

## State Health Plan PPO (non-Medicare eligible retirees)

	In-Network	Out-of-Network
<b>Preventive services (Limited to \$1,500 per calendar year per person.)</b>		
Health maintenance exam	Covered — 100% one per year	Not covered
Gynecological exam	Covered — 100% one per calendar year	
Pap smear screening — lab only <i>American Cancer Society guidelines apply</i>	Covered — 100% one per calendar year	
Well-baby and well-child care	Covered — 100%	
Adult immunizations, annual flu shot and mist, Hepatitis C screening (for those at risk)		
Prostate specific antigen screening <i>American Cancer Society guidelines apply</i>	Covered — 100% one per calendar year	
<b>Preventive services (Not subject to \$1,500 maximum.)</b>		
Childhood immunizations	Covered — 100%	Not covered
Mammography screening <i>American Cancer Society guidelines apply</i>	Covered — 100%	Covered — 90% after deductible
	One per year. Standard film mammography screening. Digital mammography covered up to the standard film rate. No age restriction.	
Colonoscopy <i>American Cancer Society guidelines apply</i>	Covered — 100%	Covered — 90% after deductible
Fecal occult blood screening <i>American Cancer Society guidelines apply</i>	Covered — 100%; one per year	
Flexible sigmoidoscopy <i>American Cancer Society guidelines apply</i>	Covered — 100%; one every 5 years	
<b>Physician office services</b>		
Office visits, consultations, osteopathic manipulation therapy and urgent care visits	Covered — \$15 copay (no deductible)	Covered — 90% after deductible
Chiropractic/spinal manipulation	Covered — \$15 copay; up to 24 visits per calendar year (up to 36 visits for MSEA)	Covered — 90% after deductible; up to 24 visits per calendar year (up to 36 visits for MSEA)
Outpatient and home visits	Covered — 100% after deductible	Covered — 90% after deductible
<b>Emergency medical care</b>		
Hospital emergency room	Covered — \$50 (waived if admitted)	
Ambulance services	Covered — 100% after deductible; air and ground if medically necessary	
<b>Diagnostic services</b>		
Laboratory and pathology tests	Covered — 100% after deductible	Covered — 90% after deductible
Diagnostic tests and X-rays		
Radiation therapy		
<b>Maternity services — Includes care provided by a certified nurse midwife</b>		
Pre-natal and post-natal care	Covered — 100% after deductible	Covered — 90% after deductible
Delivery and nursery care		
<b>Hospital care</b>		
Semi-private room, inpatient physician care, general nursing care, hospital services and supplies	Covered — 100% after deductible	Covered — 90% after deductible
	Unlimited days	
Inpatient consultations	Covered — 100% after deductible	Covered — 90% after deductible
Chemotherapy		
<b>Alternatives to hospital care</b>		
Skilled nursing care	Covered — 100% after deductible; up to 120 days per confinement (730 days for UAW)	
Hospice care	Covered — 100%; limited to the lifetime dollar maximum that is adjusted annually by the state	
Home health care	Covered — 100% after deductible, unlimited visits	
<b>Surgical services</b>		
Surgery — includes related surgical services	Covered — 100% after deductible	Covered — 90% after deductible
Voluntary sterilization		

	In-Network	Out-of-Network
<b>Human organ transplants – Contact HOTP at 1-800-242-3504 for additional information</b>		
Liver, heart, lung, pancreas and other specified human organ transplants	Covered — 100% in Quality Care Centers only; \$1 million lifetime maximum per transplant type	
<b>Organ and tissue transplants – Contact HOTP at 1-800-242-3504 for additional information</b>		
Bone marrow — specific criteria apply	Covered — 100% after deductible in designated facilities only	Covered — 90% after deductible
Kidney, cornea and skin		
<b>Other services</b>		
Allergy testing and injections	Covered — 100% after deductible	Covered — 90% after deductible
Acupuncture	Covered — 90% after deductible; if performed by or under the supervision of an MD or DO	
Durable medical equipment and prosthetic and orthotic appliances <i>SUPPORT Program, 800-321-8074</i>	Covered 100%	Covered 80% after deductible
Hearing aids	Covered — 100% when services are rendered by a participating provider. One every 36 months unless significant hearing loss occurs. For regular hearing aids only. Deluxe hearing aids covered up to the amount paid for a regular hearing aid. Member is liable for balance.	Not covered when provided by a nonparticipating provider in Michigan.
Wig, wig stand, adhesives	Lifetime maximum reimbursement of \$300 on meeting medical conditions (Additional wigs covered for children due to growth.)	
Private duty nursing	Covered — 90% after deductible	
<b>Outpatient physical, speech and occupational therapy</b>		
Outpatient physical, speech and occupational therapy — facility and clinic services	Covered — 100% after deductible	
Outpatient physical therapy — physician's office	Covered — 100% after deductible	Covered — 90% after deductible
<b>Mental health care and substance abuse treatment administered through Magellan Behavioral of Michigan: 866-503-3158</b>		
<b>Deductible, copays and out-of-pocket dollar maximums</b>		
Deductible	\$300 per member; \$600 per family	\$600 per member; \$1,200 per family
Copays	<ul style="list-style-type: none"> <li>• \$15 for office visits, office consultations, urgent care visits, osteopathic and chiropractic manipulations and medical hearing and eye exams (no deductible)</li> <li>• \$50 emergency care (waived if admitted)</li> <li>• 10% for private duty nursing</li> <li>• 10% for acupuncture</li> </ul>	<p>Not applicable</p> <p>10% for most services</p>
Annual out-of-pocket dollar maximums	\$1,000 per member; \$2,000 per family	\$2,000 per member; \$4,000 per family

**Questions?**  
**Contact BCBSM's State of Michigan**  
**Customer Service toll-free at 1-800-843-4876**

This benefit chart is intended as an easy-to-read summary. It is not a contract. 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 BCBSM-approved amount, less any applicable deductible and/or copay amount required by the SHP PPO. 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.