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2024 Comparison of PPO, State HDHP, and HMO Plans

	State Health Plan PPO (80%) Blue Cross Blue Shield of Michigan		State High Deductible Health Plan with HSA[1] Blue Cross Blue Shield of Michigan		HMOs (85%)[2]	
					Blue Care Network	Health Alliance Plan
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network
Deductible, Copays, Out-of-Pocket Maximum, and Prescription Drugs						
Deductible[3]	$400/individual[4] $800/family	$800/individual[4] $1,600/family	$1,600/individual[5] $3,200/family	$3,200/individual[5] $6,400/family	$125/individual[6] $250/family	$125/individual[6] $250/family
Coinsurance	10% for most services. 20% for acupuncture	20% for most services 50% for mental health and substance use disorder	20% for most services 40% for acupuncture	40% for most services	N/A	N/A
Out-Of-Pocket Maximum[7]	$2,000/individual $4,000/family	$3,000/individual $6,000/family	$4,000/individual $8,000/family	$8,000/individual $16,000/family	$2,000/individual $4,000/family	$2,000/individual $4,000/family
Health Savings Account (HSA) Employer Annual Contribution	N/A		$750/individual[8] $1,500/family		N/A	N/A
Prescription Drug copays[9]	Retail-$10/$30/$60 Mail Order-$20/$60/$120		**After deductible is met, the following copays apply[10]:** Retail-$10/$30/$60 Mail Order-$20/$60/$120		Retail-$10/$30/$60 Mail Order-$20/$60/$120	Retail-$10/$30/$60 Mail Order-$20/$60/$120
Preventive Services[11]						
Annual gynecological exam, 1 per plan year	Covered 100%	Not Covered	Covered 100%	Not covered	Covered 100%	Covered 100%
Childhood Immunization (through age 16)	Covered 100%	Covered 80%	Covered 100%	Covered 60% after deductible	Covered 100%	Covered 100%
Colonoscopy[12]	Covered 100%	Covered 80% after deductible	Covered 100%	Covered 60% after deductible	Covered 100%	Covered 100%
Fecal occult blood screening[12]	Covered 100%	Not Covered	Covered 100%	Not covered	Covered 100%	Covered 100%
Flexible sigmoidoscopy[12]	Covered 100%	Not Covered	Covered 100%	Not covered	Covered 100%	Covered 100%
Health maintenance exam, 1 per plan year	Covered 100%	Not Covered	Covered 100%	Not covered	Covered 100%	Covered 100%
Immunizations, annual flu shot, & Hepatitis C screening for those at risk	Covered 100%	Not Covered	Covered 100%	Not covered	Covered 100%	Covered 100%
Mammography[12]	Covered 100%	Covered 80% after deductible	Covered 100%	Covered 60% after deductible	Covered 100%	Covered 100%

[1] MSP DROP employees (bargaining unit T01 and Command Officers) and OEAIs are excluded from enrollment in the State HDHP with HSA.

[2] 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.

[3] Deductible amounts for all health plans are effective January 1 and renew annually on a calendar basis. The deductible for the HDHP is combined for medical and pharmacy.

[4] The SHP PPO individual deductible is the maximum amount that applies to any one family member. The family deductible 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.

[5] The HDHP Individual deductible only applies to employee only coverage. The HDHP Family deductible applies to the coverage of employee plus spouse and/or other dependents. The applicable deductible must be fulfilled prior to services being paid by the plan. Any one member of the family or any combination of family members may fulfill the entire family deductible.

[6] The HMO individual deductible is the maximum amount that applies to any one family member. The family deductible 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.

[7] 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, prescription drug copayments, and coinsurance apply toward the out-of-pocket maximum.

[8] Funded 100% on the 1st pay period of each plan year. The State will make a contribution of $750 for an individual employee or $1,500 for employees who enroll effective January 1st with one or more dependents. This contribution will be prorated for employees who enroll mid-year based on the number of pay periods remaining in the plan year at the time of enrollment in the HDHP.

[9] The SHP PPO and State HDHP with HSA only allow a 30-day supply at a retail pharmacy and 90-day supply through mail order. BCN allows up to a 90-day supply of non-specialty medications at both retail and mail order. HAP allows a 30-day supply at a retail pharmacy and 90-day supply through mail order. HAP allows select medications as a 90-day supply at retail.

[10] The deductible does not apply to certain preventive medications under the State HDHP with HSA.

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

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

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2024 Comparison of PPO, State HDHP, and HMO Plans

	State Health Plan PPO (80%) Blue Cross Blue Shield of Michigan		State High Deductible Health Plan with HSA[1] Blue Cross Blue Shield of Michigan		HMOs (85%)[2]	
					Blue Care Network	Health Alliance Plan
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network
Preventive Services[11] (continued)						
Pap smear screening - laboratory services only[12], 1 per plan year	Covered 100%	Not Covered	Covered 100%	Not covered	Covered 100%	Covered 100%
Prostate specific antigen screening[12], 1 per plan year	Covered 100%	Not Covered	Covered 100%	Not covered	Covered 100%	Covered 100%
Well-baby and child care	Covered 100%	Not Covered	Covered 100%	Not covered	Covered 100%	Covered 100%
Physician Office Services						
Office and Outpatient hospital visits, consultations, and urgent care visits	$20 copay (deductible not applicable)	Covered 80% after deductible	Covered 80% after deductible	Covered 60% after deductible	$20 copay (deductible not applicable)	$20 copay (deductible not applicable)
Outpatient and home visits	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 60% after deductible	$20 copay (deductible not applicable)	$20 copay (deductible not applicable)
Telemedicine (Medical) - via the Carrier's online vendor	$0 copay (deductible not applicable)	Not Covered	Covered 80% after deductible	Not covered	$10 Copay (deductible not applicable)	$10 Copay (deductible not applicable)
Telemedicine (Behavioral Health) - via the Carrier's online vendor	$0 copay (deductible not applicable)	Not Covered	Covered 80% after deductible	Not covered	$0 copay (deductible not applicable)	$10 Copay (deductible not applicable)
Telemedicine (Medical) - via the Provider's online tool	$20 copay (deductible not applicable)	Covered 80% after deductible	Covered 80% after deductible	Covered 60% after deductible	$20 copay (deductible not applicable)	$20 copay (deductible not applicable)
Telemedicine (Behavioral Health) - via the Provider's online tool	$20 copay[13] (deductible not applicable)	Covered 50% of allowed amount or billed charges (whichever is less)	Covered 80% after deductible	Covered 60% after deductible	$0 copay (deductible not applicable)	$0 copay (deductible not applicable)
Emergency Medical Care						
Ambulance services - medically necessary	Covered 90% after deductible		Covered 80% 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)
Diagnostic Services						
Diagnostic tests and x-rays	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 60% after deductible	Covered 100% after deductible (May require authorization)	Covered 100% after deductible
Laboratory and pathology tests	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 60% after deductible	Covered 100% (May require authorization)	Covered 100%
Radiation therapy	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 60% after deductible	Covered 100% after deductible (Requires authorization)	Covered 100% after deductible
Maternity Services (Includes care by a certified nurse midwife SHP PPO Only)						
Delivery and nursery care	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 60% after deductible	Covered 100% after deductible	Covered 100% after deductible
Prenatal care[11]	Covered 100%		Covered 100%		Covered 100%	Covered 100%
Postnatal care[11]						

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

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

[13] $20 copay or 10% coinsurance (whichever is less) for Telemedicine via an in-network provider's online tool for Behavioral Health.

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2024 Comparison of PPO, State HDHP, and HMO Plans

	State Health Plan PPO (80%) Blue Cross Blue Shield of Michigan		State High Deductible Health Plan with HSA[1] Blue Cross Blue Shield of Michigan		HMOs (85%)[2]	
					Blue Care Network	Health Alliance Plan
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network
Hospital Care						
Chemotherapy	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 60% after deductible	Covered 100% after Deductible	Covered 100% after deductible
Dialysis services						
Inpatient consultations						
Semi-private room, inpatient physician care, general nursing care, hospital services, and supplies (unlimited days)					Covered 100% after deductible (Requires authorization)	
Alternative to Hospital Care						
Home health care	Covered 90% after deductible (participating providers only; unlimited visits)	Not Covered	Covered 80% after deductible (participating providers only; unlimited visits)	Not Covered	Covered 100% After Deductible, $20 Copay	Covered 100% After Deductible, $20 Copay (Unlimited visits; excludes PT/OT/ST)
Hospice care	Covered 100% (participating provider only)	Not Covered	Covered 80% after deductible (participating provider only)	Not Covered	Covered 100% After Deductible (Inpatient care requires authorization)	Covered 100% after deductible
Skilled nursing care (up to 120 days per confinement)	Covered 90% after deductible (Blue Cross approved facility)	Not Covered	Covered 80% after deductible (Blue Cross approved facility)	Not Covered	Covered 100% after deductible (Requires authorization)	Covered 100% after deductible
Surgical Services						
Anesthesia	Covered 90% after deductible		Covered 80% after deductible		Covered 100% After Deductible	Covered 100% After Deductible
Female voluntary sterilization[12]	Covered 100%	Covered 80% after deductible	Covered 100%	Covered 60% after deductible	Covered 100%	Covered 100%
Male voluntary sterilization			Covered 80% after deductible		Covered 100% after deductible	Covered 100% after deductible
Surgery - includes related surgical services	Covered 90% after deductible				Covered 100% after deductible (Requires authorization)	
Human Organ Transplants						
Bone marrow-specific criteria applies	Covered 100% (in designated facilities)	Not Covered	Covered 80% after deductible (in designated facilities)	Not Covered	Covered 100% after deductible (In designated facilities; requires authorization)	Covered 100% after deductible (in designated facilities)
Kidney, cornea, and skin	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 60% after deductible	Covered 100% after deductible (Subject to medical criteria; requires authorization)	Covered 100% after deductible (subject to medical criteria)

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

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					Blue Care Network	Health Alliance Plan
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network
Human Organ Transplants (continued)						
Liver, heart, lung, pancreas, and other specified organ transplants	Covered 100% (in designated facilities)	Not Covered	Covered 80% after deductible (in designated facilities)	Not Covered	Covered 100% after deductible (In designated facilities; requires authorization)	Covered 100% after deductible (in designated facilities)
Other Services						
Acupuncture	Covered 80% after deductible (if performed by a participating acupuncturist or under the supervision of a M.D. or D.O.)		Covered 60% after deductible (if performed by a participating acupuncturist or under the supervision of a M.D. or D.O.)		Not Covered	Not Covered
Allergy injections	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 60% after deductible	Covered 100%	Covered 100%
Allergy testing and therapy (non-injection)					Covered 100% After Deductible	Covered 100% after deductible
Autism - Spectrum Disorder Applied Behavioral Analysis (ABA) treatment						Covered 100%
Bariatric Surgery	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 60% after deductible	Covered 100% After Deductible (Limited one per lifetime; requires authorization)	Covered 100% After Deductible, $1,000 Copay per admission; One procedure per lifetime
Cardiac Rehabilitation & Pulmonary Rehabilitation	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 60% after deductible	Covered, $20 Copay (Limited to 36 visits per plan year)	Covered 100% after deductible
Chiropractic/spinal manipulation	$20 copay (Up to 24 visits per calendar year)	Covered 80% after deductible (Up to 24 visits per calendar year)	Covered 80% after deductible (up to 24 visits per calendar year)	Covered 60% after deductible (up to 24 visits per calendar year)	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)
Durable medical equipment	Covered 100%	Covered 80% of the Blue Cross approved amount plus, the difference between charge and approved amount	Covered 80% after deductible	Covered 60% after deductible of the Blue Cross approved amount plus, the difference between charge and approved amount	Covered 100% (Must be authorized and obtained from a BCN supplier)	Covered 100%
Hearing Aids	Covered 100% (standard and binaural aids)	Not Covered	Covered 80% after deductible	Not Covered	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.
Hearing Care Exam	$20 copay for office visit	Covered 80% after deductible	Covered 80% after deductible	Covered 60% after deductible	Covered 100% (Performed in Physician's Office, $20 copay may apply)	Covered 100% ($20 Office copay may apply)
Infertility Counseling & Treatment	Not Covered	Not Covered	Not Covered	Not Covered	Covered 100% After Deductible (Excludes in-vitro fertilization)	Covered 100% After Deductible; (One attempt of artificial insemination per lifetime)
Nutritional & Health education and counseling	Covered 100%	Not Covered	Covered 100%	Not Covered	Covered 100%	Covered 100% (Limitations apply)

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					Blue Care Network	Health Alliance Plan
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network
Other Services (continued)						
Orthognathic Surgery	Covered 90% after deductible (Limitations apply)	Covered 80% after deductible (Limitations apply)	Covered 80% after deductible (Limitations apply)	Covered 60% after deductible (Limitations apply)	Covered 100% After Deductible (Limitations apply)	Covered 100% After Deductible
Oral Surgery	Covered 90% after deductible (Limitations apply)	Covered 80% after deductible (Limitations apply)	Covered 80% after deductible (Limitations apply)	Covered 60% after deductible (Limitations apply)	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 nonoccupational injury
Prosthetic and orthotic appliances	Covered 100%	Covered 80% of the Blue Cross approved amount plus, the difference between charge and approved amount	Covered 80% after deductible	Covered 60% after deductible of the Blue Cross approved amount plus, the difference between charge and approved amount	Covered 100% (Must be authorized and obtained from a BCN supplier)	Covered 100%
Private duty nursing	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 60% after deductible	Covered 100% After Deductible (Requires authorization)	Covered 100%
Rabies treatment after initial emergency room visit	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 60% after deductible	Office visit $20 copay; Injections Covered 100%	Office visit $20 copay; Injections Covered 100%
Temporomandibular Joint Syndrome (TMJS)	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 60% after deductible	Covered 100% After Deductible (Limitations apply)	Covered 100% After Deductible
Vision Screening (performed in a physician's office, one exam per plan year)	Covered 100%	Not Covered	Covered 100%	Not Covered	Covered 100%	Covered 100%
Wig, wig stand, adhesives	Upon meeting medical conditions, eligible for a lifetime maximum reimbursement of $300. (Additional wigs covered for children due to growth).		Not covered	Not covered	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
Behavioral Health / Substance Use Disorder						
Alcohol & Chemical Dependency Benefits - Inpatient	Covered 100%[14] Halfway House 100% (requires authorization)	Covered 50% of allowed amount or billed charges (whichever is less)[14] Halfway House 50% (requires authorization)	Covered 80%[14] after deductible (requires authorization)	Covered 60%[14] after deductible (requires authorization)	Covered 100% After Deductible (Requires authorization)	Covered 100% After Deductible (Requires authorization)
Alcohol & Chemical Dependency Benefits - Outpatient	Covered 90% of network rates	Covered 50% of allowed amount or billed charges (whichever is less)	Covered 80% after deductible	Covered 60% after deductible	Covered 100%	$20 Copay (deductible not applicable)

[14] Two 28-day admissions per year with at least 60 days between admissions. Inpatient days may be utilized for Intensive Outpatient Program (IOP) treatment at 2:1 ratio. One inpatient day equals two IOP days.

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					Blue Care Network	Health Alliance Plan
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network
Behavioral Health / Substance Use Disorder (continued)						
Behavioral Health Benefit - Inpatient	Covered 100% (up to 365 days per year[15]; requires authorization)	Covered 50% of allowed amount or billed charges (whichever is less); up to 365 days per year[15]; requires authorization	Covered 80% after deductible (unlimited days[15]; requires authorization)	Covered 60% after deductible (unlimited days[15]; requires authorization)	Covered 100% After Deductible (Requires authorization)	Covered 100% After Deductible (Requires authorization)
Behavioral Health Benefit - Outpatient	Covered 90% of network rates	Covered 50% of allowed amount or billed charges (whichever is less)	Covered 80% after deductible	Covered 60% after deductible	Covered 100%	$20 Copay (deductible not applicable)
Intensive Outpatient Program (IOP) - Behavioral Health and Substance Use Disorder	Covered 100%	Covered 50% of allowed amount or billed charges (whichever is less)				$20 Copay (deductible not applicable)
Outpatient Physical, Speech, Occupational, and Massage Therapy[15] (Combined maximum of 90 visits per calendar year)						
Outpatient Physical, Speech, Occupational, and Massage therapy - facility and clinic services[17]	Covered 90% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 60% after deductible	Covered, $20 Copay (Requires authorization; unlimited visits for spectrum disorder)	Covered, $20 Copay (Up to combined max of 100 visits per plan year)
Outpatient Physical therapy - physician's office						

[15] Inpatient days may be utilized for partial day hospitalization (PHP) at 2:1 ratio. One inpatient day equals two PHP days.

[16] Massage therapy is not a covered benefit under the HMOs.

[17] Massage therapy is performed by a massage therapist must be supervised by a chiropractor and be part of a formal course of physical therapy. Massage therapy is provided as part of a formal course of physical therapy treatment and when billed alone is not a covered benefit.