



**Blue Cross
Blue Shield
of Michigan**

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

Western Michigan Health Insurance Pool

Group Number: 71565 Package Code(s): 005

Section Code(s): 1010, 1110

Versatile 3 PPO, RX1, Hearing

Effective Date: 07/01/2018

Benefits-at-a-glance

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Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Deductibles - per calendar year | \$250 per member \$500 per family | \$500 per member \$1,000 per family |
| Copays • Fixed Dollar Copays | \$20 copay for : • Office visits | No Copay |
| Coinsurance • Percent Coinsurance | 10% up to a maximum of: \$1,000 per member \$2,000 per family | 30% Note: Services without a network are covered at the in-network level. |
| Annual out-of-pocket maximums | \$2,500 per member \$5,000 per family Includes Deductible, Coinsurance and Copays | \$2,500 per member \$5,000 per family Includes Coinsurance |
| Lifetime dollar maximum | Unlimited | |

Preventive Care Services

| Benefits | In-Network | Out-of-Network |
|---|----------------|--------------------------------|
| Health Maintenance Exam - one per calendar year | Covered - 100% | Not Covered |
| Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam | Covered - 100% | Not Covered |
| Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam | Covered - 100% | Not Covered |
| Pap Smear Screening - one per calendar year | Covered - 100% | Not Covered |
| Mammography Screening - one per calendar year | Covered - 100% | Covered - 70% after deductible |
| Contraceptive Methods and Counseling | Covered - 100% | Not Covered |
| Prostate specific antigen (PSA) screening - one per calendar year | Covered - 100% | Not Covered |
| Endoscopic Exams one per calendar year | Covered - 100% | Covered - 70% after deductible |
| Well Child Care • 8 visits per calendar year, birth through 12 months • 6 visits per calendar year, 13 months through 35 months • 2 visits per calendar year, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit | Covered - 100% | Not Covered |
| Immunizations - pediatric and adult | Covered - 100% | Not Covered |

Physician Office Services

| Benefits | In-Network | Out-of-Network |
|--|---------------------------------|--------------------------------|
| Office Visits | Covered - 100% after \$20 copay | Covered - 70% after deductible |
| Online Visits Note: Services are payable when rendered by American Well or BCBS providers | Covered - 100% after \$20 copay | Covered - 70% after deductible |
| Office Consultations | Covered - 100% after \$20 copay | Covered - 70% after deductible |
| Pre-Surgical Consultations | Covered - 100% | Covered - 70% after deductible |

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Emergency Medical Care

| Benefits | In-Network | Out-of-Network |
|--|--|--|
| Hospital Emergency Room Qualified medical emergency | Covered - \$50 copay then 90% after deductible; copay waived if admitted | Covered - \$50 copay then 90% after deductible; copay waived if admitted |
| Non-Emergency use of the Emergency Room | Covered - \$50 copay then 90% after deductible | Covered - \$50 copay then 70% after deductible |
| Urgent Care Services Facility Professional | Covered - 90% after deductible Covered - 100% after \$20 copay | Covered - 70% after deductible Covered - 70% after deductible |
| Ambulance Services - Medically Necessary Transport | Covered - 90% after deductible | Covered - 90% after deductible |

Diagnostic Services

| Benefits | In-Network | Out-of-Network |
|--|--------------------------------|--------------------------------|
| MRI, MRA, PET and CAT Scans and Nuclear Medicine | Covered - 90% after deductible | Covered - 70% after deductible |
| Diagnostic Tests, X-rays, Laboratory & Pathology | Covered - 90% after deductible | Covered - 70% after deductible |
| Radiation Therapy and Chemotherapy | Covered - 90% after deductible | Covered - 70% after deductible |

Maternity Services Provided by a Physician

| Benefits | In-Network | Out-of-Network |
|------------------------------------|--------------------------------|--------------------------------|
| Prenatal and Postnatal Care Visits | Covered - 100% | Covered - 70% after deductible |
| Delivery and Nursery Care | Covered - 90% after deductible | Covered - 70% after deductible |

Hospital Care

| Benefits | In-Network | Out-of-Network |
|---|--------------------------------|--------------------------------|
| Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies | Covered - 90% after deductible | Covered - 70% after deductible |
| Inpatient Medical Care | Covered - 90% after deductible | Covered - 70% after deductible |

Alternatives to Hospital Care

| Benefits | In-Network | Out-of-Network |
|---|--------------------------------|--------------------------------|
| Hospice Care | Covered - 90% after deductible | Covered - 90% after deductible |
| Home Health Care | Covered - 90% after deductible | Covered - 90% after deductible |
| Skilled Nursing Limited to a maximum of 120 days per calendar year | Covered - 90% after deductible | Covered - 90% after deductible |

Surgical Services

| Benefits | In-Network | Out-of-Network |
|---|--------------------------------|---|
| Surgery (includes related surgical services) | Covered - 90% after deductible | Covered - 70% after deductible |
| Bariatric Surgery | Covered - 90% after deductible | Covered - 70% after deductible |
| Oral Surgery Wisdom teeth extractions | Covered - 90% after deductible | Covered - 90% after in-network deductible |
| Sterilization - males only excludes reversal sterilization | Covered - 90% after deductible | Covered - 70% after deductible |
| Sterilization - females only excludes reversal sterilization | Covered - 100% | Covered - 70% after deductible |

Human Organ Transplants

| Benefits | In-Network | Out-of-Network |
|--|--------------------------------|---|
| Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504) | Covered - 100% | Not covered except in designated facilities |
| Kidney, Cornea, Bone Marrow and Skin | Covered - 90% after deductible | Covered - 70% after deductible |

Behavioral Health Care and Substance Abuse Treatment Services

| Benefits | In-Network | Out-of-Network |
|--|--|--|
| Inpatient Behavioral Health Care | Covered - 90% after deductible | Covered - 70% after deductible |
| Inpatient Substance Abuse Treatment | Covered - 90% after deductible | Covered - 90% after deductible |
| Outpatient Behavioral Health Care • Online Behavioral Health Visits | Covered - 100% after \$20 copay Covered - 100% after \$20 copay | Covered - 70% after deductible Covered - 70% after deductible |
| Outpatient Substance Abuse Treatment | Covered - 100% after \$20 copay | Covered - 90% after deductible |

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

| Benefits | In-Network | Out-of-Network |
|---|--------------------------------|--------------------------------|
| Applied Behavioral Analysis (ABA) Pre-authorization required | Covered - 90% after deductible | Covered - 70% after deductible |
| Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment. | | |
| Physical, Occupational and Speech Therapy | Covered - 90% after deductible | Covered - 70% after deductible |
| Physical, Occupational and Speech therapy with an autism diagnosis is unlimited | | |
| Nutritional Counseling | Covered - 90% after deductible | Covered - 70% after deductible |

Other Covered Services

| Benefits | In-Network | Out-of-Network |
|---|--------------------------------|--------------------------------|
| Cardiac Rehabilitation | Covered - 90% after deductible | Covered - 70% after deductible |
| Chiropractic Spinal Manipulation Limited to a maximum of 24 visits per calendar year | Covered - 90% after deductible | Covered - 70% after deductible |
| Durable Medical Equipment | Covered - 90% after deductible | Covered - 70% after deductible |
| Prosthetic and Orthotic Devices | Covered - 90% after deductible | Covered - 70% after deductible |
| Private Duty Nursing Care | Covered - 90% after deductible | Covered - 90% after deductible |
| Allergy Testing and Therapy | Covered - 90% after deductible | Covered - 70% after deductible |

Therapy Services

| Benefits | In-Network | Out-of-Network |
|---|--------------------------------|--------------------------------|
| Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year | Covered - 90% after deductible | Covered - 70% after deductible |
| Massage Therapy Limited to a maximum of 24 visits per calendar year | Covered - 90% after deductible | Covered - 70% after deductible |

Note: The following services require preapproval: Inpatient Care, select Radiology and Diagnostic Services, Inpatient Behavioral Health Care and Substance Abuse Treatment, and Skilled Nursing.



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Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 005
Section Code(s): 1010, 1110
Prescription Drugs
Effective Date: 07/01/2018
Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

| Benefits | Coverage |
|--|--|
| Retail - 30 day supply | \$10 copay - Generic drugs \$40 copay - Brand drugs \$0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D) Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay. |
| Mail Order - 90 day supply | \$20 copay - Generic drugs \$80 copay - Brand drugs |
| Specialty Drugs – 30 day supply Retail and Mail Order | \$10 copay - Generic drugs \$40 copay - Brand drugs Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill. |
| Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA | Covered - 100% |
| Oral and Injectable Contraceptives Retail and Mail Order | Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance |
| Additional Services | |
| Smoking Cessation Drugs | Covered |
| Weight Loss Drugs | Covered |
| Impotency Drugs | Covered |
| Infertility Drugs | Covered |
| Diabetic Supplies | Not Covered |

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Features of your prescription drug plan

| | |
|--|--|
| Prior authorization/step therapy | A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. Step Therapy , an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at bcbsm.com/pharmacy . |
| Mandatory maximum allowable cost drugs | If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the difference in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug plus your applicable copay regardless of whether you or your physician requests the brand name drug. Exception: If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. Note: This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum. |



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Hearing Care Coverage
Effective Date: 07/01/2018
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Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

| Benefits | Coverage |
|-----------------------------|---|
| Frequency Limitation | Once every 36 months |
| Audiometric Exam | Covered - 100% |
| Hearing Aid Evaluation | Covered - 100% |
| Hearing Aid | Covered - 100% |
| | Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid. |
| Hearing Aid Conformity Test | Covered - 100% |