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): 214, 215
# Division Code(s): 3020, 3120
# PPO - ENHANCED HSA 2500 214 215, Rx 86, Hearing
# Effective Date: 01/01/2026
# Benefits-at-a-glance

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.

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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<br>The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract. | $2,500 per member<br>$5,000 per family | $4,000 per member<br>$8,000 per family |
| **Copays**<br>• Fixed Dollar Copays | No Copay | No Copay |
| **Coinsurance**<br>• Percent Coinsurance | 20% up to a maximum of:<br>$2,000 per member<br>$4,000 per family | 40%<br>**Note:** Services without a network are covered at the in-network level. |
| **Annual out-of-pocket maximums**<br>The full family out of pocket maximum must be met before it is considered satisfied. | $4,500 per member<br>$9,000 per family<br>Includes Deductible, Coinsurance and Copays | $6,000 per member<br>$12,000 per family<br>Excludes Deductible and includes Coinsurance |
| **Lifetime dollar maximum** | Unlimited | |

## Preventive Care Services

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Health Maintenance Exam - 1 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 - 2 per calendar year, in addition to health maintenance exam | Covered - 100% | Not Covered |
| Pap Smear Screening - 1 per calendar year | Covered - 100% | Not Covered |

| | | |
|---|---|---|
| Mammography Screening - 1 per calendar year<br>includes 3D Mammography | Covered - 100% | Covered - 60% after deductible |
| Contraceptive Methods and Counseling | Covered - 100% | Not Covered |
| Prostate Specific Antigen (PSA) screening - 1 per calendar year | Covered - 100% | Not Covered |
| Endoscopic Exams - 1 per calendar year | Covered - 100% | Covered - 60% after deductible |
| Well Child Care<br>• 8 visits, birth through 12 months<br>• 6 visits, 13 months through 23 months<br>• 6 visits, 24 months through 35 months<br>• 2 visits, 36 months through 47 months<br><br>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 - 80% after deductible | Covered - 60% after deductible |
| Telemedicine Visits | Covered - 80% after deductible | Covered - 60% after deductible |
| Virtual Care - Online Medical Visits<br>Note: Online Medical visits by a non-BCBSM selected vendor are not covered. | Covered - 80% after deductible | Not Covered |
| Office Consultations | Covered - 80% after deductible | Covered - 60% after deductible |
| Pre-Surgical Consultations | Covered - 80% after deductible | Covered - 60% after deductible |

## Emergency Medical Care

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Hospital Emergency Room<br>Qualified medical emergency | Covered - 80% after deductible | Covered - 80% after deductible |
| Non-Emergency use of the Emergency Room | Covered - 80% after deductible | Covered - 60% after deductible |
| Facility Urgent Care Services | Covered - 80% after deductible | Covered - 60% after deductible |
| Physician Urgent Care Services | Covered - 80% after deductible | Covered - 60% after deductible |
| Ambulance Services - Medically Necessary Transport | Covered - 80% after deductible | Covered - 80% after deductible |

## Diagnostic Services

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| MRI, MRA, PET and CAT Scans and Nuclear Medicine | Covered - 80% after deductible | Covered - 60% after deductible |
| Diagnostic Tests, X-rays, Laboratory & Pathology | Covered - 80% after deductible | Covered - 60% after deductible |
| Radiation Therapy and Chemotherapy | Covered - 80% after deductible | Covered - 60% after deductible |

## Maternity Services Provided by a Physician

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Prenatal and Postnatal Care Visits | Covered - 100% | Covered - 60% after deductible |
| Delivery and Nursery Care | Covered - 80% after deductible | Covered - 60% after deductible |

## Hospital Care

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies | Covered - 80% after deductible | Covered - 60% after deductible |
| Inpatient Medical Care | Covered - 80% after deductible | Covered - 60% after deductible |

## Alternatives to Hospital Care

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Hospice Care | Covered - 80% after deductible | Covered - 80% after deductible |
| Home Health Care | Covered - 80% after deductible | Covered - 80% after deductible |
| Skilled Nursing<br>Limited to 90 days per calendar year | Covered - 80% after deductible | Covered - 80% after deductible |

## Surgical Services

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Surgery (includes related surgical services) | Covered - 80% after deductible | Covered - 60% after deductible |
| Bariatric Surgery | Covered - 80% after deductible | Covered - 60% after deductible |
| Oral Surgery<br>Wisdom teeth extractions | Covered - 80% after deductible | Covered - 80% after deductible after in-network deductible |
| Sterilization - male reproductive organs<br>excludes reversal sterilization | Covered - 80% after deductible | Covered - 60% after deductible |
| Sterilization - female reproductive organs<br>excludes reversal sterilization | Covered - 100% | Covered - 60% after deductible |
| Expanded Abortion Services<br><br>**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<br>In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504) | Covered - 80% after deductible | Not covered except in designated facilities |
| Kidney, Cornea, Bone Marrow and Skin | Covered - 80% after deductible | Covered - 60% after deductible |

## Behavioral Health Services (Mental Health and Substance Use Disorder)

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Inpatient Mental Health Care and Substance Use Disorder Treatment | Covered - 80% after deductible | Covered - 60% after deductible |
| Outpatient Mental Health Care and Substance Use Disorder Treatment | Covered - 80% after deductible | Covered - 60% after deductible |
| Telemedicine Mental Health Care | Covered - 80% after deductible | Covered - 60% after deductible |
| Virtual Care - Online Mental Health Visits<br>Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered. | Covered - 80% after deductible | Not Covered |

## Autism Spectrum Disorders, Diagnoses and Treatment

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Applied Behavior Analysis (ABA)<br>Prior authorization required<br><br>**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 - 80% after deductible | Covered - 60% after deductible |
| Physical, Occupational and Speech Therapy<br>Physical, Occupational and Speech therapy with an autism diagnosis is unlimited | Covered - 80% after deductible | Covered - 60% after deductible |
| Nutritional Counseling | Covered - 80% after deductible | Covered - 60% after deductible |

## Other Covered Services

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Cardiac Rehabilitation | Covered - 80% after deductible | Covered - 60% after deductible |
| Chiropractic Spinal Manipulation Services<br>Limited to a maximum of 24 visits per member per calendar year | Covered - 80% after deductible | Covered - 60% after deductible |
| Durable Medical Equipment | Covered - 80% after deductible | Covered - 60% after deductible |
| Diabetic Supplies<br>Test Strips, Lancets, Needles and Syringes | Covered - 80% after deductible | Covered - 60% after deductible |
| Prosthetic and Orthotic Devices | Covered - 80% after deductible | Covered - 60% after deductible |
| Private Duty Nursing Care | Covered - 80% after deductible | Covered - 60% after deductible |
| Allergy Testing and Therapy | Covered - 80% after deductible | Covered - 60% after deductible |
| Facility Clinic Visit | Covered - 80% after deductible | Covered - 60% after deductible |

## Therapy Services

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Physical, Occupational and Speech Therapy<br>Limited to a combined maximum of 60 visits per calendar year | Covered - 80% after deductible | Covered - 60% after deductible |

# Western Michigan Health Insurance Pool
# Group Number: 71565 Package Code(s): 214, 215
# Division Code(s): 3020, 3120
# Hearing Care Coverage
# Effective Date: 01/01/2026
# 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<br>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): 214, 215
# Division Code(s): 3020, 3120
# Prescription Drugs
# Effective Date: 01/01/2026
# 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 |
|---|---|
| Deductible | $2,500 per member<br>$5,000 per family |
| Retail - 30-day supply | $10 copay after deductible - Generic drugs<br>20% coinsurance after deductible - Preferred brand drugs $80 maximum<br>20% coinsurance after deductible - Non-Preferred brand drugs $200 maximum<br><br>Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 80% of the approved amount, less the member's copay. |
| Retail and Mail Order - 90-day supply | $20 copay after deductible - Generic drugs<br>20% coinsurance after deductible - Preferred brand drugs $160 maximum<br>20% coinsurance after deductible - Non-Preferred brand drugs $200 maximum |
| Specialty Drugs<br><br>**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:<br>$10 copay after deductible - Generic drugs<br>20% coinsurance after deductible - Preferred brand drugs $80 maximum<br>20% coinsurance after deductible - Non-Preferred brand drugs $200 maximum<br><br>Members are restricted to a 30-day supply and certain specialty drugs are limited to only a 15-day supply for each fill. |

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| 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**<br>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<br>GLP-1 products for conditions other than diabetes are not 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.<br><br>• Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement.<br>• “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.<br>• 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. |

## Features of your prescription drug plan

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| 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.<br>**Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum. |

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