State Health Plan PPO

Benefits at a glance

For State of Michigan Employees

January 1 through December 31, 2024

	In network	Out of network
Out-of-pocket costs		
Out-of-pocket maximums	$2,000 per member $4,000 per family	$3,000 per member $6,000 per family
Deductible	$400 per member $800 per family	$800 per member $1,600 per family
Coinsurance	10% for most medical services 10% (where applicable) for behavioral health/substance use disorder services 20% for acupuncture	20% for most medical services 50% for most behavioral health/substance use disorder services
Copays	$20 copay for office and urgent care visits, medical eye exam, medical hearing exam, osteopathic, chiropractic manipulation $0 copay for medical and behavioral health/substance use disorder telehealth (Blue Cross online tool)	N/A
Preventive services **For a complete list, visit www.bcbsm.com/som**		
Annual gynecological exam	Covered 100%	Not covered
Annual physical		
Adult vaccinations		
Childhood immunizations		Covered 80%
Colonoscopy		Covered 80% after deductible
Contraceptive services – devices, counseling, medications and injections		
Fecal occult blood screening		Not covered
Flexible sigmoidoscopy		
Mammography		Covered 80% after deductible
Pap smear screening (lab only)		Not covered
Prostate screening		
Well-baby visits		
Emergency medical care		
Ambulance services – medically necessary	Covered 90% after deductible	
Emergency medical care – physician services	Covered 100%	
Emergency room (Medical – waived if admitted as inpatient; Behavioral health/substance use disorder – waived if admitted as inpatient to the same hospital)	Covered, $200 copay	
Observation care	Covered 100% (No network required)	

	In network	Out of network
Diagnostic tests and radiation services		
Diagnostic mammography	Covered 90% after deductible	Covered 80% after deductible
Diagnostic tests		
Lab and pathology tests		
Position Emission Tomography (PET) scans		
Radiation therapy		
X-rays, ultrasound, MRI and CAT scans		
Maternity services provided by a physician or certified nurse midwife		
Prenatal care	Covered 100%	Covered 80% after deductible
Delivery and nursery care	Covered 90% after deductible	
Postnatal care	Covered 100%	
Hospital care (medical services)		
Chemotherapy	Covered 90% after deductible	Covered 80% after deductible
Consultations – inpatient and outpatient (Including pre-surgical)		
Inpatient care – unlimited days		
Hospital care (behavioral health/substance use disorder services) – Inpatient		
Hospital care – behavioral health (requires prior authorization)	Covered 100%	Covered 50% of allowed amount or billed charges (whichever is less)
Hospital care – substance use disorder (requires prior authorization)		
Consultations		
Neuropsychological testing		
Psychological testing		
Alternatives to hospital care		
Home health care (unlimited visits)	Covered 90% after deductible (participating provider only)	Not Covered
Hospice care	Covered 100% (limited to the lifetime dollar maximum that is adjusted annually by the State; participating provider only)	
Home Infusion Therapy (HIT) (Must be rendered by a participating HIT provider or participating freestanding Ambulatory Infusion Center)	Covered 90% after deductible (participating provider only)	
Private duty nursing – (requires prior authorization)	Covered 90% after deductible	Covered 80% after deductible
Skilled nursing care (Up to 120 skilled days per confinement)	Covered 90% after deductible (in a Blue Cross-approved facility)	Not covered
Urgent care visit	Covered $20 copay	Covered 80% after deductible
Behavioral health		
Autism spectrum disorders – ABA (requires prior authorization)	Covered 90% after deductible	Covered 80% after deductible
Electro-Convulsive Therapy (ECT)	Covered 100%	Covered 50% of allowed amount or billed charges (whichever is less)
Intensive Outpatient Program (IOP)	Covered 100%	Covered 50% of allowed amount or billed charges (whichever is less)

	In network	Out of network
Behavioral health continued		
Neuropsychological testing outpatient or office setting	Covered 90%	
Outpatient behavioral health	Covered 90%	Covered 50% of allowed amount or billed charges (whichever is less)
Partial Hospitalization Program (PHP) (requires prior authorization)	Covered 100%	Covered 50% of allowed amount or billed charges (whichever is less)
Psychological testing – outpatient or office setting	Covered 90%	
Human organ transplants – Contact HOTP at 1-800-242-3504 for additional criteria and information		
Bone marrow	Covered 100% (in designated facilities)	Not covered
Kidney, cornea and skin	Covered 90% after deductible	Covered 80% after deductible
Liver, heart, lung, pancreas and other specified organs	Covered 100% (in designated facilities)	Not covered
Substance use disorder		
Intensive Outpatient Program (IOP)	Covered 100%	Covered 50% of allowed amount or billed charges (whichever is less)
Outpatient care (includes office-based opioid treatment and methadone maintenance)	Covered 90%	
Partial Hospitalization Program (PHP) (requires prior authorization)	Covered 100%	
Residential Substance Use Disorder treatment (requires prior authorization)		
Surgical services		
Surgery	Covered 90% after deductible	Covered 80% after deductible
Voluntary female sterilization	Covered 100%	
Voluntary male sterilization		
Hearing care (Participating providers only)		
Audiometric exam	Covered 100%	Not covered
Hearing aid evaluation and conformity test		
Hearing aid (ordering and fitting)		
Hearing aids (standard only)		
Medical hearing clearance exam	Covered $20 copay	Covered 80% after deductible
Other services		
Acupuncture	Covered 80% after deductible (if performed by a participating acupuncturist or under the supervision of a M.D. or D.O.)	
Allergy testing and therapy	Covered 90% after deductible	Covered 80% after deductible
Anesthesia	Covered 90% after deductible	
Cardiac rehabilitation (Phase 1 and Phase 2)	Covered 90% after deductible	Covered 80% after deductible
Chiropractic / spinal manipulation 24 visits per calendar year	Covered $20 copay	Covered 80% after deductible
Durable medical equipment; prosthetic and orthotic appliances and medical supplies	Covered 100%	Covered 80% of Blue Cross-approved amount (member responsible for difference)
Hemodialysis	Covered 90% after deductible	Covered 80% after deductible
Home visits		
Injections		
Office consultations	Covered $20 copay	
Other services continued		

	In network	Out of network
Office visit	Covered $20 copay	Covered 80% after deductible
Osteopathic manipulation therapy		
Outpatient hospital office visits		
Outpatient physical, speech and occupational therapy (combined 90 visit maximum per calendar year)	Covered 90% after deductible	
Rabies treatment after initial emergency room visit		
Rural health clinic	Covered $20 copay	
Sleep studies	Covered 90% after deductible	
Specified oncology trials (Phases 1, 2, 3 and 4)	Covered 90% after deductible (in designated facilities when pre-approved)	
Telehealth (Medical and behavioral health/substance use disorder online visits – Blue Cross Online Tool)	Covered $0 copay	Not covered
Telehealth (Medical online visits – Provider's Tool)	Covered $20 copay	Covered 80% after deductible
Telehealth (Behavioral health/substance use disorder online visits – Provider's Tool)	Covered $20 copay or 10% of allowed amount (whichever is less)	Covered 50% of allowed amount or billed charges (whichever is less)
Temporomandibular Joint Syndrome	Covered 90% after deductible	Covered 80% after deductible
Weight loss	Covered $300 lifetime maximum	
Wig, wig stand, adhesives	Covered $300 lifetime maximum Additional wigs covered for children due to growth	

Questions?

For the full list of benefits, view the 2024 State Health Plan PPO benefit guide at **bcbsm.com/som**.
Contact Blue Cross State of Michigan Customer Service toll-free at 1-800-843-4876
OPTUM Rx Customer Service Center (toll-free): 1-866-633-6433

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

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A Healthier Michigan

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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 Blue Cross-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.