


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	\$20	\$20	\$20 (Sparrow FastCare \$0 copay)	\$20
Emergency Room Visit Copay (Waived if admitted)	\$200	\$200	\$200	\$200	\$200
Telehealth (Medical)	\$10 Copay	\$10 Copay	\$10 Copay	\$10 Copay	\$10 Copay
Telehealth (Behavioral Health)	\$0 copay. There is no member copay for outpatient mental health; therefore, mental health parity rules will not allow for a member copay.	Not covered	Not covered	\$10 Copay	\$10 Copay

Preventive Services



**Blue Care
Network (BCN)**



**Health Alliance
Plan (HAP)**



**McLaren
Health Plan**



**Physicians Health
Plan (PHP)**



Priority Health

Service

**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



**Blue Care
Network (BCN)**



**Health Alliance
Plan (HAP)**



**McLaren
Health Plan**



**Physicians Health
Plan (PHP)**



Priority Health

Service

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	Covered \$1,000 Copay After Deductible Bariatric Surgery & Related Services. 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)	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



**Blue Care
Network (BCN)**



**Health Alliance
Plan (HAP)**



**McLaren
Health Plan**



**Physicians Health
Plan (PHP)**



Priority Health

Service

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



Blue Care Network (BCN)



Health Alliance Plan (HAP)



McLaren Health Plan



Physicians Health Plan (PHP)



Priority Health

Service

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**

**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



**Blue Care
Network (BCN)**



**Health Alliance
Plan (HAP)**



**McLaren
Health Plan**



**Physicians Health
Plan (PHP)**



Priority Health

Service

**Retail Pharmacy
(30-Day Supply)**

\$10 Generic
\$30 Brand-Name
Preferred
\$60 Brand-Name
Non-Preferred

\$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

\$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	 <p>Blue Care Network (BCN)</p>	 <p>Health Alliance Plan (HAP)</p>	 <p>McLaren Health Plan</p>	 <p>Physicians Health Plan (PHP)</p>	 <p>Priority Health</p>
<p>Skilled Nursing Care in a Nursing Home</p>	<p>Covered 100% After Deductible (Up to 120 days per confinement)</p>	<p>Covered 100% After Deductible (Up to 120 days per confinement)</p>	<p>Covered 100% After Deductible (Up to 120 days per confinement)</p>	<p>Covered 100% After Deductible (Up to 120 days per confinement)</p>	<p>Covered 100% After Deductible (Up to 120 days per confinement)</p>
<p>Home Health Care</p>	<p>Covered 100% After Deductible, \$20 Copay</p>	<p>Covered 100% After Deductible, \$20 Copay Unlimited visits; excludes PT/OT/ST</p>	<p>Covered 100% After Deductible, \$20 Copay Limit of 60 visits per plan year.</p>	<p>Covered 100% After Deductible, \$20 Copay Limit of 60 visits per plan year.</p>	<p>Covered 100% After Deductible, \$20 Copay Includes Hospice; excludes rehab services.</p>
<p>Hospice Care</p>	<p>Covered 100% After Deductible</p>	<p>Covered 100% After Deductible</p>	<p>Covered 100% After Deductible</p>	<p>Covered 100% After Deductible</p>	<p>Covered 100% After Deductible</p>

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% After Deductible	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 Abuse (Alcohol and Drug Use)



Blue Care Network (BCN)



Health Alliance Plan (HAP)



McLaren Health Plan



Physicians Health Plan (PHP)



Priority Health

Alcohol & Chemical Dependency Benefits - Outpatient

Covered,
\$20 Copay

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.)



Blue Care Network (BCN)



Health Alliance Plan (HAP)



McLaren Health Plan



Physicians Health Plan (PHP)



Priority Health

Service

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



Blue Care Network (BCN)



Health Alliance Plan (HAP)



McLaren Health Plan



Physicians Health Plan (PHP)



Priority Health

Service

Vision Screening

Eyeglasses

Covered 100%
(Performed in
Physician's Office,
\$20 Copay May
Apply)

Not Covered

Covered 100%
(\$20 Office Copay
May Apply)

Not Covered

Covered,
\$20 Copay

Not Covered






Covered 100%
(1 exam per
plan year)

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 100% (Limited to one every 36 months, including binaural)	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



Blue Care Network (BCN)



Health Alliance Plan (HAP)



McLaren Health Plan



Physicians Health Plan (PHP)



Priority Health

Service

Manipulations or adjustments; diagnostic radiological services; evaluation and treatment

Chiropractic spinal manipulation when referred by PCP, covered - \$20 Copay after deductible.






Covered After Deductible
\$20 Copay
(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.	\$20 Copay per visit (Up to 6 visits per plan year)
Mammography Screening	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Temporomandibular Joint Syndrome (TMJS)	Covered 100% After Deductible	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	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	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 36 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	Covered 100% After Deductible	Underlying conditions that cause infertility covered as any other medical condition without limits; A.I. covered depending on where service received.	Covered 100%
Private Duty Nursing	Covered 100% After Deductible (When Authorized)	Covered 100%	Covered 100%	Not Covered	Covered 100% After Deductible

Miscellaneous



Blue Care Network (BCN)



Health Alliance Plan (HAP)



McLaren Health Plan



Physicians Health Plan (PHP)



Priority Health

Service

Conversion Option

Covered 100%

Covered 100%

Available

Not Available

Not Available

Pre-existing Condition

Covered
100%

Covered
100%

Covered
100%

Covered
100%

Covered
100%

**Worldwide Coverage
(Emergency care only)**

Covered 100%

Covered
\$200 Copay
(Waived if admitted)

Covered
\$200 Copay
(Waived if admitted)

Covered
(As in-network;
applicable
deductibles/copays
apply)

Covered
\$200 Copay
(Waived if admitted)