



**Blue Cross
Blue Shield**
of Michigan

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

Flexible Blue 2, RX5 Benefits-at-a-Glance Western Michigan Health Insurance Pool

In-Network

Out-of-Network

Deductible, Copays, Coinsurance and Dollar Maximums

Deductible - per calendar year <i>(The family deductible can be met by one person on contracts of 2 or more people)</i>	\$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 <i>Includes Deductible and RX copays</i>	\$4,500 per member \$9,000 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 deductible	Covered - 80% after deductible
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Emergency Medical Care

Hospital Emergency Room	Covered -100% after deductible	Covered -100% after deductible
Qualified medical emergency		
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	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 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



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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% 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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Note: The following services require preapproval: Inpatient Care, select Radiology and Diagnostic Services, Inpatient Behavioral Health Care and Substance Abuse Treatment, and Skilled Nursing



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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.

Deductible <i>(The family deductible can be met by one person on contracts of 2 or more people)</i>	\$1,300 per individual \$2,600 per family
Retail- 30 day supply	\$5 copay - Generic drugs \$30 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	\$10 copay - Generic drugs \$60 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.