

**APPENDIX F**  
**HEALTH INSURANCE BENEFIT CHART**

<b>Preventive Services</b>	<b>State Health Plan PPO “SHP – PPO” Benefits</b>		<b>HMO Plan “HMO” Benefits</b>
	<b>In-network</b>	<b>Out-of-network</b>	
Health maintenance exam	Covered 100% 1 per year	Not Covered	Covered 100%
Annual gynecological exam	Covered 100% 1 per calendar year	Not Covered	Covered 100%
Pap smear screening – laboratory services only <sup>1</sup>	Covered 100% 1 per year	Not Covered	Covered 100%
Well-baby and child care	Covered 100%	Not Covered	Covered 100%
Immunizations, annual flu shot & Hepatitis C screening for those at risk	Covered 100%	Not Covered	Covered 100%
Childhood Immunizations	Covered 100% through age 16	Covered 80%	Covered 100%
Fecal occult blood screening <sup>1</sup>	Covered 100%	Not Covered	Covered 100%
Flexible sigmoidoscopy <sup>1</sup>	Covered 100%	Not Covered	Covered 100%
Prostate specific antigen screening <sup>1</sup>	Covered 100% one per year	Not Covered	Covered 100%
Mammography, annual standard film mammography screening (covers digital mammography up to the standard film rate) <sup>1</sup>	Covered 100%	Covered 80% after deductible	Covered 100%
Colonoscopy <sup>1</sup>	Covered 100%	Covered 80% after deductible	Covered 100%

<sup>1</sup> American Cancer Society guidelines apply

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<b>Physician Office Services</b>	<b>State Health Plan PPO “SHP – PPO” Benefits</b>		<b>HMO Plan “HMO” Benefits</b>
	<b>In-network</b>	<b>Out-of-network</b>	
Office visits, consultations and urgent care visits and telemedicine <sup>2</sup>	Covered, \$20 co-pay	Covered 80% after deductible	Covered, \$20 co-pay
Outpatient and home visits	Covered 90% after deductible	Covered 80% after deductible	Covered, \$20 co-pay

<b>Emergency Medical Care</b>	<b>State Health Plan PPO “SHP – PPO” Benefits</b>		<b>HMO Plan “HMO” Benefits</b>
	<b>In-network</b>	<b>Out-of-network</b>	
Hospital emergency room for medical emergency or accidental injury	Covered, \$200 co-pay if not admitted		Covered, \$200 co-pay if not admitted
Ambulance services – medically necessary	Covered, 90% after deductible		Covered, 100% after deductible

<b>Diagnostic Services</b>	<b>State Health Plan PPO “SHP – PPO” Benefits</b>		<b>HMO Plan “HMO” Benefits</b>
	<b>In-network</b>	<b>Out-of-network</b>	
Laboratory and pathology tests	Covered 90% after deductible	Covered 80% after deductible	Covered 100%
Diagnostic tests and x-rays	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible
Radiation therapy	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible

<b>Maternity Services</b> Includes care by a certified nurse midwife (State Health Plan PPO only)	<b>State Health Plan PPO “SHP – PPO” Benefits</b>		<b>HMO Plan “HMO” Benefits</b>
	<b>In-network</b>	<b>Out-of-network</b>	
Prenatal care	Covered 100%	Covered 80% after deductible	Covered 100%
Postnatal care	Covered 90% after deductible	Covered 80% after deductible	Covered, \$20 co-pay
Delivery and nursery care	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible

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<b>Hospital Care</b>	<b>State Health Plan PPO "SHP – PPO" Benefits</b>		<b>HMO Plan "HMO" Benefits</b>
	<b>In-network</b>	<b>Out-of-network</b>	
Semi-private room, inpatient physician care, general nursing care, hospital services and supplies	Covered 90% after deductible, unlimited days	Covered 80% after deductible, unlimited days	Covered 100% after deductible Unlimited days
Inpatient consultations	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible
Self-donated blood storage prior to surgery	Covered 90% after deductible	Covered 80% after deductible	Check with your HMO
Chemotherapy	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible

<b>Alternatives to Hospital Care</b>	<b>State Health Plan PPO "SHP – PPO" Benefits</b>		<b>HMO Plan "HMO" Benefits</b>
	<b>In-network</b>	<b>Out-of-network</b>	
Skilled nursing care up to 120 days per confinement	Covered 90% after deductible		Covered 100% after deductible
Hospice care	Covered 100% Limited to the lifetime dollar maximum that is adjusted annually by the State		Covered 100% after deductible
Home health care	Covered 90% after deductible, unlimited visits		Check with your HMO

<b>Surgical Services</b>	<b>State Health Plan PPO "SHP – PPO" Benefits</b>		<b>HMO Plan "HMO" Benefits</b>
	<b>In-network</b>	<b>Out-of-network</b>	
Surgery—includes related surgical services.	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible
Male Voluntary sterilization	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible
Female Voluntary sterilization	Covered 100%	Covered 80% after deductible	Covered 100%

<b>Human Organ and Tissue Transplants</b>	<b>State Health Plan PPO "SHP – PPO" Benefits</b>		<b>HMO Plan "HMO" Benefits</b>
	<b>In-network</b>	<b>Out-of-network</b>	
Liver, heart, lung, pancreas, and other specified organ transplants	Covered 100% In designated facilities only. Up to \$1 million lifetime maximum for each organ transplant		Covered 100% after deductible in designated facilities
Bone marrow—specific criteria apply	Covered 100% after deductible in designated facilities		Covered 100% after deductible in designated facilities
Kidney, cornea, and skin	Covered 90% after deductible in designated facilities	Covered 80% after deductible	Covered 100% after deductible subject to medical criteria

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<b>Other Services</b>	<b>State Health Plan PPO “SHP – PPO” Benefits</b>		<b>HMO Plan “HMO” Benefits</b>
	<b>In-network</b>	<b>Out-of-network</b>	
Allergy testing and therapy (non-injection)	Covered 90% after deductible	Covered 80% after deductible	Covered, 100% after deductible.
Allergy injections	Covered 90% after deductible	Covered 80% after deductible	Covered 100%
Acupuncture	Covered 80% after deductible if performed by or under the supervision of a M.D. or D.O.		Check with your HMO
Rabies treatment after initial emergency room visit	Covered 90% after deductible	Covered 80% after deductible	Office visits: \$20 co-pay. Injections: Covered 100%
Autism-Spectrum Disorder Applied Behavioral Analysis (ABA) treatment	Covered 90% after deductible	Covered 80% after deductible	Covered, 100% after deductible
Chiropractic/spinal manipulation	Covered, \$20 co-pay Up to 24 visits per calendar year	Covered 80% after deductible Up to 24 visits per calendar year	Check with your HMO
Durable medical equipment	Covered 100%	Covered 80% of approved amount	Covered, check with your HMO
Prosthetic and orthotic appliances	Covered 100%	Covered 80% of approved amount	Covered, check with your HMO
On-line Tobacco Cessation counseling	No charge	Not covered	Covered, check with your HMO
Private duty nursing	Covered 80% after deductible		Check with your HMO
Wig, wig stand, adhesives	Upon meeting medical conditions, eligible for a lifetime maximum reimbursement of \$300. (Additional wigs covered for children due to growth).		Check with your HMO
Hearing Care Exam	Covered, \$20 co-pay	Covered 80% after deductible	Check with your HMO
Hearing aids <sup>3</sup>	Covered	Not covered	Check with your HMO

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<b>Mental Health/Substance Abuse</b>	<b>State Health Plan PPO "SHP – PPO" Benefits</b>		<b>HMO Plan "HMO" Benefits</b>
	<b>In-network</b>	<b>Out-of-network</b>	
Mental Health Benefits - <b>Inpatient</b>	Covered 100% up to 365 days per year <sup>4</sup>	Covered 50% up to 365 days per year	Check with your HMO; Inpatient services subject to deductible.
Mental Health Benefits – <b>Outpatient, including Telemedicine</b> <sup>2</sup>	As necessary 90% of network rates 10% co-pay	As necessary 50% of network rates	Check with your HMO
Alcohol & Chemical Dependency Benefits – <b>Inpatient</b>	Covered 100% <sup>5</sup> Halfway House 100%	Covered 50% <sup>5</sup> Halfway House 50%	Check with your HMO; Inpatient services subject to deductible.
Alcohol & Chemical Dependency Benefits - <b>Outpatient</b>	\$3,500 per calendar year 90% of network rates 10% co-pay <sup>6</sup>	\$3,500 per calendar year 50% of network rates <sup>6</sup>	Check with your HMO

<sup>2</sup> Telemedicine benefit is available effective beginning the first full pay period in October 2016.

<sup>3</sup> Deluxe hearing aids are covered at the same rate as basic hearing aids with the member paying the remainder. Discount hearing aids are offered through the SHP PPO.

<sup>4</sup> Inpatient days may be utilized for partial day hospitalization (PHP) at 2:1 ratio. One inpatient day equals two PHP days.

<sup>5</sup> Up to two 28-day admissions per year. There must be at least 60 days between admissions. Inpatient days may be utilized for intensive outpatient treatment (IOP) at 2:1 ratio. One inpatient day equals two IOP days.

<sup>6</sup> \$3,500 per calendar year limitation pertains to services for chemical dependency only.

### Prescription Drugs

Prescription medications for the State Health Plan PPO are carved out and administered by a Pharmacy Benefit Manager (PBM).

Prescriptions filled at a participating pharmacy may only be approved for up to a 34-day supply. Employees can still receive a 90-day supply by mail order.

To check the co-pay for drugs you may be taking, visit the Civil Service Commission Employee Benefits Division website at <http://www.michigan.gov/employeebenefits> and select Benefit Plan Administrators.

The chart below shows the SHP and HMO prescription drug member co-pays:

<b>Generic</b>	<b>Brand Name Preferred</b>	<b>Brand Name Non-Preferred</b>
Retail \$10	Retail \$30	Retail \$60
Mail Order \$20	Mail Order \$60	Mail Order \$120

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<b>Outpatient Physical, Speech, and Occupational Therapy</b> Combined maximum of 90 visits per calendar year.	<b>State Health Plan PPO "SHP – PPO" Benefits</b>		<b>HMO Plan "HMO" Benefits</b>
	<b>In-network</b>	<b>Out-of-network</b>	
Outpatient physical, speech and occupational therapy – facility and clinic services	Covered 90% after deductible	Covered 90% after deductible	Covered, \$20 co-pay
Outpatient physical therapy – physician's office	Covered 90% after deductible	Covered 80% after deductible	Covered, \$20 co-pay

<b>Deductible, Co-Pays, and Out-of-Pocket Dollar Maximums</b>	<b>State Health Plan PPO "SHP – PPO" Benefits</b>		<b>HMO Plan "HMO" Benefits</b>
	<b>In-network</b>	<b>Out-of-network</b>	
Deductible <sup>7</sup>	\$400 per member \$800 per family	\$800 per member \$1,600 per family	\$125 per member \$250 per family
Fixed dollar co-pays	\$20 for office visits, office consultations, urgent care visits, osteopathic manipulations, chiropractic manipulations and medical hearing exams. \$200 for emergency room visits, if not admitted	Not applicable	\$20 for office visits \$200 for emergency room visits, if not admitted
Coinsurance	10% for most services and 20% for private duty nursing and acupuncture	20% for most services. MHSA at 50%	None
Annual out-of-pocket dollar maximums <sup>8</sup>	\$2,000 per member and \$4,000 per family	\$3,000 per member \$6,000 per family	\$2,000 per member and \$4,000 per family

<sup>7</sup> Deductible amounts for the SHP – PPO are effective January 1, 2015 and renew annually on a calendar year basis. Deductible amounts for the HMOs are effective October 12, 2014 and renew annually each October with the start of the new plan year.

<sup>8</sup> Beginning October 12, 2014, in-network deductibles, in-network fixed dollar co-payments and in-network co-insurance all apply toward the out-of-pocket annual limit. In addition, in HMOs, prescription drug co-payments also apply toward the annual out-of-pocket limit. Beginning with the October 2015 plan year, prescription drug co-payments in the SHP PPO also apply to the annual out-of-pocket limit.

<b>Premium Sharing</b>	<b>State Health Plan PPO "SHP – PPO" Benefits</b>		<b>HMO Plan "HMO" Benefits</b>	
	<b>Employee</b>	<b>State</b>	<b>Employee</b>	<b>State</b>
Premium	20%	80%	15%	85% <sup>9</sup>

<sup>9</sup> 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.