Versatile 3 PPO, RX1, Hearing Benefits-at-a-Glance
Western Michigan Health Insurance Pool
Group Number: 71565
Package Code(s):005
Section Code(s):1000, 1100

Final

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/Coinsurance • Fixed Dollar Copays	$20 copay for: • Office Visits • Professional Urgent Care Services $25 copay for: • Non-emergency visits in emergency room	$25 copay for: • Non-emergency visits in emergency room
• Percent Coinsurance	10%	30% **Note**: Services without a network are covered at the in-network level.
Out-of-Pocket Maximum • Percent Coinsurance	$1,000 per member $2,000 per family	$2,000 per member $4,000 per family
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 - one 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
Contraceptives 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 – 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 & Adult	Covered - 100%	Not Covered

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 - $25 copay then 90% after deductible	Covered - $25 copay then 90% after deductible
Facility Urgent Care Services	Covered - 90% after deductible	Covered - 70% after deductible
Professional Urgent Care Services	Covered - 100% after $20 copay	Covered - 70% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 90% after deductible	Covered - 90%after deductible

Diagnostic and Therapeutic 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	Covered - 90% after deductible	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 and Substance Abuse 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

Other Services

Cardiac Rehabilitation	Covered - 90% after deductible	Covered - 70% after deductible
Chiropractic Services 24 visit maximum 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	Covered - 90% after deductible	Covered - 70% after deductible

Note: The following services require preapproval: Inpatient Care, select Radiology Services, Inpatient Behavioral Health and Substance Abuse Care, 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

Retail- 30 day supply	$ 0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D) $10 copay for generic drugs $40 copay for brand name drugs
Mail Order- 90 day supply	$20 copay for generic drugs $80 copay for 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– limited to 12 doses per month Covered
Diabetic Supplies	Not Covered

The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This document is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

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. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-At-A-Glance and any applicable plan document, the plan document will control.