Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

State of Michigan

Benefits Open Enrollment
October 16 – November 6

State of Michigan Employees

Plan options	State Health Plan PPO		Blue Care Network In-network only	State High Deductible Health Plan w/ HSA	
	In network	Out of network		In network	Out of network
Out-of-pocket costs					
Annual deductibles	$400 per member $800 per family	$800 per member $1,600 per family	$125 per member $250 per family	$1,600/employee only $3,200/family	$3,200/employee only $6,400/family
Out-of-pocket maximums[1]	$2,000 per member $4,000 per family	$3,000 per member $6,000 per family	$2,000 per member $4,000 per family	$4,000 per member $8,000 per family	$8,000 per member $16,000 per family
SOM HSA Annual Employer Contribution				$750 per member; $1,500 per family Funded on the 1st pay period of each year. Prorated for mid-year enrollments based on the number of pay periods remaining in the year.	
Coinsurance	10% for most services 20% for acupuncture	20% for most services 50% for behavioral health and substance use disorder	None	20% for most services 40% for acupuncture	40% for most services
Copays	$0 for Telehealth – Blue Cross online tool for medical and behavioral health online visits. $20 for office visits and urgent care $20 for medical eye exam $200 for emergency room[2]	N/A	$10 for Telehealth – Blue Cross online tool for medical online visits $20 for office visits and urgent care $20 for referral physician visits $200 for emergency room[2]	N/A	N/A
Deductible amounts effective	January 1, 2024		January 1, 2024	January 1, 2024	

Prescription drugs (administered by OptumRx)		State Health Plan PPO	Blue Care Network In-network only	State High Deductible Health Plan w/ HSA[3]
Retail (30-day supply)	Tier 1: Generic	$10 copay	$10 copay	$10 Copay after deductible
	Tier 2: Preferred brand	$30 copay	$30 copay	$30 Copay after deductible
	Tier 3: Non-preferred brand	$60 copay	$60 copay	$60 Copay after deductible
Mail Order (90-day supply)	Tier 1: Generic	$20 copay	$20 copay	$20 Copay after deductible
	Tier 2: Preferred brand	$60 copay	$60 copay	$60 Copay after deductible
	Tier 3: Non-preferred brand	$120 copay	$120 copay	$120 Copay after deductible

Benefits	State Health Plan PPO		Blue Care Network In-network only	State High Deductible Health Plan w/ HSA	
	In network	Out of network		In network	Out of network
Preventive services					
Annual gynecological exam	Covered 100%	Not covered	Covered 100%	Covered 100%	Not covered
Annual physical					
Adult vaccinations					
Childhood immunizations		Covered 80%			Covered 60% after deductible
Colonoscopy		Covered 80% after deductible			
Mammography					
Prostate screening		Not covered			Not covered
Well-baby visits					
Emergency medical care					
Ambulance services	Covered 90% after deductible		Covered 100% after deductible	Covered 80% after deductible	
Emergency room	Covered, $200 copay (Medical – waived if admitted as inpatient; Behavioral health/ substance use disorder – waived if admitted as inpatient to the same hospital)		Covered, $200 copay (waived if admitted as inpatient)		
Diagnostic services					
Diagnostic mammography	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible	Covered 80% after deductible	Covered 60% after deductible
Diagnostic tests					
Lab and pathology tests			Covered 100%		
Position Emission Tomography (PET) scans			Covered 100% after deductible		
Radiation therapy					
X-rays, ultrasound, MRI and CAT scans					

Benefits	State Health Plan PPO		Blue Care Network In-network only	State High Deductible Health Plan w/ HSA	
	In network	Out of network		In network	Out of network
Maternity services					
Prenatal care	Covered 100%	Covered 80% after deductible	Covered 100%	Covered 100%	Covered 60% after deductible
Delivery and nursery care	Covered 90% after deductible		Covered 100% after deductible	Covered 80% after deductible	
Postnatal care	Covered 100%		Covered 100%	Covered 100%	
Hospital care					
Chemotherapy	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible	Covered 80% after deductible	Covered 60% after deductible
Consultations, inpatient and outpatient					
Inpatient care (unlimited days)					
Human organ transplants — Contact HOTP at 1-800-242-3504 for more information					
Bone marrow	Covered 100% (in designated facilities)	Not covered	Covered 100% after deductible (in designated facilities)	Covered 80% after deductible (in designated facilities)	Not covered
Kidney, cornea and skin	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible (subject to medical criteria)	Covered 80% after deductible	Covered 60% after deductible
Liver, heart, lung, pancreas and other specified organs	Covered 100% (in designated facilities)	Not covered	Covered 100% after deductible (in designated facilities)	Covered 80% after deductible (in designated facilities)	Not covered
Surgical services					
Surgery	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible	Covered 80% after deductible	Covered 60% after deductible
Voluntary female sterilization	Covered 100%		Covered 100%	Covered 100%	
Voluntary male sterilization			Covered 100% after deductible	Covered 80% after deductible	
Alternatives to hospital care					
Home health care (unlimited visits)	Covered 90% after deductible (participating providers only)	Not covered	Covered 100% after deductible, $20 copay	Covered 80% after deductible (participating providers only)	Not covered
Hospice	Covered 100% (Limited to the lifetime dollar maximum that is adjusted annually by the State; participating provider only)	Not covered	Covered 100% after deductible with prior authorization	Covered 80% after deductible (Limited to the lifetime dollar maximum that is adjusted annually by the State; participating provider only)	Not covered
Private duty nursing (requires prior authorization)	Covered 90% after deductible	Covered 80% after deductible		Covered 80% after deductible	Covered 60% after deductible
Skilled nursing care	Covered 90% after deductible (up to 120 days per confinement; in a Blue Cross-approved facility)	Not covered	Covered 100% after deductible (up to 120 skilled days per confinement)	Covered 80% after deductible (up to 120 days per confinement; in a Blue Cross-approved facility)	Not covered
Urgent care visit	Covered, $20 copay	Covered 80% after deductible	Covered, $20 copay	Covered 80% after deductible	Covered 60% after deductible
Behavioral health services (Mental health and substance use disorder)					
Inpatient mental health	Covered 100% (up to 365 days per year; prior authorization required)	Covered 50% of allowed amount or billed charges, whichever is less (up to 365 days per year; prior authorization required)	Covered 100% after deductible with prior authorization	Covered 80% after deductible (unlimited days, prior authorization required)	Covered 60% after deductible (unlimited days, prior authorization required)
Inpatient substance use disorder	Covered 100% (prior authorization required)	Covered 50% of allowed amount or billed charges, whichever is less (prior authorization required)		Covered 80% after deductible (prior authorization required)	Covered 60% after deductible (prior authorization required)

Benefits	State Health Plan PPO		Blue Care Network In-network only	State High Deductible Health Plan w/ HSA	
	In network	Out of network		In network	Out of network
Outpatient mental health Outpatient substance use disorder	Covered 90%	Covered 50% of allowed amount or billed charges (whichever is less)	Covered 100%	Covered 80% after deductible	Covered 60% after deductible
Autism spectrum disorder					
Applied behavioral analysis	Covered 90% after deductible (prior authorization required)	Covered 80% after deductible (prior authorization required)	Covered 100% after deductible	Covered 80% after deductible (prior authorization required)	Covered 60% after deductible (prior authorization required)
Other services					
Acupuncture (if performed by a participating acupuncturist or under the supervision of a M.D. or D.O.)	Covered 80% after deductible		Not covered	Covered 60% after deductible	
Allergy testing and therapy	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible	Covered 80% after deductible	Covered 60% after deductible
Chiropractic / spinal manipulation	Covered, $20 copay (24 visits per calendar year)	Covered 80% after deductible (24 visits per calendar year)	Covered 100% after deductible, $20 copay (when referred)	Covered 80% after deductible (24 visits per calendar year)	Covered 60% after deductible (24 visits per calendar year)
Durable medical equipment; prosthetic and orthotic appliances and medical supplies Participating provider only	Covered 100%	Covered 80% of Blue Cross-approved amount	Covered 100%	Covered 80% after deductible	Covered 60% after deductible (plus the difference between charge and approved amount; Based on Blue Cross-approved amount)
Hair prosthesis Wig or hair piece for hair loss due to a medical condition or treatment.	Covered, $300 lifetime maximum (Additional wigs covered for children due to growth)		Covered 100% One per calendar year; max benefit $225 per year	Not covered	

[1]The in-network out-of-pocket maximums apply to in-network deductibles, copays and coinsurance (where applicable).

[2]Emergency room copay waived if admitted as inpatient.

[3]The deductible does not apply to certain preventive medications under the State High Deductible Health Plan with HSA.

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Learn more.

Website: bcbsm.com/som

Phone: Blue Cross State of Michigan Customer Service (toll-free): 1-800-843-4876

BCN's Customer Service Center (toll-free): 1-800-662-6667

Optum Rx Customer Service Center (toll-free): 1-866-633-6433

Check us out online:

A Healthier Michigan

news.bcbsm.com | ahealthiermichigan.org | twitter.com/bcbsm

facebook.com/bcbsm | facebook.com/mibcn | youtube.com/bcbsmnews | linkd.in/LeadingMI

These benefit charts are intended as easy-to-read summaries. They are not contracts. Additional limitations and exclusions may apply to covered services. Every effort has been made to ensure the accuracy of this information. However, if statements in this description differ from the applicable coverage documents, then the terms and conditions of those documents will prevail. Payment amounts are based on the Blue Cross-approved amount, less any applicable deductible and/or copay amount required by the State Health Plan Blue Care Network, State Health Plan PPO and the State High Deductible Health Plan with Health Savings Account. This coverage is provided pursuant to a contract entered into with the State of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.