017 Plan Year

## Vision Screening



**Blue Care Network (BCN)**



**Health Alliance Plan (HAP)**



**McLaren Health Plan**



**Physicians Health Plan (PHP)**



**Priority Health**

**Service**

**Vision Screening**

**Eyeglasses**

Covered 100%  
Performed in  
Physician's Office  
\$20 Copay May  
Apply

Covered 100%  
\$20 Office Copay  
May Apply

Covered  
\$20 Copay

Covered 100%  
1 exam per year

Not Covered

Not Covered

Not Covered

Not Covered

Not Covered

Not Covered

2016-2017 Plan Year

# Hearing Services



**Blue Care Network (BCN)**



**Health Alliance Plan (HAP)**



**McLaren Health Plan**



**Physicians Health Plan (PHP)**



**Priority Health**

**Service**

**Hearing Screening/  
Examination**

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

One hearing exam,  
one audiometric  
exam every 36  
months. Exams  
covered 100%

**Hearing Aids**

Covered 100%  
(Limited to one every  
36 months, including  
binaural)

Covered 100%  
After Deductible  
(Authorized  
conventional hearing  
aids)

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.

One basic hearing  
aid per ear every 36  
months. Covered  
100% to a max of  
\$500 per hearing aid.

2016-2017 Plan Year

# Chiropractic Services



**Blue Care Network (BCN)**



**Health Alliance Plan (HAP)**



**McLaren Health Plan**



**Physicians Health Plan (PHP)**



**Priority Health**

**Manipulations or adjustments; diagnostic radiological services; evaluation and treatment**

Chiropractic spinal manipulation when referred by PCP, covered - \$20 Copay after deductible.

Covered After Deductible  
\$20 Copay  
(Up to 24 visits per benefit period)

Covered After Deductible  
\$20 Copay  
(Up to 24 visits per benefit period)

Covered After Deductible  
\$20 Copay  
(Up to 20 visits per year)

\$20 Copay  
(Up to a combined benefit max of 30 visits per Contract Year)

## Other Services



**Blue Care  
Network (BCN)**



**Health Alliance  
Plan (HAP)**



**McLaren  
Health Plan**



**Physicians Health  
Plan (PHP)**



**Priority Health**

## Service

<b>Allergy testing &amp; therapy</b>	Covered 100% After Deductible \$20 Copay May Apply Injections - Covered 100%	Covered 100% After Deductible Injections - Covered 100%	Covered 100% \$20 Copay may apply	Testing: Covered - 100% after deductible Injections/Therapy: Covered - 100%	100% Coverage for testing, injections, and serum. \$20 Copay may apply.
<b>Nutritional &amp; Health education and counseling</b>	Covered 100%	Covered 100%	Covered 100%	Dependent on where services are received.	\$20 Copay per visit (Up to 6 visits per Contract Year)
<b>Mammography Screening</b>	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
<b>Temporomandibular Joint Syndrome (TMJS)</b>	Covered 100% After Deductible	Covered 100% After Deductible. Limitations apply	Covered 100% After Deductible. (Surgical Fees)	Please see Certificate of Coverage.	Covered 50% After Deductible
<b>Orthognathic Surgery</b>	Covered 100% After Deductible	Covered 100% After Deductible Limitations apply	Covered 100% After Deductible (Surgical Fees)	Please see Certificate of Coverage.	Covered 50% After Deductible
<b>Oral Surgery</b>	Covered 100% After Deductible	Covered for accidental injury after deductible. Limitations apply.	Covered 100% After Deductible	As medically necessary such as injury from an accident. Removal of wisdom teeth is excluded.	Covered - 100% for medical treatment, office copay may apply. Deductible applies if performed in hospital.
<b>Outpatient Physical, Speech &amp; Occupational Therapy</b>	Covered \$20 Copay (Limited to 90 visits per plan year)	Covered 100% (Up to 100 combined visits per benefit period) May be rendered at home.	\$20 Copay (Up to combined max of 90 visits per year)	Covered \$20 Copay (Limited to combined (with pulmonary) 60 visits per calendar year)	\$20 Copay (Up to combined max of 90 visits per Contract Year)
<b>Cardiac Rehabilitation &amp; Pulmonary Rehabilitation</b>	Covered \$20 Copay (Limited to 90 visits per plan year)	Covered 100% After Deductible	Covered 100% After Deductible	Covered \$20 Copay (Limited to 36 visits per calendar year)	Covered \$20 Copay (Up to 30 visits per contract year)
<b>Infertility counseling &amp; treatment</b>	Covered 100% After Deductible (Excludes in-vitro fertilization)	Covered 100%	Covered 100% After Deductible	Covered 100% After Deductible (Limit 5 office visits & 3 diagnostic/ surgical procedures per plan year)	Covered 100%
<b>Private Duty Nursing</b>	Covered 100% After Deductible (When Authorized)	Covered 100%	Covered 100%	Not Covered	Covered 100% After Deductible

2016-2017 Plan Year

## Miscellaneous



**Blue Care Network (BCN)**



**Health Alliance Plan (HAP)**



**McLaren Health Plan**



**Physicians Health Plan (PHP)**



**Priority Health**

**Service**

**Conversion Option**

Covered 100%

Covered 100%

Covered 100%

Not Available

Not Available

**Pre-existing Condition**

Covered  
100%

Covered  
100%

Covered  
100%

Covered  
100%

Covered  
100%

**Worldwide Coverage  
(Emergency care only)**

Covered 100%

Covered  
\$200 Copay  
(Waived if admitted)

Covered 100%

Covered 100%

Covered  
\$200 Copay  
(Waived if admitted)