

MICHIGAN SENATE MEDICAL BENEFIT COMPARISON

January 1, 2025 – December 31, 2025 Plan Year

Listed below are some of the benefits provided by the Michigan Senate’s medical plan. **Only in-network costs are shown.** This list is not comprehensive; the plan covers more than is listed below. Please refer to the plan documents for additional information. In the event of any inconsistency between this information and any federal or state law or regulation, policy, written plan document or agreement, the provisions of the relevant law, policy, plan document or agreement will govern.

ITEM	BCBSM PPO COMMUNITY BLUE PPO 1	BCBSM HDHP SIMPLY BLUE WITH HSA – WITH SENATE CONTRIBUTION	BCBSM HDHP SIMPLY BLUE WITH HSA – WITHOUT SENATE CONTRIBUTION
	IN-NETWORK PROVIDERS	IN-NETWORK PROVIDERS	IN-NETWORK PROVIDERS
Annual Deductible One Person Two Person/Family	\$100 \$200	\$1,650 \$3,300	\$1,650 \$3,300
Annual Coinsurance One Person Two Person/Family	10% to \$100 10% to \$200	-0- -0-	-0- -0-
Employee Premium One Person Two Person Family	Biweekly Payroll Deduction \$71.46 \$171.50 \$214.40	Biweekly Payroll Deduction \$38.44 \$90.40 \$110.71	Biweekly Payroll Deduction \$16.23 \$38.95 \$48.69
BCBSM Annual Out-of- Pocket Maximum (OOPM) One Person Two Person/Family	Including Copayments \$6,350 \$12,700	Including Pharmacy Copayments \$2,250 \$4,500	Including Pharmacy Copayments \$2,250 \$4,500
The BCBSM Annual Out-of-Pocket Maximum includes the deductible, coinsurance, and flat dollar copayments. This calculated maximum does not include the annual employee premium.			
WHEN YOU GO TO THE HOSPITAL, YOU PAY...			
Hospital Pre-Certification	Required of Physician – No Penalty to Insured		
Hospital Room & Board	10% after deductible	-0- after deductible	-0- after deductible
In-Patient Surgery	10% after deductible	-0- after deductible	-0- after deductible
In-Patient Psychiatric & Substance Abuse	10% after deductible	-0- after deductible	-0- after deductible
Emergency Room	\$75 copayment – Waived if admitted or accidental injury	-0- after deductible	-0- after deductible
Urgent Care	\$20 copayment	-0- after deductible	-0- after deductible
Diagnostic X-Ray & Lab	10% after deductible	-0- after deductible	-0- after deductible
Therapeutic Radiology	10% after deductible	-0- after deductible	-0- after deductible
WHEN YOU GO TO THE DOCTOR'S OFFICE, YOU PAY...			
Doctor Office Visits	\$20 copayment	-0- after deductible	-0- after deductible
Outpatient & Home Visits	10% after deductible	-0- after deductible	-0- after deductible
Second Surgical Opinion	\$20 copayment	-0- after deductible	-0- after deductible
Pre & Post Natal Care	\$0 copayment	-0- after deductible	-0- after deductible
Allergy Testing & Therapy	-0-	-0- after deductible	-0- after deductible
Chiropractic Care	\$20 copayment 24 visits per year	-0- after deductible 24 visits per year	-0- after deductible 24 visits per year
Outpatient Surgery	10% after deductible	-0- after deductible	-0- after deductible
Outpatient Mental Health & Substance Abuse	10% after deductible	-0- after deductible	-0- after deductible
Autism Benefits	10% after deductible	-0- after deductible	-0- after deductible
Autism Therapy Benefits	90 visits per year	90 visits per year	90 visits per year

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	IN-NETWORK PROVIDERS	IN-NETWORK PROVIDERS	IN-NETWORK PROVIDERS
WHEN YOU RECEIVE PREVENTIVE SERVICES, YOU PAY...			
Routine Physical Exam	-0-	-0-	-0-
Routine GYN Exam	-0-	-0-	-0-
Well Child Care	-0-	-0-	-0-
Immunizations	-0-	-0-	-0-
Routine Pap Smear	-0-	-0-	-0-
Routine Mammogram & 3D Mammogram	-0-	-0-	-0-
Routine Colonoscopy With Diagnosis	-0- 10% after deductible	-0- -0- after deductible	-0- -0- after deductible
WHEN YOU RECEIVE THESE OTHER SERVICES, BCBSM PAYS...			
Fertility Services (Including medical evaluation, diagnostic services, and assisted reproductive technology treatment)	Lifetime maximum of \$25,000 per contract (after deductible) for covered professional fertility services Please see the BCBSM plan summary for specific plan details and any applicable restrictions.	Lifetime maximum of \$25,000 per contract (after deductible) for covered professional fertility services Please see the BCBSM plan summary for specific plan details and any applicable restrictions.	Lifetime maximum of \$25,000 per contract (after deductible) for covered professional fertility services Please see the BCBSM plan summary for specific plan details and any applicable restrictions.
WHEN YOU RECEIVE THESE OTHER SERVICES, YOU PAY...			
Physical/Occupational Therapy	10% after deductible 90 visits per calendar year	-0- after deductible 90 visits per calendar year	-0- after deductible 90 visits per calendar year
Ambulance Services	10% after deductible	-0- after deductible	-0- after deductible
Durable Medical Equip	10% after deductible	-0- after deductible	-0- after deductible
Prosthetics & Orthotics	10% after deductible	-0- after deductible	-0- after deductible
Hearing Exam	-0-	-0- after deductible	-0- after deductible
Hearing Aids	-0- Every 36 months up to \$2,500 monaural/\$5,000 binaural covered	-0- Every 36 months after deductible up to \$2,500 monaural/\$5,000 binaural covered	-0- Every 36 months after deductible up to \$2,500 monaural/\$5,000 binaural covered
Retail Prescriptions: Generic Preferred Brand Nonpreferred Brand	30-day supply \$10 copayment \$40 copayment \$80 copayment	30-day supply \$10 copayment after deductible \$40 copayment after deductible \$80 copayment after deductible	30-day supply \$10 copayment after deductible \$40 copayment after deductible \$80 copayment after deductible
Mail Order Prescriptions: Generic Preferred Brand Nonpreferred Brand	90-day supply \$10 copayment \$40 copayment \$80 copayment	90-day supply \$20 copayment after deductible \$80 copayment after deductible \$160 copayment after deductible	90-day supply \$20 copayment after deductible \$80 copayment after deductible \$160 copayment after deductible