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

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 or plan sponsor is financially responsible for claims.

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

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	Covered - 90% after deductible	Covered - 70% after deductible
Professional	Covered - 100% after $20 copay	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 **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.	Covered - 90% after deductible	Covered - 70% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 90% after deductible	Covered - 70% after deductible
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.

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

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 or plan sponsor is financially responsible for claims.

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

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.

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

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 or plan sponsor is financially responsible for claims.

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%

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 029
Section Code(s): 1020, 1120, 1200
PPO Plan 3, RX 14
Effective Date: 01/01/2018
Benefits-at-a-glance

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 or plan sponsor is financially responsible for claims.

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

Benefits	In-Network	Out-of-Network
Deductibles - 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.
Annual out-of-pocket maximums	$4,500 per member $9,000 per family Includes Deductible, Coinsurance and Copays	$7,000 per member $14,000 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 - 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 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 - 60% after deductible
Online Visits Note: Services are payable when rendered by American Well or BCBS providers	Covered - 100% after $20 copay	Covered - 60% after deductible
Office Consultations	Covered - 100% after $20 copay	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 100%	Covered - 60% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $50 copay; copay waived if admitted	Covered - 100% after $50 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Urgent Care Services		
Facility	Covered - 80% after deductible	Covered - 60% after deductible
Professional	Covered - 100% after $20 copay	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
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

Benefits	In-Network	Out-of-Network
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

Benefits	In-Network	Out-of-Network

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

Benefits	In-Network	Out-of-Network
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

Benefits	In-Network	Out-of-Network
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

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 - 80% after deductible	Covered - 60% after deductible

Behavioral Health Care and Substance Abuse Treatment Services

Benefits	In-Network	Out-of-Network
Inpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Outpatient Behavioral Health Care and Substance Abuse Treatment • Online Behavioral Health Visits	Covered - 100% after $20 copay Covered - 100% after $20 copay	Covered - 60% after deductible Covered - 60% 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 **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.	Covered - 80% after deductible	Covered - 60% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 80% after deductible	Covered - 60% after deductible
Nutritional Counseling	Covered - 80% after deductible	Covered - 60% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
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 Care	Covered - 50% after deductible	Covered - 50% after deductible
Allergy Testing and Therapy	Covered - 100%	Covered - 60% 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 - 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.

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 029
Section Code(s): 1020, 1120, 1200
Prescription Drugs
Effective Date: 01/01/2018
Benefits-at-a-glance

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 or plan sponsor is financially responsible for claims.

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 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 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

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.

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.

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 036, 037
Section Code(s): 3000, 3100
PPO - Flexible Blue 2, RX6
Effective Date: 01/01/2020
Benefits-at-a-glance

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 or plan sponsor is financially responsible for claims.

Note: A list of services that require approval **before** they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services**.

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

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract.	$1,400 per member $2,800 per family	$2,800 per member $5,600 per family
Copays • Fixed Dollar Copays	No Copay	No Copay
Coinsurance • Percent Coinsurance	0%	20%

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.
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.

		Note: Services without a network are covered at the in-network level.
Annual out-of-pocket maximums The full family out of pocket maximum must be met before it is considered satisfied.	$2,300 per member $4,600 per family Includes Deductible, Coinsurance and Copays	$4,500 per member $9,000 per family Excludes Deductible and 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 includes 3D Mammography	Covered - 100%	Covered - 80% 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 - 80% 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	Covered - 100%	Not Covered

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.

Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit		
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after deductible	Covered - 80% after deductible
Online Visits Note: Services are payable when rendered by American Well providers through Blue Cross Online Visits SM or BCBS providers	Covered - 100% after deductible	Covered - 80% after deductible
Office Consultations	Covered - 100% after deductible	Covered - 80% after deductible
Pre-Surgical Consultations	Covered - 100% after deductible	Covered - 80% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
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

Benefits	In-Network	Out-of-Network

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

Benefits	In-Network	Out-of-Network
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

Benefits	In-Network	Out-of-Network
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

Benefits	In-Network	Out-of-Network
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 a maximum of 90 days per calendar year	Covered - 100% after deductible	Covered - 100% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 100% after deductible	Covered - 80% after deductible
Bariatric Surgery	Covered - 100% after deductible	Covered - 80% after deductible
Oral Surgery Wisdom teeth extractions	Covered - 100% after deductible	Covered - 100% after in-network 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

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% after deductible	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 100% after deductible	Covered - 80% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 100% after deductible	Covered - 80% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment • Online Mental Health Visits	Covered - 100% after deductible Covered - 100% after deductible	Covered - 80% after deductible Covered - 80% 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 **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.	Covered - 100% after deductible	Covered - 80% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 100% after deductible	Covered - 80% after deductible
Nutritional Counseling	Covered - 100% after deductible	Covered - 80% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 100% after deductible	Covered - 80% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 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 Care	Covered - 80% after deductible	Covered - 80% after deductible
Allergy Testing and Therapy	Covered - 100% after deductible	Covered - 80% 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 - 100% after deductible	Covered - 80% after deductible

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 036, 037
Section Code(s): 3000, 3100
Prescription Drugs
Effective Date: 01/01/2020 Benefits-at-a-glance

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 or plan sponsor is financially responsible for claims.

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
Deductible	$1,400 per individual $2,800 per family
Retail - 30 day supply	$10 copay after deductible - Generic drugs $40 copay after deductible - Brand drugs $0 copay after deductible – 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 after deductible - Generic drugs $80 copay after deductible - Brand drugs
Specialty Drugs – 30 day supply Retail and Mail Order	$10 copay after deductible - Generic drugs $40 copay after deductible - 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

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. 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.

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 068
Section Code(s): 1020, 1120
PPO - CB500, RX1, Hearing
Effective Date: 07/01/2018
Benefits-at-a-glance

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 or plan sponsor is financially responsible for claims.

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	$500 per member $1,000 per family	$1,000 per member $2,000 per family
Copays • Fixed Dollar Copays	$20 copay for : • Office visits	No Copay
Coinsurance • Percent Coinsurance	0%	20% **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	$3,000 per member $6,000 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 - 80% 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 - 80% 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 - 80% after deductible
Online Visits Note: Services are payable when rendered by American Well or BCBS providers	Covered - 100% after $20 copay	Covered - 80% after deductible
Office Consultations	Covered - 100% after $20 copay	Covered - 80% after deductible
Pre-Surgical Consultations	Covered - 100%	Covered - 80% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $50 copay; copay waived if admitted	Covered - 100% after $50 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Covered - 100% after $50 copay	Covered - 100% after $50 copay
Urgent Care Services		
Facility	Covered - 100% after deductible	Covered - 80% after deductible
Professional	Covered - 100% after $20 copay	Covered - 80% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 100% after deductible	Covered - 100% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
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

Benefits	In-Network	Out-of-Network

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 80% after deductible
Delivery and Nursery Care	Covered - 100% after deductible	Covered - 80% after deductible

Benefits	In-Network	Out-of-Network

Hospital Care

Benefits	In-Network	Out-of-Network

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

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 100%	Covered - 100%
Home Health Care	Covered - 100% after deductible	Covered - 100% after deductible
Skilled Nursing Limited to a maximum of 120 days per calendar year	Covered - 100% after deductible	Covered - 100% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 100% after deductible	Covered - 80% after deductible
Bariatric Surgery	Covered - 100% after deductible	Covered - 80% after deductible
Oral Surgery Wisdom teeth extractions	Covered - 100% after deductible	Covered - 100% after in-network 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

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 - 100% after deductible	Covered - 80% after deductible

Behavioral Health Care and Substance Abuse Treatment Services

Benefits	In-Network	Out-of-Network
Inpatient Behavioral Health Care	Covered - 100% after deductible	Covered - 80% after deductible
Inpatient Substance Abuse Treatment	Covered - 100% after deductible	Covered - 100% after deductible
Outpatient Behavioral Health Care • Online Behavioral Health Visits	Covered - 100% after $20 copay Covered - 100% after $20 copay	Covered - 80% after deductible Covered - 80% 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 **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.	Covered - 100% after deductible	Covered - 80% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 100% after deductible	Covered - 80% after deductible
Nutritional Counseling	Covered - 100% after deductible	Covered - 80% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 100% after deductible	Covered - 80% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 24 visits per calendar year	Covered - 100%	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 Care	Covered - 90% after deductible	Covered - 90% after deductible
Allergy Testing and Therapy	Covered - 100%	Covered - 80% 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 - 100% after deductible	Covered - 80% after deductible
Massage Therapy Limited to a maximum of 24 visits 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.

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): 068
Section Code(s): 1020, 1120
Prescription Drugs
Effective Date: 07/01/2018
Benefits-at-a-glance

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 or plan sponsor is financially responsible for claims.

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

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.

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): 068
Section Code(s): 1020, 1120
Hearing Care Coverage
Effective Date: 07/01/2018
Benefits-at-a-glance

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 or plan sponsor is financially responsible for claims.

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%