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): 002
Division Code(s): 1010, 1110
PPO - ENHANCED 250 002, Rx1, Hearing, Dental 1
Effective Date: 01/01/2025
Benefits-at-a-glance

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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	$250 per member $500 per family	$500 per member $1,000 per family
Copays • Fixed Dollar Copays	$10 copay for : • Professional Urgent care services • Office visits $50 copay for : • Facility medical emergency	$50 copay for : • Facility medical emergency
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 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 - 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, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $10 copay	Covered - 70% after deductible
Telemedicine Visits	Covered - 100% after $10 copay	Covered - 70% after deductible
Virtual Care - Online Medical Visits Note: Online Medical visits by a non-BCBSM selected vendor are not covered.	Covered - 100% after $10 copay	Not Covered
Office Consultations	Covered - 100% after $10 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 or for an accidental injury	Covered - $50 copay then 90% after deductible; copay waived if admitted or for an accidental injury
Non-Emergency use of the Emergency Room	Covered - $50 copay then 90% after deductible	Covered - $50 copay then 70% after deductible
Facility Urgent Care Services	Covered - 90% after deductible	Covered - 70% after deductible
Physician Urgent Care Services	Covered - 100% after $10 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 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 - male reproductive organs excludes reversal sterilization	Covered - 90% after deductible	Covered - 70% after deductible
Sterilization - female reproductive organs excludes reversal sterilization	Covered - 100%	Covered - 70% after deductible
Expanded Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	Not Covered	Not Covered

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 Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care	Covered - 90% after deductible	Covered - 70% after deductible
Inpatient Substance Use Disorder Treatment	Covered - 90% after deductible	Covered - 90% after deductible
Outpatient Mental Health Care	Covered - 100% after $10 copay	Covered - 70% after deductible
Telemedicine Mental Health Care	Covered - 100% after $10 copay	Covered - 70% after deductible
Virtual Care - Online Mental Health Visits Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered.	Covered - 100% after $10 copay	Not Covered
Outpatient Substance Use Disorder Treatment	Covered - 100% after $10 copay	Covered - 90% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out-of-Network
Applied Behavior Analysis (ABA) Pre-authorization required **Note:** Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).	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 Services Limited to a maximum of 24 visits per member 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
Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 90% after deductible	Covered - 70% after deductible
Allergy Testing and Therapy	Covered - 90% after deductible	Covered - 70% after deductible
Facility Clinic Visit	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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 002
Division Code(s): 1010, 1110
Hearing Care Coverage
Effective Date: 01/01/2025
Benefits-at-a-glance

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Member's responsibility (coinsurance)

Benefits	Participating Provider	Non-Participating Provider
Coinsurance	No Coinsurance	Not Covered

Covered services

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

Benefits	Participating Provider	Non-Participating Provider
Frequency Limitation	Once every 36 months	
Audiometric Exam	Covered - 100%	Not Covered
Hearing Aid Evaluation	Covered - 100%	Not Covered
Hearing Aid Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.	Covered - 100%	Not Covered
Hearing Aid Conformity Test	Covered - 100%	Not Covered

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Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 002
Division Code(s): 1010, 1110
Prescription Drugs
Effective Date: 1/01/2025
Benefits-at-a-glance

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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.
Retail and Mail Order - 90-day supply	$20 copay - Generic drugs $80 copay - Brand drugs
Specialty Drugs **Exclusive Specialty Network**: We only cover specialty drugs when obtained from our exclusive specialty pharmacy network. Covered drugs will be subject to the member's cost-share requirements. If a member obtains specialty drugs from any other provider, they may be responsible for the total cost	Retail 30-day: $10 copay - Generic drugs $40 copay - Brand drugs Members are restricted to a 30-day supply and certain specialty drugs are limited to only a 15-day supply for each fill.
High-Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum. Note - Adjustments may be required to accurately reflect your annual out-of-pocket maximum with your true out-of-pocket costs.
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	Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs. • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement. • “Preferred” devices will be covered at 100% of our approved amount. “Nonpreferred” devices will be subject to your nonpreferred brand-name drugs cost-share requirement. • If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies. Also see *Other Covered Services* for Test Strips, Lancets, Needles and Syringes

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.

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Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 002
Division Code(s): 1010, 1110
Dental Coverage - Blue Dental PPO Plus
Effective Date: 01/01/2025
Benefits-at-a-glance

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Dentist information
With Blue Dental PPO, you can choose any licensed dentist anywhere. However, you'll get the best coverage and save the most money when you choose a Tier 1 PPO (in-network) dentist.

You have outstanding access to thousands of Tier 1 PPO dentists across the country through the Blue Dental PPO network. Tier 1 PPO dentists agree to accept our PPO approved amount as full payment for covered services, so you'll pay your applicable coinsurance and deductible amounts. To find a Tier 1 PPO dentist near you, log into your member account at **bcbsm.com** or call **1-888-826-8152.**

If you go to a non-PPO dentist, you can still save money by choosing a Tier 2 participating non-PPO (out-of-network) dentist. Tier 2 dentists participate with us on a "per claim" basis through our Blue Par Select (BPS) arrangement. They accept our BPS approved amount as full payment for covered services, so you'll pay your applicable coinsurance and deductible amounts. To find a Tier 2 participating non-PPO dentist near you, log into your member account at **bcbsm.com.** You should ask your dentist if they participate with BCBSM before every treatment.

Note: If you go to a nonparticipating dentist, you are responsible for any difference between our approved amount and the dentist's charge.

Member's responsibility (deductible, coinsurance and dollar maximums)

Benefits	Coverage
Benefit Period	Calendar Year
Deductible	$50 Individual - Applies to Class II, Class III & Class IV
Class I services	0%
Class II services	20%
Class III services	50%
Class IV services	50%
Dollar Maximums - Annual Maximum	$1,000 per member Class I, II & III services
Lifetime Orthodontic Maximum	$1,500 per member

Class I services

Benefits	Coverage
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 or Panoramic X-Rays	Covered - 100%, once every 36 months
Fluoride Treatment	Covered - 100%, twice per calendar year
Space Maintainers	Covered - 100%, once per quadrant per lifetime, up to and including age 18
Palliative Emergency Treatment	Covered - 100%
Sealants	Covered - 100%, once per tooth every 36 months, 1st and 2nd permanent molars, up to and including age 19

Class II services

Benefits	Coverage
Fillings - permanent teeth	Covered - 80% after deductible, once per tooth per surface every 24 months
Fillings - primary teeth	Covered - 80% after deductible, once per tooth per surface every 12 months
Inlays, Onlays, Crowns and Veneers - permanent teeth	Covered - 80% after deductible, once per tooth every 60 months age 12 and older
Recementing of Inlays, Onlays, Crowns, Bridges and Veneers	Covered - 80% after deductible, three per calendar year
Root Canal Therapy	Covered - 80% after deductible, once per tooth per lifetime
Periodontal Scaling and Root Planing	Covered - 80% after deductible, once per quadrant every 24 months
Occlusal Adjustment	Covered - 80% after deductible, up to five times in a 60 month period
Occlusal Biteguards	Covered - 80% after deductible, once every 12 months
General Anesthesia or IV Sedation with oral surgery	Covered - 80% after deductible
Oral Surgery	Covered - 80% after deductible
Relining or Rebasing of Partials or Dentures	Covered - 80% after deductible, once per arch every 36 months
Tissue Conditioning	Covered - 80% after deductible, once per arch every 36 months
Repair to Existing Partials or Dentures	Covered - 80% after deductible, once every 12 months

Class III services

Benefits	Coverage
Removable Dentures - Complete and Partials	Covered - 50% after deductible, once per arch every 60 months
Fixed Bridges	Covered - 50% after deductible, once per tooth every 60 months age 16 and older
Implants	Covered - 50% after deductible, once per tooth per lifetime age 16 and older

Class IV services - Orthodontic services

Benefits	Coverage
Orthodontic Services	Covered - 50% after deductible
Cephalometric Films and Oral Facial Photos	Covered - 50% after deductible