# 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 |
|---|---|---|
| **MAXIMUM LIFETIME BENEFIT AMOUNT** | UNLIMITED | |
| **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.** | | |
| **DEDUCTIBLE, PER CALENDAR YEAR (Embedded)** | | |
| Per Covered Person | $500 | $1,000 |
| Per Family Unit | $1,000 | $2,000 |
| **COPAYMENTS** | | |
| Physician Visit | $20 | Not Applicable |
| Urgent Care | $20 | Not Applicable |
| Emergency Room | $200 | $200 |
| **COINSURANCE, PER CALENDAR YEAR (Embedded)** – Does not include deductible | | |
| Per Covered Person | $1,500 | $2,000 |
| Per Family Unit | $3,000 | $4,000 |
| **MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR** **Including Deductible, Coinsurance and Medical and Prescription Copays** | | |
| Per Covered Person | $6,350 | $12,700 |
| Per Family Unit | $12,700 | $25,400 |
| **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%** | | |
| **COVERED CHARGES** ***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.*** | | |
| **Hospital Services** | | |
| 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 Provider and Facility Charges | 100% after $20 copay | 80% after deductible |
| **Skilled Nursing Facility** 100 day calendar year maximum | 90% after deductible | 80% after deductible |
| **Diagnostic Services** | | |
| Endoscopic Services | 90% after deductible | 80% after deductible |
| Diagnostic Services (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 |
|---|---|---|
| **Physician Services** | | |
| 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 |
| **Inpatient Prescription Drugs** | 90% after deductible | 80% after deductible |
| **Home Health Care** | 90% after deductible | 80% after deductible |
| **Private Duty Nursing** | 90% after deductible | 80% after deductible |
| **Hospice Care** | 90% after deductible | 80% after deductible |
| Bereavement Counseling | 90% after deductible | 80% after deductible |
| **Ambulance Service** (Emergency) | 90% after deductible | |
| **Wig After Chemotherapy** | 90% after deductible | 80% after deductible |
| **Temporomandibular Services** | 90% after deductible | 80% after deductible |
| **Spinal Manipulation/Chiropractic** 30 visit calendar year maximum | deductible then 90% after $20 copay | 80% after deductible |
| **Speech Therapy** 30 visit calendar year maximum | *All therapies In Office setting:* deductible then 100% after $20 copay *All therapies In Facility setting:* 90% after deductible | 80% after deductible |
| **Physical and Occupational Therapy** 30 visit calendar year maximum combined | | 80% after deductible |
| **Cardiac Rehabilitation** | 90% after deductible | 80% after deductible |
| **Pulmonary Rehabilitation** | 90% after deductible | 80% after deductible |
| **Durable Medical Equipment** | 100% after deductible | 80% after deductible |
| **Prosthetics** | 100% after deductible | 80% after deductible |
| **Orthotics** | 90% after deductible | 80% after deductible |
| **Ostomy Supplies** | 90% after deductible | 80% after deductible |
| **Diabetic Education, Training and Supplies** | 90% after deductible | 80% after deductible |
| **Dietician Services** 6 visit calendar year maximum | deductible then 100% after $20 copay | 80% after deductible |
| **Neurobiological Disorders/Autism Spectrum Disorder Services** | 90% after deductible *Refer to Plan for ABA limitations* | 80% after deductible *Refer to Plan for ABA limitations* |
| **LASIK Surgery** | 90% after deductible | 80% after deductible |
| **Hearing Aids** Payable once every 36 months | 100% after deductible | 80% after deductible |
| **Accident Only Dental Services** | 90% after deductible | 80% after deductible |
| **Mental Disorders/Substance Abuse** | | |
| Inpatient | 100% after deductible | 80% after deductible |
| Partial Hospitalization/IOP | 90% after deductible | 80% after deductible |
| Outpatient | 100% after $20 copay | 80% after deductible |
| **Human Organ Transplant** | 90% after deductible | 80% after deductible |
| **Infertility Counseling and Treatment** Limited benefits | 90% after deductible | 80% after deductible |
| **Pregnancy** Dependent daughters included | 90% after deductible | 80% after deductible |

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| | NETWORK PROVIDERS | NON-NETWORK PROVIDERS |
|---|---|---|
| **PREVENTIVE CARE** | | |
| **Routine Well Adult Care*** | 100% not subject to deductible | 80% after deductible |
| *Screening Tests* | 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. | |
| | Preventive health services \| HealthCare.gov | |
| *Immunizations* | Hepatitis A, Hepatitis B, HIB, HPV, MMR, HIV, DTP, Shingles and Flu Shots. | |
| | Recommended Adult Immunization Schedule (cdc.gov) | |
| *Women's Preventive* | Mammography, Thermography (3D) gynecological exam, PAP, HPV screening, pregnancy related screenings, breast feeding support and supplies, Contraceptive coverage (prescriptions subject to prescription plan copayment.) | |
| | Preventive care benefits for women \| HealthCare.gov | |
| **Routine Well Child Care*** | 100% not subject to deductible | 80% after deductible |
| *Screening Tests* | Standard Preventive tests, routine physical examination, x- rays, laboratory tests, vision tests, newborn hearing screening, developmental screening. | |
| | Preventive care benefits for children \| HealthCare.gov | |
| *Immunuizations* | DTaP, HIB, Hepatitis A, Hepatitis B, HPV, RV, IPV, MCV, PCV, Flu Shots. | |
| | Combined Recommended Immunization Schedule for Persons Aged 0 - 18 years (cdc.gov)<br>Recommended Immunizations for Children from 7 - 18 Years Old (cdc.gov) | |
| *Pediatric Vision* | For dependents under age 19:<br>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 RX Plan 1

**OptumRx through Blue Cross Blue Shield**

| | Retail 30 day Supply | Retail 90 day Supply | Mail Service 90 day Supply |
|---|---|---|---|
| **Generic Drugs** | $5 copayment | $10 copayment | $10 copayment |
| **Formulary Drugs** | $20 copayment | $40 copayment | $40 copayment |
| **Non-Formulary Drugs** | $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

**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**
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