2022 State of Michigan Employee HMO Comparison Chart

Deductibles, Copayments, & Maximums

Service	Blue Care Network (BCN)	Health Alliance Plan (HAP)	McLaren Health Plan	Physicians Health Plan (PHP)	Priority Health
Deductible	$125 Individual $250 Family	$125 Individual $250 Family	$125 Individual $250 Family	$125 Individual $250 Family	$125 Individual $250 Family
Out-of-Pocket Maximum (OOPM)	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family
Fixed-Dollar Copays (Office, referral, specialist, and urgent care visits)	$20 Copay	$20 Copay	$20 Copay	$20 Copay (Sparrow FastCare $0 copay)	$20 Copay
Emergency Room Visit Copay (Waived if admitted)	$200 Copay	$200 Copay	$200 Copay	$200 Copay	$200 Copay
Telehealth - Carrier's Vendor (Medical)	$10 Copay	$10 Copay	$10 Copay	$10 Copay	$10 Copay
Telehealth - Carrier's Vendor (Behavioral Health)	$0 Copay	Not covered	$10 Copay	$10 Copay	$10 Copay
Telehealth - Provider's Tool (Medical)	$20 Copay	$20 Copay	$20 Copay	$20 Copay	$20 Copay
Telehealth - Provider's Tool (Behavioral Health)	$0 Copay	$20 Copay	$20 Copay	$20 Copay	$20 Copay

Preventive Services

Service	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%

Services In-Hospital

Service	Blue Care Network (BCN)	Health Alliance Plan (HAP)	McLaren Health Plan	Physicians Health Plan (PHP)	Priority Health
Number of Days in Care	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Semi-private room, intensive care, surgery, general nursing, hospital services/supplies	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Surgery & all related surgical services	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Anesthesia	Covered 100% After Deductible	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%	Covered 100%
Diagnostic tests & X-Rays	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Inpatient Consultation	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Chemotherapy	Covered 100% After Deductible	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	Covered 100% After Deductible
Hemodialysis	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible

Surgical Services

Service	Blue Care Network (BCN)	Health Alliance Plan (HAP)	McLaren Health Plan	Physicians Health Plan (PHP)	Priority Health
Inpatient Includes related surgical services	Covered 100% After Deductible	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	Covered 100% After Deductible Prior approval required for certain radiology exams.
Certain Surgeries & Treatments	Covered 100% After Deductible	Bariatric Surgery & Related Services Covered $1,000 Copay per admission After Deductible; One procedure per lifetime	Covered 100% After Deductible See plan outline for approved procedures.	Bariatric Surgery Covered 10% co-insurance up to $1,000 copay	Covered 100% After Deductible See plan outline for approved procedures.
Sterilization Female	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Sterilization Male	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Human Organ Transplant Procedures Liver, heart, lung, pancreas, & other specified organs. 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	Covered 100% After Deductible In Designated Facilities
Human Organ Transplant Procedures Kidney, Cornea, & 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	Covered 100% After Deductible Subject to Medical Criteria

Emergency Medical Care: Medical & Accidental Injury

Service	Blue Care Network (BCN)	Health Alliance Plan (HAP)	McLaren Health Plan	Physicians Health Plan (PHP)	Priority Health
Hospital Emergency Room Visit (Copay waived if admitted as inpatient)	Covered $200 Copay	Covered $200 Copay	Covered $200 Copay	Covered $200 Copay	Covered $200 Copay
Physician's Office Visit	Covered $20 Copay	Covered $20 Copay	Covered $20 Copay	Covered $20 Copay	Covered $20 Copay
Urgent Care Visit	Covered $20 Copay	Covered $20 Copay	Covered $20 Copay	Covered $20 Copay (Sparrow FastCare $0 copay)	Covered $20 Copay
Ambulance (Medically necessary)	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible

Maternity Services

Service	Blue Care Network (BCN)	Health Alliance Plan (HAP)	McLaren Health Plan	Physicians Health Plan (PHP)	Priority Health
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	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Newborn Care in Hospital	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible

Diagnostic Services

Service	Blue Care Network (BCN)	Health Alliance Plan (HAP)	McLaren Health Plan	Physicians Health Plan (PHP)	Priority Health
Laboratory and Pathology Tests	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Radiology Examinations & Laboratory Procedures (Non-hospital facility)	Covered 100% After Deductible (Deductible does not apply to laboratory procedures).	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible (Prior approval required for certain radiology exams)
Diagnostic tests and X-rays	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible

Prescription Drugs

Service	Blue Care Network (BCN)	Health Alliance Plan (HAP)	McLaren Health Plan	Physicians Health Plan (PHP)	Priority Health
Retail Pharmacy (30-Day Supply)	$10 Generic $30 Brand-Name Preferred $60 Brand-Name Non-Preferred (90 day supply available at retail)	$10 Generic $30 Brand-Name Preferred $60 Brand-Name Non-Preferred	$10 Generic $30 Brand-Name Preferred $60 Brand-Name Non-Preferred (90 day supply of most generics available at retail for one copay)	$10 Generic $30 Brand-Name Preferred $60 Brand-Name Non-Preferred (90 day supply available at retail)	$10 Generic $30 Brand-Name Preferred $60 Brand-Name Non-Preferred
Mail Order Pharmacy (90-Day Supply)	$20 Generic $60 Brand-Name Preferred $120 Brand-Name Non-Preferred	$20 Generic $60 Brand-Name Preferred $120 Brand-Name Non-Preferred; (Specialty Drugs limited to 30 day supply)	$20 Generic $60 Brand-Name Preferred $120 Brand-Name Non-Preferred	$20 Generic $60 Brand-Name Preferred $120 Brand-Name Non-Preferred	$20 Generic $60 Brand-Name Preferred $120 Brand-Name Non-Preferred

Alternatives to Hospital Care

Service	Blue Care Network (BCN)	Health Alliance Plan (HAP)	McLaren Health Plan	Physicians Health Plan (PHP)	Priority Health
Skilled Nursing Care in a Nursing Home	Covered 100% After Deductible (Up to 120 days per confinement)	Covered 100% After Deductible (Up to 120 days per confinement)	Covered 100% After Deductible (Up to 120 days per confinement)	Covered 100% After Deductible (Unlimited)	Covered 100% After Deductible (Up to 120 days per confinement)
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.	Covered 100% After Deductible, $20 Copay Includes Hospice; excludes rehab services.
Hospice Care	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible

Behavioral Health Care

Service	Blue Care Network (BCN)	Health Alliance Plan (HAP)	McLaren Health Plan	Physicians Health Plan (PHP)	Priority Health
Behavioral Health Benefits – Outpatient	Covered 100%	Covered $20 Copay	Covered $20 Copay	Covered $20 Copay (ABA for autism covered 100% after deductible)	Covered $20 Copay
Behavioral Health Benefits – Inpatient	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible (Prior approval required)

Substance Use Disorder

	Blue Care Network (BCN)	Health Alliance Plan (HAP)	McLaren Health Plan	Physicians Health Plan (PHP)	Priority Health
Alcohol & Chemical Dependency Benefits – Outpatient	Covered 100%	Covered, $20 Copay	Covered, $20 Copay	Covered, $20 Copay	Covered, $20 Copay
Alcohol & Chemical Dependency Benefits – Inpatient	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible (Prior approval required)

Appliances & Prosthetics (Leg Braces, Artificial Limbs, etc.)

Service	Blue Care Network (BCN)	Health Alliance Plan (HAP)	McLaren Health Plan	Physicians Health Plan (PHP)	Priority Health
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%

Vision Screening

Service	Blue Care Network (BCN)	Health Alliance Plan (HAP)	McLaren Health Plan	Physicians Health Plan (PHP)	Priority Health
Vision Screening (performed in a physician's office, one exam per plan year)	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Eyeglasses	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

Hearing Services

Service	Blue Care Network (BCN)	Health Alliance Plan (HAP)	McLaren Health Plan	Physicians Health Plan (PHP)	Priority Health
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)	Covered 100% (One hearing exam, one audiometric exam every 36 months)
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)	One basic hearing aid per ear every 36 months. Covered 100% to a max of $500 per hearing aid.

Chiropractic Services

Service	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. 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)	$20 Copay (Up to a combined benefit max of 30 visits per plan year. Deductible applies to x-ray.)

Other Services

Service	Blue Care Network (BCN)	Health Alliance Plan (HAP)	McLaren Health Plan	Physicians Health Plan (PHP)	Priority Health
Allergy testing & therapy (non-injection)	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible	Covered 100% After Deductible
Allergy injections	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Nutritional & Health education and counseling	Covered 100%	Covered 100% Limitations apply	Covered 100%	Dependent on where services are received.	Covered 100%
Mammography Screening	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Temporomandibular Joint Syndrome (TMJS)	Covered 100% After Deductible. Limitations apply	Covered 100% After Deductible. Limitations apply	Covered 100% After Deductible	Please see Certificate of Coverage.	Covered 50% After Deductible
Orthognathic Surgery	Covered 100% After Deductible Limitations apply	Covered 100% After Deductible Limitations apply	Covered 100% After Deductible	Please see Certificate of Coverage.	Covered 50% After Deductible
Oral Surgery	Covered 100% After Deductible for accidental injury. Limitations apply	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.
Outpatient Physical, Speech & Occupational Therapy	Covered, $20 Copay (Up to combined max of 90 visits per plan year)	Covered, $20 Copay (Up to combined max of 100 visits per plan year)	Covered, $20 Copay (Up to combined max of 90 visits per plan year)	Covered, $20 Copay (Up to combined max of 90 visits per plan year)	Covered, $20 Copay (Up to combined max of 90 visits per plan year)
Cardiac Rehabilitation & Pulmonary Rehabilitation	Covered, $20 Copay (Limited to 90 visits per plan year)	Covered 100% After Deductible	Covered 100% After Deductible	Covered, $20 Copay (Limited to 90 visits per plan year)	Covered, $20 Copay (Up to 30 visits per plan year)
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	Underlying conditions that cause infertility covered as any other medical condition without limits; A.I. covered depending on where service is received.	Covered 100%
Private Duty Nursing	Covered 100% After Deductible (When Authorized)	Covered 100%	Covered 100%	Not Covered	Covered 100% After Deductible

Miscellaneous

Service	Blue Care Network (BCN)	Health Alliance Plan (HAP)	McLaren Health Plan	Physicians Health Plan (PHP)	Priority Health
Pre-existing Condition	Covered 100% (As in-network; applicable deductibles/ copays apply)	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Worldwide Coverage (Emergency care only)	Covered $200 Copay (Waived if admitted as inpatient)	Covered $200 Copay (Waived if admitted as inpatient)	Covered $200 Copay (Waived if admitted as inpatient)	Covered $200 Copay (Waived if admitted as inpatient)	Covered $200 Copay (Waived if admitted as inpatient)