$1,000/$2,000 DEDUCTIBLE PLAN

PPO Plan 3, RX 14 Benefits-at-a-Glance
Western Michigan Health Insurance Pool

Deductible, Copays, Coinsurance and Dollar Maximum

	In-Network	Out-of-Network
Deductible - per calendar year	$1,000 per member $2,000 per family	$2,000 per member $4,000 per family
Copays • Fixed Dollar Copays	$20 copay for : • Chiropractic spinal manipulations • Office visits $50 copay for : • Facility medical emergency	$50 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	20% up to a maximum of: $2,500 per member $5,000 per family	40% **Note:** Services without a network are covered at the in-network level.
Out-of-Pocket Maximum	$4,500 per member $9,000 per family *Includes Deductible, Coinsurance and Copays*	$7,000 per member $14,000 per family *Includes Coinsurance*
Lifetime Maximum	Unlimited	

Preventive Services

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 - 60% 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 - 60% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 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

Office Visits	Covered - 100% after $20 copay	Covered - 60% after deductible
Office Consultation	Covered - 100% after $20 copay	Covered - 60% after deductible
Pre-Surgical Consultation	Covered - 100%	Covered - 60% after deductible

Emergency Medical Care

Hospital Emergency Room Qualified medical emergency	Covered - 100% after $50 copay; copay waived if admitted or for an accidental injury	Covered - 100% after $50 copay; copay waived if admitted or for an accidental injury
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Urgent Care Services	Covered - 80% after deductible	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

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	In-Network	Out-of-Network
Diagnostic Services		
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 60% after deductible
Maternity Services Provided by a Physician		
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 60% after deductible
Delivery and Nursery Care	Covered - 80% after deductible	Covered - 60% after deductible
Hospital Care		
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible	Covered - 60% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 60% after deductible
Alternatives to Hospital Care		
Hospice Care	Covered - 100%	Covered - 100%
Home Health Care	Covered - 80% after deductible	Covered - 80% after deductible
Skilled Nursing Limited to a maximum of 120 days per calendar year	Covered - 80% after deductible	Covered - 80% after deductible
Surgical Services		
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Bariatric Surgery	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - males only; excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - females only; excludes reversal sterilization	Covered - 100%	Covered - 60% after deductible
Human Organ Transplants		
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 - 80% after deductible	Covered - 60% after deductible
Behavioral Health Care and Substance Abuse Treatment Services		
Inpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Outpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 100% after $20 copay	Covered - 60% after deductible
Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18		
Applied Behavioral Analysis (ABA) Limited to a visit maximum of: 30 units (7.5 hrs per week) birth through age 6 24 units (6 hrs per week) age 7 - 12 18 units (4.5 hrs per week) age 13 - 18	Covered - 80% after deductible	Covered - 60% after deductible
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible
Nutritional Counseling	Covered - 80% after deductible	Covered - 60% after deductible

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	In-Network	Out-of-Network
Other Services		
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 24 visits per calendar year	Covered - 100% after $20 copay	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 60% after deductible
Private Duty Nursing	Covered - 50% after deductible	Covered - 50% after deductible
Allergy Testing and Therapy	Covered - 100%	Covered - 60% after deductible
Therapy Services		
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 80% after deductible	Covered - 60% 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

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control. BCBSM provides administrative claims services only. Your employer is financially responsible for claims.

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Prescription Drugs

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

Retail - 30 day supply	$10 copay - Generic drugs $40 copay - Brand name drugs Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Retail and Mail Order - 90 day supply	$10 copay - Generic drugs $40 copay - Brand name drugs
Specialty Drugs – 30 day supply Retail and Mail Order	$10 copay - Generic drugs $40 copay - Brand name drugs Member 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.
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic drugs; Brand name drugs are subject to the applicable copay/coinsurance
Additional Services Smoking Cessation Drugs Weight Loss Drugs Impotency Drugs Infertility Drugs	 Covered Covered Covered Covered
Diabetic Supplies	Not Covered

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 prior authorization) 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 prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online 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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