Blue Cross Blue Shield of Michigan

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

Versatile 1 PPO, RX1, Hearing Benefits-at-a-Glance Western Michigan Health Insurance Pool

Deductible, Copays, Coinsurance and Dollar Maximums

	In-Network	Out-of-Network
Deductible - per calendar year	$250 per member $500 per family	$500 per member $1,000 per family
Copays • Fixed Dollar Copays	$10 copay for: • Office visits	
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.
Out-of-Pocket Maximum	$6,600 per member $13,200 per family *Includes Deductible, Coinsurance and Copays*	$2,500 per member $5,000 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 no age restrictions	Covered - 100%	Covered - 70% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Covered - 70% after deductible
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– – 6 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

	In-Network	Out-of-Network
Physician Office Services		
Office Visits	Covered - 100% after $10 copay	Covered - 70% after deductible
Emergency Medical Care		
Hospital Emergency Room Qualified medical emergency	Covered -90% after deductible	Covered -90% after deductible
Non-Emergency use of the Emergency Room	Covered - 100% after $25 copay	Covered - 100% after $25 copay
Urgent Care Services	Covered - 90% after deductible	Covered - 70% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 90% after deductible	Covered - 90% after deductible
Diagnostic Services		
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		
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		
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		
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 120 days per calendar year	Covered - 90% after deductible	Covered - 90% after deductible
Surgical Services		
Surgery (includes related surgical services)	Covered - 90% after deductible	Covered - 70% after 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		
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		
Inpatient Behavioral Health	Covered - 90% after deductible	Covered - 70% after deductible
Inpatient Substance Abuse Care	Covered - 90% after deductible	Covered - 90% after deductible
Outpatient Behavioral Health	Covered - 100% after $20 copay	Covered - 70% after deductible
Outpatient Substance Abuse Care	Covered - 100% after $20 copay	Covered - 90% after deductible

	In-Network	Out-of-Network

Autism Spectrum Disorders, Diagnoses and Treatment (up to and including age 18)

Applied behavioral analyses (ABA) Limited to a visit maximum of 25 hours per week Annual ABA benefit maximum per calendar year: • $15,000 – Birth through age 6 • $12,000 – Age 7 - 12 • $ 9,000 – Age 13 – 18	Covered – 90% after deductible	Covered – 70% after deductible
Physical, Occupational and Speech Therapy	Covered – 90% after deductible	Covered – 70% after deductible
Nutritional Counseling	Covered – 90% after deductible	Covered – 70% after deductible

Other Services

Cardiac Rehabilitation	Covered - 90% after deductible	Covered - 70% after deductible
Chiropractic Services Limited to 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	Covered - 90% after deductible	Covered - 90% after deductible
Allergy Therapy and Testing	Covered - 90% after deductible	Covered - 70% after deductible

Therapy Services

Physical, Occupational and Speech Therapy Limited to 60 visits combined 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.

Hearing

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

Frequency Limitation	Once every 36 months
Audiometric Exam	Covered – 100%
Hearing Aid Evaluation	Covered – 100%
Hearing Aid	Covered – 100%
Hearing Aid Conformity Test	Covered – 100%

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 $ 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 name drugs
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

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.

Blue Cross Blue Shield of Michigan

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Versatile 3 PPO, RX1, Hearing
Benefits-at-a-Glance
Western Michigan Health Insurance Pool

Deductible, Copays, Coinsurance and Dollar Maximums

	In-Network	Out-of-Network
Deductible - 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	
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.
Out-of-Pocket Maximum	$6,600 per member $13,200 per family *Includes Deductible, Coinsurance and Copays*	$2,500 per member $5,000 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 no age restrictions	Covered - 100%	Covered - 70% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Covered - 70% after deductible
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– – 6 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

	In-Network	Out-of-Network
Physician Office Services		
Office Visits	Covered - 100% after $20 copay	Covered - 70% after deductible
Emergency Medical Care		
Hospital Emergency Room Qualified medical emergency	Covered -90% after deductible	Covered -90% after deductible
Non-Emergency use of the Emergency Room	Covered - 90% after deductible, after $25 copay	Covered - 70% after deductible, after $25 copay
Urgent Care Services	Covered - 90% after deductible	Covered - 70% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 90% after deductible	Covered - 90% after deductible
Diagnostic Services		
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		
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		
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		
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 120 days per calendar year	Covered - 90% after deductible	Covered - 90% after deductible
Surgical Services		
Surgery (includes related surgical services)	Covered - 90% after deductible	Covered - 70% after 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		
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		
Inpatient Behavioral Health	Covered - 90% after deductible	Covered - 70% after deductible
Inpatient Substance Abuse Care	Covered - 90% after deductible	Covered - 90% after deductible
Outpatient Behavioral Health	Covered - 100% after $20 copay	Covered - 70% after deductible
Outpatient Substance Abuse Care	Covered - 100% after $20 copay	Covered - 90% after deductible

	In-Network	Out-of-Network

Autism Spectrum Disorders, Diagnoses and Treatment (up to and including age 18)

Applied behavioral analyses (ABA) Limited to a visit maximum of 25 hours per week Annual ABA benefit maximum per calendar year: • $15,000 – Birth through age 6 • $12,000 – Age 7 - 12 • $ 9,000 – Age 13 – 18	Covered – 90% after deductible	Covered – 70% after deductible
Physical, Occupational and Speech Therapy	Covered – 90% after deductible	Covered – 70% after deductible
Nutritional Counseling	Covered – 90% after deductible	Covered – 70% after deductible

Other Services

Cardiac Rehabilitation	Covered - 90% after deductible	Covered - 70% after deductible
Chiropractic Services Limited to 24 visits per calendar year	Covered - 90% after deductible	Covered - 90% 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	Covered - 90% after deductible	Covered - 90% after deductible
Allergy Therapy and Testing	Covered - 90% after deductible	Covered - 70% after deductible

Therapy Services

Physical, Occupational and Speech Therapy Limited to 60 visits combined 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.

Hearing

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

Frequency Limitation	Once every 36 months
Audiometric Exam	Covered – 100%
Hearing Aid Evaluation	Covered – 100%
Hearing Aid	Covered – 100%
Hearing Aid Conformity Test	Covered – 100%

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 $ 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 name drugs
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

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.

Blue Cross Blue Shield of Michigan

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Versatile 4 PPO, RX1, Hearing Benefits-at-a-Glance Western Michigan Health Insurance Pool

Deductible, Copays, Coinsurance and Dollar Maximums

	In-Network	Out-of-Network
Deductible - per calendar year	$500 per member $1,000 per family	$1,000 per member $2,000 per family
Copays • Fixed Dollar Copays	$20 copay for: • Office visits	
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.
Out-of-Pocket Maximum	$6,600 per member $13,200 per family *Includes Deductible, Coinsurance and Copays*	$3,000 per member $6,000 per family *Includes Deductible and 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 no age restrictions	Covered - 100%	Covered - 70% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Covered - 70% after deductible
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– – 6 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

	In-Network	Out-of-Network
Physician Office Services		
Office Visits	Covered - 100% after $20 copay	Covered - 70% after deductible
Emergency Medical Care		
Hospital Emergency Room Qualified medical emergency	Covered -90% after deductible	Covered -90% after deductible
Non-Emergency use of the Emergency Room	Covered - 90% after deductible, after $25 copay	Covered - 70% after deductible, after $25 copay
Urgent Care Services	Covered - 90% after deductible	Covered - 70% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 90% after deductible	Covered - 90% after deductible
Diagnostic Services		
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		
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		
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		
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 120 days per calendar year	Covered - 90% after deductible	Covered - 90% after deductible
Surgical Services		
Surgery (includes related surgical services)	Covered - 90% after deductible	Covered - 70% after 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		
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		
Inpatient Behavioral Health	Covered - 90% after deductible	Covered - 70% after deductible
Inpatient Substance Abuse Care	Covered - 90% after deductible	Covered - 90% after deductible
Outpatient Behavioral Health	Covered - 100% after $20 copay	Covered - 70% after deductible
Outpatient Substance Abuse Care	Covered - 100% after $20 copay	Covered - 90% after deductible

	In-Network	Out-of-Network

Autism Spectrum Disorders, Diagnoses and Treatment (up to and including age 18)

Applied behavioral analyses (ABA) Limited to a visit maximum of 25 hours per week Annual ABA benefit maximum per calendar year: • $15,000 – Birth through age 6 • $12,000 – Age 7 - 12 • $ 9,000 – Age 13 – 18	Covered – 90% after deductible	Covered – 70% after deductible
Physical, Occupational and Speech Therapy	Covered – 90% after deductible	Covered – 70% after deductible
Nutritional Counseling	Covered – 90% after deductible	Covered – 70% after deductible

Other Services

Cardiac Rehabilitation	Covered - 90% after deductible	Covered - 70% after deductible
Chiropractic Services Limited to 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	Covered - 90% after deductible	Covered - 90% after deductible
Allergy Therapy and Testing	Covered - 90% after deductible	Covered - 70% after deductible

Therapy Services

Physical, Occupational and Speech Therapy Limited to 60 visits combined 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.

Hearing

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

Frequency Limitation	Once every 36 months
Audiometric Exam	Covered – 100%
Hearing Aid Evaluation	Covered – 100%
Hearing Aid	Covered – 100%
Hearing Aid Conformity Test	Covered – 100%

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 $ 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 name drugs
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

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Flexible Blue 2, RX6
Benefits-at-a-Glance
Western Michigan Health Insurance Pool

	In-Network	Out-of-Network
Deductible, Copays, Coinsurance and Dollar Maximums		
Deductible - per calendar year *(The family deductible can be met by one person on contracts of 2 or more people)*	$1,300 per member $2,600 per family	$2,500 per member $5,000 per family
Copays • Fixed Dollar Copays	No Copay	No Copay
Coinsurance • Percent Coinsurance	0%	20% **Note**: Services without a network are covered at the in-network level.
Out-of-Pocket Maximum	$2,250 per member $4,500 per family *Includes Deductible and RX copays*	$4,500 per member $9,000 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 no age restrictions	Covered - 100%	Covered - 80% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Covered - 80% after deductible
Prostate Specific Antigen (PSA) Screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 80% after deductible
Well Child Care– – 6 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

	In-Network	Out-of-Network
Physician Office Services		
Office Visits	Covered - 100% after deductible	Covered - 80% after deductible
Emergency Medical Care		
Hospital Emergency Room Qualified medical emergency	Covered -100% after deductible	Covered -100% after deductible
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Urgent Care Services	Covered - 100% after deductible	Covered - 80% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 100% after deductible	Covered - 100% after deductible
Diagnostic Services		
MRI,MRA, PET and CAT Scans and Nuclear Medicine	Covered - 100% after deductible	Covered - 80% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 100% after deductible	Covered - 80% after deductible
Radiation Therapy and Chemotherapy	Covered - 100% after deductible	Covered - 80% after deductible
Maternity Services Provided by a Physician		
Prenatal Care Visits	Covered - 100%	Covered - 80% after deductible
Postnatal Care Visits	Covered - 100% after deductible	Covered - 80% after deductible
Delivery and Nursery Care	Covered - 100% after deductible	Covered - 80% after deductible
Hospital Care		
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 100% after deductible	Covered - 80% after deductible
Inpatient Medical Care	Covered - 100% after deductible	Covered - 80% after deductible
Alternatives to Hospital Care		
Hospice Care	Covered - 100% after deductible	Covered - 100% after deductible
Home Health Care	Covered - 100% after deductible	Covered - 100% after deductible
Skilled Nursing Limited to 90 days per calendar year	Covered - 100% after deductible	Covered - 100% after deductible
Surgical Services		
Surgery (includes related surgical services)	Covered - 100% after deductible	Covered - 80% after deductible
Sterilization - males only; excludes reversal sterilization	Covered - 100% after deductible	Covered - 80% after deductible
Sterilization - females only; excludes reversal sterilization	Covered - 100%	Covered - 80% 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% after deductible	Covered - 80% after deductible
Kidney, Cornea, Bone Marrow and Skin	Covered - 100% after deductible	Covered - 80% after deductible
Behavioral Health Care and Substance Abuse Treatment Services		
Inpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 100% after deductible	Covered - 80% after deductible
Outpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 100% after deductible	Covered - 80% after deductible

	In-Network	Out-of-Network

Autism Spectrum Disorders, Diagnoses and Treatment (up to and including age 18)

Applied behavioral analyses (ABA) Limited to a visit maximum of 25 hours per week Annual ABA benefit maximum per calendar year: • $15,000 – Birth through age 6 • $12,000 – Age 7 - 12 • $ 9,000 – Age 13 – 18	Covered – 100% after deductible	Covered – 80% after deductible
Physical, Occupational and Speech Therapy	Covered – 100% after deductible	Covered – 80% after deductible
Nutritional Counseling	Covered – 100% after deductible	Covered – 80% after deductible

Other Services

Cardiac Rehabilitation	Covered - 100% after deductible	Covered - 80% after deductible
Chiropractic Services Limited to 24 visits per calendar year	Covered - 100% after deductible	Covered - 80% after deductible
Durable Medical Equipment	Covered - 100% after deductible	Covered - 80% after deductible
Prosthetic and Orthotic Devices	Covered - 100% after deductible	Covered - 80% after deductible
Private Duty Nursing	Covered - 100% after deductible	Covered - 80% after deductible
Allergy Therapy and Testing	Covered - 100% after deductible	Covered - 80% after deductible

Therapy Services

Physical, Occupational and Speech Therapy Limited to 60 visits combined per calendar year	Covered - 100% after deductible	Covered - 80% 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

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.

Deductible *(The family deductible can be met by one person on contracts of 2 or more people)*	$1,300 per individual $2,600 per family
Retail- 30 day supply	$10 copay - Generic drugs $40 copay - Brand name 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 80% of the approved amount, less the member's copay.
Mail Order - 90 day supply	$20 copay - Generic drugs $80 copay - Brand name drugs
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

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Blue Cross Blue Shield of Michigan

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

Flexible Blue 3, RX7
Benefits-at-a-Glance
Western Michigan Health Insurance Pool

Deductible, Copays, Coinsurance and Dollar Maximums

	In-Network	Out-of-Network
Deductible - per calendar year *(The family deductible can be met by one person on contracts of 2 or more people)*	$2,000 per member $4,000 per family	$4,000 per member $8,000 per family
Copays • Fixed Dollar Copays	No Copay	No Copay
Coinsurance • Percent Coinsurance	0%	20% **Note**: Services without a network are covered at the in-network level.
Out-of-Pocket Maximum	$3,000 per member $6,000 per family *Includes Deductible, and RX Copays*	$6,000 per member $12,000 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 no age restrictions	Covered - 100%	Covered - 80% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Covered - 80% after deductible
Prostate Specific Antigen (PSA) Screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 80% after deductible
Well Child Care– – 6 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

	In-Network	Out-of-Network
Physician Office Services		
Office Visits	Covered - 100% after deductible	Covered - 80% after deductible
Emergency Medical Care		
Hospital Emergency Room Qualified medical emergency	Covered -100% after deductible	Covered -100% after deductible
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Urgent Care Services	Covered - 100% after deductible	Covered - 80% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 100% after deductible	Covered - 100% after deductible
Diagnostic Services		
MRI,MRA, PET and CAT Scans and Nuclear Medicine	Covered - 100% after deductible	Covered - 80% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 100% after deductible	Covered - 80% after deductible
Radiation Therapy and Chemotherapy	Covered - 100% after deductible	Covered - 80% after deductible
Maternity Services Provided by a Physician		
Prenatal Care Visits	Covered - 100%	Covered - 80% after deductible
Postnatal Care Visits	Covered - 100% after deductible	Covered - 80% after deductible
Delivery and Nursery Care	Covered - 100% after deductible	Covered - 80% after deductible
Hospital Care		
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 100% after deductible	Covered - 80% after deductible
Inpatient Medical Care	Covered - 100% after deductible	Covered - 80% after deductible
Alternatives to Hospital Care		
Hospice Care	Covered - 100% after deductible	Covered - 100% after deductible
Home Health Care	Covered - 100% after deductible	Covered - 100% after deductible
Skilled Nursing Limited to 90 days per calendar year	Covered - 100% after deductible	Covered - 100% after deductible
Surgical Services		
Surgery (includes related surgical services)	Covered - 100% after deductible	Covered - 80% after deductible
Sterilization - males only; excludes reversal sterilization	Covered - 100% after deductible	Covered - 80% after deductible
Sterilization - females only; excludes reversal sterilization	Covered - 100%	Covered - 80% 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% after deductible	Covered - 80% after deductible
Kidney, Cornea, Bone Marrow and Skin	Covered - 100% after deductible	Covered - 80% after deductible
Behavioral Health Care and Substance Abuse Treatment Services		
Inpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 100% after deductible	Covered - 80% after deductible
Outpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 100% after deductible	Covered - 80% after deductible

	In-Network	Out-of-Network

Autism Spectrum Disorders, Diagnoses and Treatment (up to and including age 18)

Applied behavioral analyses (ABA) Limited to a visit maximum of 25 hours per week Annual ABA benefit maximum per calendar year: • $15,000 – Birth through age 6 • $12,000 – Age 7 - 12 • $ 9,000 – Age 13 – 18	Covered – 100% after deductible	Covered – 80% after deductible
Physical, Occupational and Speech Therapy	Covered – 100% after deductible	Covered – 80% after deductible
Nutritional Counseling	Covered – 100% after deductible	Covered – 80% after deductible

Other Services

Cardiac Rehabilitation	Covered - 100% after deductible	Covered - 80% after deductible
Chiropractic Services Limited to 24 visits per calendar year	Covered - 100% after deductible	Covered - 80% after deductible
Durable Medical Equipment	Covered - 100% after deductible	Covered - 80% after deductible
Prosthetic and Orthotic Devices	Covered - 100% after deductible	Covered - 80% after deductible
Private Duty Nursing	Covered - 80% after deductible	Covered - 80% after deductible
Allergy Therapy and Testing	Covered - 100% after deductible	Covered - 80% after deductible

Therapy Services

Physical, Occupational and Speech Therapy Limited to 60 visits combined per calendar year	Covered - 100% after deductible	Covered - 80% after deductible

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