	State Health Plan (PPO)		State Health Plan
	In-Network	Out-of-Network	Advantage
Preventive Services - Limited to $500 per calendar year per person (In Jan. 2004, limit increases to $750)			
Health Maintenance Exam - includes chest X-ray, EKG and select lab procedures	Covered-100%, one per calendar year	Not covered	Covered with Multiphasic Screening Benefit Services provided by personal care physician up to $114. Employee and Spouse only.
Annual Gynecological Exam	Covered-100%, one per calendar year	Not covered	Covered 90% after deductible
Pap Smear Screening-laboratory services only	Covered-100%, one per calendar year	Not covered	Covered 100%
Well-Baby and Child Care	Covered-100% -6 visits per year through age 1 -2 visits per year, age 2 through 3 -1 visit per year, age 4 through 15	Not covered	Covered 90% , after deductible
Immunizations (no age limit). Annual flu shot; Hepatitis C screening covered for those at risk	Covered 100%	Not covered	Covered 90% after deductible for children & infants only. Flu shots - at risk only.
Fecal Occult Blood Screening	Covered-100%, one per calendar year	Not covered	Covered 100% according to American Cancer Society guidelines. One every year starting at age 50.
Flexible Sigmoidoscopy Exam	Covered 100%	Not covered	Covered 100% according to American Cancer Society guidelines; schedule depends on test results; start at age 50
Prostate Specific Antigen (PSA) Screening	Covered-100%, one per calendar year	Not covered	Covered 100% according to American Cancer Society guidelines. One every year starting at age 50.
Mammography			
Mammography Screening	Covered 100% One per calendar year, no age restrictions	Covered-90% after deductible	Covered 100% according to American Cancer Society guidelines. One every 5 years ages 35-39, annually age 40 and up.
Physician Office Services			
Office Visits	Covered - $10 copay	Covered - 90% after deductible, must be medically necessary	Covered 90% after deductible
Outpatient and Home Visits	Covered - 100% after deductible	Covered - 90% after deductible, must be medically necessary	Covered 90% after deductible
Office Consultations	Covered - $10 copay	Covered - 90% after deductible, must be medically necessary	Covered 90% after deductible

Emergency Medical Care			
Hospital Emergency Room-approved diagnosis, prudent person rule	Covered 100% for emergency medical illness or accidental injury	Covered 100% for emergency medical illness or accidental injury	Covered 100% prudent person rule
Ambulance Services - medically necessary for illness and injury	Covered 100% after deductible	Covered 100% after deductible	Service covered in full up to first $25. Balance is subject to deductible and copay.
Diagnostic Services			
Laboratory and Pathology Tests	Covered - 100% after deductible	Covered - 90% after deductible	Covered 100%
Diagnostic Tests and X-rays	Covered - 100% after deductible	Covered - 90% after deductible	Covered 100%
Radiation Therapy	Covered - 100% after deductible	Covered - 90% after deductible	Covered 100%
Maternity Services Provided by a Physician			
Pre-Natal and Post-Natal Care	Covered - 100% after deductible	Covered - 90% after deductible	Covered - 90% after deductible
	Includes care provided by a Certified Nurse Midwife		
Delivery and Nursery Care	Covered - 100% after deductible	Covered - 90% after deductible	Covered 100%
	Includes delivery provided by a Certified Nurse Midwife		
Hospital Care			
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies, and Blood Storage	Covered – 100% after deductible - Unlimited Days	Covered – 90% after deductible - Unlimited Days	Covered 100% up to 365 days
Inpatient Consultations	Covered - 100% after deductible	Covered – 90% after deductible	Covered 100%
Chemotherapy	Covered - 100% after deductible	Covered – 90% after deductible	Covered 100%
Alternatives to Hospital Care			
Skilled Nursing Care	Covered - 100% after deductible	Covered – 90% after deductible	Covered 100% - 120 days per confinement
	Number of days varies by bargaining unit		
Hospice Care	Covered – 100%	Covered – 100%	Covered 100% to 210 days/lifetime
	Limited to the lifetime dollar max. which is adjusted annually by the state		
Home Health Care	Covered - 100% after deductible	Covered – 100% after deductible	Covered – 100% to 120 visits per calendar year
	Unlimited visits		

Surgical Services			
Surgery - includes related surgical services	Covered - 100% after deductible	Covered – 90% after deductible	Covered 100%
Voluntary Sterilization	Covered - 100% after deductible	Covered – 90% after deductible	Covered 100%
Human Organ Transplants			
Specified Organ Transplants - in designated facilities only - when coordinated through the TPA	Covered - 100% after deductible	Covered – in designated facilities only	Covered 100% in designated facilities only
	Up to $1 million maximum per transplant type		Up to $1 million lifetime maximum for each organ transplant
Bone Marrow - when coordinated through the TPA - specific criteria applies	Covered - 100% after deductible	Covered – 90% after deductible	Covered 100% Specific criteria applies
Kidney, Cornea and Skin	Covered - 100% after deductible	Covered – 90% after deductible	Covered 100%
Mental Health Care and Substance Abuse - Covered under non-BCBSM contract			
Inpatient Mental Health	100% to 365 days per year. Partial Day Hospitalization at 2:1 ratio	50%, to 365 days per year	There are no changes in the Mental Health & Alcohol and Chemical Abuse benefits. The benefits under the State Health Plan Advantage are continued as outlined for the proposed State Health Plan (PPO).
Outpatient Mental Health	90% of network rates	50% of network rates	There are no changes in the Mental Health & Alcohol and Chemical Abuse benefits. The benefits under the State Health Plan Advantage are continued as outlined for the proposed State Health Plan (PPO).
Inpatient Alcohol & Chemical Abuse Care	100% to two 28-day admissions per calendar year, with 60 day interval. Intensive Outpatient Treatment at 2:1 ratio. Halfway House 100%	50% to two 28-day admissions per calendar year, with 60 day interval. Intensive Outpatient Treatment at 2:1 ratio. Halfway House 50%	There are no changes in the Mental Health & Alcohol and Chemical Abuse benefits. The benefits under the State Health Plan Advantage are continued as outlined for the proposed State Health Plan (PPO).
Outpatient Alcohol & Chemical Abuse	90% of network rates; Limit $3,500/year chemical dependency only	50% of network rates Limit $3,500/year chemical dependency only	There are no changes in the Mental Health & Alcohol and Chemical Abuse benefits. The benefits under the State Health Plan Advantage are continued as outlined for the proposed State Health Plan (PPO).
Other Services			
Allergy Testing and Therapy	Covered - 100% after deductible	Covered – 90% after deductible	Covered 100%
Rabies treatment after initial emergency room treatment	Covered - 100% after deductible	Covered – 90% after deductible	**Not Covered**
Chiropractic Spinal Manipulation	Covered – 90% after deductible	Covered – 90% after deductible	Covered 90% after deductible
Outpatient Physical, Speech and Occupational Therapy	Up to 24 visits per calendar year		

- Facility and Clinic	Covered - 100% after deductible	Covered – 100% after deductible	Covered 90% after deductible
- Physician's Office - excludes speech and occupational therapy	Covered - 100% after deductible	Covered – 90% after deductible	Covered 90% after deductible
	Up to a combined maximum of 60 visits per calendar year		
Durable Medical Equipment	Covered – 90% after deductible	Covered – 90% after deductible	Covered 90% after deductible
Prosthetic and Orthotic Appliances	Covered – 90% after deductible	Covered – 90% after deductible	Covered 90% after deductible
Private Duty Nursing	Covered – 90% after deductible	Covered – 90% after deductible	Covered 90% after deductible
Prescription Drugs	Covered under non-BCBSM contract	Covered under non-BCBSM contract	Covered under non-BCBSM contract
Hearing Care Program	$10 office visits; more frequent than 36 months if standards met.		100% but no more frequent than 36 months
Acupuncture Therapy Benefit – Under the supervision of a MD/DO	Covered – 90% after deductible (up to 20 visits annually)	Covered – 90% after deductible (up to 20 visits annually)	Covered 90% after deductible only if performed by M.D., D.O.
Weight Loss Benefit	Upon meeting conditions, eligible for a lifetime maximum reimbursement of $300 for non-medical, weight reduction.		Upon meeting conditions, eligible for a lifetime maximum reimbursement of $300 for non-medical, weight reduction.
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
Deductible, Copays and Dollar Maximums			
Deductible	$200 per member;$400 per family	$500 per member; $1,000 per family	$300 per member; $600 per family
Copays			
- Fixed Dollar Copays - Do not apply toward deductible	$10 for office visits/consultations		N/A
- Percent Copays - MH/SA copays do not apply toward deductible - Services without a network are covered at the in-network level	10% for MHSA outpatient, chiropractic, durable medical equip., prosthetic and orthotic appliances, and private duty nursing	10% for most services; MHSA at 50%	10% copay for most services
Annual Dollar Maximums			
- Fixed Dollar Copays - Do not apply toward out-of-pocket maximum	N/A	None	N/A
- Percent Copays - MH/SA and private duty nursing copays do not apply toward out-of-pocket maximum	$1,000 per member; $2,000 per family	$2,000 per member; $4,000 per family	$1,000 per member, No Family Limit
Dollar Maximums	$5 million lifetime per member for all covered services and as noted above for individual services		N/A

1/3/2002