Versatile 1 PPO, RX1, Hearing Benefits-at-a-Glance
Western Michigan Health Insurance Pool

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	$10 copay for: • Office Visits • Professional Urgent Care	
• 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 $10 copay	Covered - 70% after deductible

Emergency Medical Care

Hospital Emergency Room Qualified medical emergency	Covered - 90% after deductible	Covered - 90% after deductible
Facility Urgent Care Services	Covered - 90% after deductible	Covered - 70% after deductible
Professional 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 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 $10 copay	Covered - 70% after deductible
Outpatient Substance Abuse Care	Covered - 100% after $10 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	$ 0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D) $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

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.
will control.