



**Blue Cross
Blue Shield**
of Michigan

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

PPO Select 5, RX1, Hearing, Dental 1 Benefits-at-a-Glance Western Michigan Health Insurance Pool

In-Network

Out-of-Network

Deductible, Copays, Coinsurance and Dollar Maximums

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	0%	20% Note: Services without a network are covered at the in-network level.
Out-of-Pocket Maximum	\$6,600 per member \$13,200 per family <i>Includes Deductible and Copays</i>	\$2,500 per member \$5,000 per family <i>Includes Coinsurance</i>
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



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Physician Office Services

Office Visits	Covered - 100% after \$10 copay	Covered - 80% after deductible
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Emergency Medical Care

Hospital Emergency Room Qualified medical emergency	Covered -100%	Covered -100%
Non-Emergency use of the Emergency Room	Covered – 100% after \$25 copay	Covered – 100% after \$25 copay
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 and Postnatal Care Visits	Covered - 100%	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%	Covered - 100%
Home Health Care	Covered - 100% after deductible	Covered - 100% after deductible
Skilled Nursing Limited to 120 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%	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

Inpatient Behavioral Health	Covered – 100% after deductible	Covered - 80% after deductible
Inpatient Substance Abuse Care	Covered – 100% after deductible	Covered - 100% after deductible
Outpatient Behavioral Health	Covered - 100% after \$10 copay	Covered - 80% after deductible
Outpatient Substance Abuse Care	Covered - 100% after \$10 copay	Covered - 90% after deductible



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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: <ul style="list-style-type: none"> \$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%	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 - 90% after deductible	Covered - 90% after deductible
Allergy Therapy and Testing	Covered - 100%	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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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%



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Prescription Drugs

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

Retail- 30 day supply	<p>\$10 copay - Generic drugs \$40 copay - Brand name drugs</p> <p>\$ 0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children’s Claritin, Claritin RediTabs and Claritin-D)</p> <p>Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member’s copay.</p>
Mail Order - 90 day supply	<p>\$20 copay - Generic drugs \$80 copay - Brand name drugs</p>
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	<p>Covered Covered Covered Covered</p>
Diabetic Supplies	Not Covered

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Traditional Plus Dental Coverage Western Michigan Health Insurance Pool

Benefits-at-a-Glance

Class I Services

Periodic Oral Exams	Covered - 100%, twice per calendar year
Prophylaxis (Teeth Cleaning)	Covered - 100%, twice per calendar year
Bitewing X-Rays	Covered - 100%, twice per calendar year
Full-mouth and Panoramic X-Rays	Covered - 100%, once every 36 months
Fluoride Treatment	Covered - 100%, through
Space Maintainers	Covered - 100%, once per quadrant per lifetime, through age 18
Palliative Emergency Treatment	Covered - 100%
Sealants	Covered - 100%, once per tooth every 36 months, through age 19

Class II Services

Fillings - permanent teeth	Covered - 80% after deductible, once every 24 months
Fillings - primary teeth	Covered - 80% after deductible, once every 12 months
Inlays, Onlays and Crowns - permanent teeth	Covered - 80% after deductible, once every 60 months, payable for members age 12 and older
Recementing of Crowns, Inlays, Onlays and Bridges	Covered - 80% after deductible, three per calendar year
Root Canal Therapy	Covered - 80% after deductible, once per tooth, per lifetime
Periodontal Scaling and Planing	Covered - 80% after deductible, once every 24 months
Occlusal Adjustment	Covered - 80% after deductible, up to five times in a 60-month period
Occlusal Guards/Biteguards	Covered - 80% after deductible, once every 12 months
General Anesthesia or IV Sedation	Covered - 80% after deductible, when medically necessary and with oral or dental surgery
Oral Surgery including extractions (excludes removal of impacted teeth)	Covered - 80% after deductible
Relining or Rebasement of Partials or Dentures	Covered - 80% after deductible, once every 36 months per arch
Tissuing Conditioning	Covered - 80% after deductible, once every 36 months per arch
Repair to Existing Partials or Dentures	Covered - 80% after deductible

Class III Services

Removal Dentures - Complete and Partials	Covered - 50% after deductible, once every 60 months
Fixed Bridges	Covered - 50% after deductible, once every 60 months for members age 16 and older
Implants	Covered - 50% after deductible, once per tooth in a member lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31, age 16 or older

Class IV Services – Orthodontic services for dependents No age limits

Habit Breaking Appliances	Covered - 50% after deductible
Minor Tooth Guidance Appliances	Covered - 50% after deductible
Full Banding Treatment	Covered - 50% after deductible

Benefit Period Copays and Dollar Maximums

Benefit Period	Calendar Year
Deductible	\$50 Individual, No Deductible Family – Applies to Class II & Class III & Class IV
Member Coinsurance	Covered 0% for Class I services, Covered 20% for Class II services, Covered 50% for Class III services and Covered 50% for Class IV services
Dollar Maximums - Annual Maximum	\$1000 per member for covered Class I, II & III services
• Lifetime Orthodontic Maximum	\$1500 per member

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