MICHIGAN SENATE MEDICAL BENEFIT COMPARISON
January 1, 2026 - December 31, 2026 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 what 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.

EMPLOYEE MEDICAL PREMIUMS – 2026 BIWEEKLY PAYROLL DEDUCTIONS			
COVERAGE LEVEL	**BCBSM PPO COMMUNITY BLUE PPO 1**	**BCBSM HDHP SIMPLY BLUE WITH HSA –** WITH SENATE CONTRIBUTION	**BCBSM HDHP SIMPLY BLUE WITH HSA –** WITHOUT SENATE CONTRIBUTION
One Person	$81.91	$53.65	$33.16
Two Person	$196.58	$126.54	$79.58
Family	$245.72	$155.39	$99.47

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	 $250 $500	 $2,000 $4,000	 $2,000 $4,000
Annual Coinsurance & Coinsurance Maximum One Person Two Person/Family	 10% to $250 10% to $500	 N/A N/A	 N/A N/A
BCBSM Annual Out-of- Pocket Maximum (OOPM) One Person Two Person/Family	**Including Copayments** $6,350 $12,700	**Including Pharmacy Copayments** $3,000 $6,000	**Including Pharmacy Copayments** $3,000 $6,000
The BCBSM Annual Out-of-Pocket Maximum includes the deductible, coinsurance, and flat dollar copayments. This calculated maximum does <u>not</u> 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	$150 copayment – Waived if admitted or accidental injury	-0- after deductible	-0- after deductible
Urgent Care	$50 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

MEDICAL BENEFIT COMPARISON (CONTINUED)

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
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
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 PRESCRIPTION DRUG PROGRAM

RETAIL PRESCRIPTIONS	PRESCRIPTION TIER INFORMATION	30-DAY SUPPLY (IN-NETWORK) BCBSM PPO COMMUNITY BLUE PPO 1	30-DAY SUPPLY (IN-NETWORK) BCBSM HDHP SIMPLY BLUE WITH HSA
Generic	**Tier 1** – Generic drugs have a proven record of safety and effectiveness while offering the best value. Generic drugs require the lowest copayment and are formulary preferred.	$10 copayment	$10 copayment after deductible
Preferred Brand	**Tier 2** – Preferred brand name drugs require a higher copayment than generic drugs since they are essentially a less cost-effective therapy than the generic alternative.	$50 copayment	$50 copayment after deductible
Nonpreferred Brand	**Tier 3** – Nonpreferred brands have the highest out-of-pocket cost since there are more cost-effective preferred brands or generic alternatives available.	$90 copayment	$90 copayment after deductible