Coalition of Public Safety Employees Health Trust

Michigan State Troopers Plan 3

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	$250	$500
Per Family Unit	$500	$1,000
COPAYMENTS		
Physician Visit	$10	Not Applicable
Urgent Care	$10	Not Applicable
Emergency Room	$100	$100
COINSURANCE, PER CALENDAR YEAR (Embedded) – Does not include Deductible		
Per Covered Person	$500	$1,000
Per Family Unit	$1,000	$2,000
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	100% after deductible the semiprivate room rate	80% after deductible the semiprivate room rate
Intensive Care Unit	100% after deductible Hospital's ICU Charge	80% after deductible Hospital's ICU Charge
Emergency Room Facility Charges	100% after $100 copay	
Emergency Room Provider Charges	100% after deductible	
Urgent Care Center	100% after $10 copay	80% after deductible
Skilled Nursing Facility 100 day calendar year maximum	100% after deductible	80% after deductible
Diagnostic Services		
Endoscopic Services	100% after deductible	80% after deductible
Diagnostic Services (Laboratory, X-rays, Medical Tests)	100% after $10 copay	80% after deductible
Diagnostic Services (CT, MRI/MRA, Nuclear Medicine)	deductible then 100% after $10 copay	80% after deductible

THIS PLAN UTILIZES THE BLUE CROSS BLUE SHIELD of MICHIGAN NETWORK

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Physician Services		
Inpatient visits	100% after deductible	80% after deductible
Office visits	100% after $10 copay	80% after deductible
Virtual visits	100% after $10 copay	80% after deductible
Surgery in Office	100% after $10 copay	80% after deductible
Surgery in Facility	100% after deductible	80% after deductible
Allergy testing serum and injections	deductible then 100% after $10 copay	80% after deductible
Inpatient Prescription Drugs	100% after deductible	80% after deductible
Home Health Care	90% after deductible	80% after deductible
Private Duty Nursing In Home	90% after deductible	80% after deductible
Hospice Care	90% after deductible	80% after deductible
Bereavement Counseling	100% after deductible	80% after deductible
Ambulance Service (Emergency)	100% not subject to deductible	
Wig After Chemotherapy	100% after deductible	80% after deductible
Temporomandibular Services	100% after deductible	80% after deductible
Spinal Manipulation/Chiropractic 30 visit calendar year maximum	deductible then 100% after $10 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	100% after deductible	80% after deductible
Pulmonary Rehabilitation	100% after deductible	80% after deductible
Durable Medical Equipment	90% after deductible	80% after deductible
Prosthetics/Orthotics	90% after deductible	80% after deductible
Ostomy Supplies	100% after deductible	80% after deductible
Diabetic Education, Training and Supplies	100% after deductible	80% after deductible
Dietician Services 6 visit calendar year maximum	deductible then 100% after $10 copay	80% after deductible
Neurobiological Disorders/Autism Spectrum Disorder Services	100% after deductible *Refer to Plan for ABA limitations*	80% after deductible *Refer to Plan for ABA limitations*
LASIK Surgery	100% after deductible	80% after deductible
Hearing Aids Payable once every 36 months	100% after deductible	80% after deductible
Accident Only Dental Services	100% after deductible	80% after deductible
Mental Disorders/Substance Abuse		
Inpatient	100% after deductible	80% after deductible
Partial Hospitalization/IOP	100% after deductible	80% after deductible
Outpatient	100% after $10 copay	80% after deductible
Human Organ Transplant	100% after deductible	80% after deductible
Infertility Counseling and Treatment Limited benefits	100% after deductible	80% after deductible
Pregnancy Dependent daughters included	100% not subject to 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) Recommended Immunizations for Children from 7 - 18 Years Old (cdc.gov)	
Pediatric Vision	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 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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