

**Coalition of Public Safety Employees  
Health Trust**  
**Michigan State Troopers Plan 1**  
**SCHEDULE OF BENEFITS**



(800) 229-2210 (888) 229-2210

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
<b>MAXIMUM LIFETIME BENEFIT AMOUNT</b>	UNLIMITED	
<p>Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers. NETWORK AND NON-NETWORK DEDUCTIBLES, COPAYMENTS, COINSURANCE, AND OUT OF POCKET LIMITS DO NOT CROSS ACCUMULATE.</p>		
<b>DEDUCTIBLE, PER CALENDAR YEAR (Embedded)</b>		
Per Covered Person	\$500	\$1,000
Per Family Unit	\$1,000	\$2,000
<b>COPAYMENTS (Global)</b>		
Physician Visit	\$20	Not Applicable
Specialist Visit	\$20	Not Applicable
Urgent Care	\$20	Not Applicable
Emergency Room	\$200	\$200
<b>COINSURANCE, PER CALENDAR YEAR (Embedded) – Does not include deductible</b>		
Per Covered Person	\$1,500	\$2,000
Per Family Unit	\$3,000	\$4,000
<b>MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR Including Deductible, Coinsurance and Medical and Prescription Copays</b>		
Per Covered Person	\$6,350	\$12,700
Per Family Unit	\$12,700	\$25,400
<p>Member maximum cost share, as designated by the Affordable Care Act (ACA) includes medical and prescription copayments, deductible, and coinsurance per Plan year. Non-covered, cost containment, and balance billing charges do not apply toward the out-of-pocket maximum and are never paid at 100%</p>		
<b>COVERED CHARGES</b>		
<p>Note: Benefits are payable as shown below. However, to the extent that a service is specifically described in the Summary of Benefits and Coverage and it is not specifically addressed below, benefits will be payable at the levels shown in the Summary of Benefits and Coverage.</p>		
<b>Hospital Services</b>		
Room and Board	90% after deductible the semiprivate room rate	80% after deductible the semiprivate room rate
Intensive Care Unit	90% after deductible Hospital's ICU Charge	80% after deductible Hospital's ICU Charge
Emergency Room Facility Charges	100% after \$200 copay	
Emergency Room Provider Charges	100% after deductible	
Urgent Care Center	100% after \$20 copay	80% after deductible
<b>Skilled Nursing Facility</b> 100 day calendar year maximum	90% after deductible	80% after deductible
<b>Diagnostic Services</b>		
Endoscopic Services	90% after deductible	80% after deductible
Diagnostic Services in office (Laboratory, X-rays, Medical Tests)	100% after \$20 copay	80% after deductible
Diagnostic Services (CT, MRI/MRA, Nuclear Medicine)	deductible then 90% after \$20 copay	80% after deductible

**THIS PLAN UTILIZES THE BLUE CROSS BLUE SHIELD of MICHIGAN NETWORK**

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
<b>Physician Services</b>		
Inpatient visits	90% after deductible	80% after deductible
Office visits	100% after \$20 copay	80% after deductible
Virtual visits	100% after \$20 copay	80% after deductible
Surgery in Office	100% after \$20 copay	80% after deductible
Surgery in Facility	90% after deductible	80% after deductible
Allergy testing serum and injections	deductible then 100% after \$20 copay	80% after deductible
<b>Inpatient Prescription Drugs</b>	90% after deductible	80% after deductible
<b>Home Health Care</b>	90% after deductible	80% after deductible
<b>Private Duty Nursing</b>	90% after deductible	80% after deductible
<b>Hospice Care</b>	90% after deductible	80% after deductible
Bereavement Counseling	90% after deductible	80% after deductible
<b>Ambulance Service</b> (Emergency)	90% after deductible	
<b>Wig After Chemotherapy</b>	90% after deductible	80% after deductible
<b>Temporomandibular Services</b>	90% after deductible	80% after deductible
<b>Spinal Manipulation/Chiropractic</b> 30 visit calendar year maximum	deductible then 100% after \$20 copay	80% after deductible
<b>Speech Therapy (ST)</b> 30 visit calendar year maximum	deductible then 100% after \$20 copay	80% after deductible
<b>Physical Therapy (PT)</b> 30 visit calendar year maximum combined PT, OT	deductible then 100% after \$20 copay	80% after deductible
<b>Occupational Therapy (OT)</b> 30 visit calendar year maximum combined OT, PT	deductible then 100% after \$20 copay	80% after deductible
<b>Cardiac Rehabilitation</b>	90% after deductible	80% after deductible
<b>Pulmonary Rehabilitation</b>	90% after deductible	80% after deductible
<b>Durable Medical Equipment</b>	100% after deductible	80% after deductible
<b>Prosthetics/Orthotics</b>	90% after deductible	80% after deductible
<b>Ostomy Supplies</b>	90% after deductible	80% after deductible
<b>Diabetic Education, Training and Supplies</b>	90% after deductible	80% after deductible
<b>Dietician Services</b> 6 visit calendar year maximum	deductible then 100% after \$20 copay	80% after deductible
<b>Neurobiological Disorders/Autism Spectrum Disorder Services</b>	90% after deductible <i>Refer to Plan for ABA limitations</i>	80% after deductible <i>Refer to Plan for ABA limitations</i>
<b>LASIK Surgery</b>	90% after deductible	80% after deductible
<b>Hearing Aids</b> Payable once every 36 months	90% after deductible	80% after deductible
<b>Accident Only Dental Services</b>	90% after deductible	80% after deductible
<b>Mental Disorders/Substance Abuse</b>		
Inpatient	90% after deductible	80% after deductible
Partial Hospitalization/IOP	90% after deductible	80% after deductible
Outpatient	100% after \$20 copay	80% after deductible
<b>Human Organ Transplant</b>	90% after deductible	80% after deductible
<b>Infertility Counseling and Treatment</b> Limited benefits	90% after deductible	80% after deductible
<b>Pregnancy</b> Dependent daughters included	90% after deductible	80% after deductible

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	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
<b>PREVENTIVE CARE</b>		
<b>Routine Well Adult Care*</b>	100% not subject to deductible	80% after deductible
<i>Screening Tests</i>	Standard Preventive tests Cholesterol, High Blood Pressure, Diabetic, routine physical examination, prostate (PSA), Cologuard, x-rays, laboratory tests, vision tests, STI and HIV screening and counseling, tobacco cessation program, colonoscopies, bone density scans, stress tests and sigmoidoscopies.	
	<a href="#">Preventive health services   HealthCare.gov</a>	
<i>Immunizations</i>	Hepatitis A, Hepatitis B, HIB, HPV, MMR, HIV, DTP, Shingles and Flu Shots.	
	<a href="#">Recommended Adult Immunization Schedule (cdc.gov)</a>	
<i>Women's Preventive</i>	Mammography, Thermography (3D) gynecological exam, PAP, HPV screening, pregnancy related screenings, breast feeding support and supplies, Contraceptive coverage (prescriptions subject to prescription plan copayment.)	
	<a href="#">Preventive care benefits for women   HealthCare.gov</a>	
<b>Routine Well Child Care*</b>	100% not subject to deductible	80% after deductible
<i>Screening Tests</i>	Standard Preventive tests, routine physical examination, x- rays, laboratory tests, vision tests, newborn hearing screening, developmental screening.	
	<a href="#">Preventive care benefits for children   HealthCare.gov</a>	
<i>Immunizations</i>	DTaP, HIB, Hepatitis A, Hepatitis B, HPV, RV, IPV, MCV, PCV, Flu Shots.	
	<a href="#">Combined Recommended Immunization Schedule for Persons Aged 0 - 18 years (cdc.gov)</a>	
	<a href="#">Recommended Immunizations for Children from 7 - 18 Years Old (cdc.gov)</a>	
<i>Pediatric Vision</i>	For dependents under age 19: 1 exam, 1 pair of glasses or contacts, 1 frame per calendar year	
*Other preventive care and services required by applicable law if provided by a Network Provider.		
*Preventive Care and Screening Services and Immunizations for children, adolescents and adults that: -- have a rating of A or B in the current United States Preventive Services Task Force recommendations, or -- are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or -- are provided for in comprehensive guidelines supported by the Health Resources and Services Admin., with respect to the individual --are included in the Women's Preventive Services outline by the Dept. of Health and Human Services Please consult the recommendations and guidelines for age, frequency and other guidelines. You may also call 800-229-2210 to obtain a no-cost paper copy from Blue Water Benefits Administrators		
Frequency limits for routine mammogram: Ages 40 and over Limited to one (1) per Calendar Year; and limited to the maximum allowed under designated state limits.		
Frequency limits for pap smear (Cytologic Screenings): One (1) per Calendar Year		
Frequency limits for Colon/Rectal exam, Colonoscopy, Cologuard, and Prostate Screening: Ages 45 and over Limited to one (1) per Calendar Year		
Frequency limits for Routine Vision exam: One (1) per every Calendar Year		
Frequency limits for Routine Hearing exam: One (1) per every Calendar Year		

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**PRESCRIPTION BENEFITS**  
**OptumRx through Blue Cross Blue Shield**

**RX Plan 1**

	<b>Retail 30 day Supply</b>	<b>Retail 90 day Supply</b>	<b>Mail Service 90 day Supply</b>
<b>Generic Drugs</b>	\$5 copayment	\$10 copayment	\$10 copayment
<b>Formulary Drugs</b>	\$20 copayment	\$40 copayment	\$40 copayment
<b>Non-Formulary Drugs</b>	\$40 copayment	\$80 copayment	\$80 copayment

Specialty Drugs limited to 30 day supply and applicable copay.

**UTILIZATION REVIEW SERVICES PHONE NUMBER**

**AMERICAN HEALTH HOLDINGS**  
**(800) 641-5566**  
[bluewaterbenefits.ahhinc.com](http://bluewaterbenefits.ahhinc.com)



**Note: The following services must be certified or reimbursement from the Plan may be reduced**

- All hospital admissions and Inpatient confinements (including partial hospitalization programs for mental health). Inpatient Maternity stays do not require precertification as long as the member's care does not exceed Federal mandated inpatient requirements: Vaginal Delivery: 48 hours or Cesarean Section Delivery: 96 hours
- Skilled Nursing and Sub-Acute facility admissions and confinements
- Inpatient and Outpatient Surgical Procedures

**THIS PLAN UTILIZES THE BLUE CROSS BLUE SHIELD of MICHIGAN NETWORK.  
BLUE CROSS BLUE SHIELD HAS MULTIPLE NETWORKS.**

**THIS PLAN IS PAIRED WITH BLUE CROSS BLUE SHIELD of MICHIGAN NETWORK.  
BENEFITS ARE NOT INSURED BY BLUE CROSS BLUE SHIELD OR ITS AFFILIATES.**

**BCBS PROVIDERS FILE CLAIMS WITH THE LOCAL BCBS PLAN.  
FOR MEDICARE CLAIMS, BILL MEDICARE.**

**BLUE CROSS BLUE SHIELD OF MICHIGAN  
600 E LAFAYETTE BLVD  
DETROIT MI 48226-2998**

**A nonprofit corporation and independent licensee of the Blue Cross and  
Blue Shield Association.**

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