SB 90% PPO Clinton County RESA
Benefits-at-a-Glance
Western Michigan Health Insurance Pool

Deductible, Copays, Coinsurance and Dollar Maximum	In-Network	Out-of-Network
Deductible - per calendar year	$250 per member $500 per family	$500 per member $1,000 per family
Copays • Fixed Dollar Copays	$20 copay for: • Primary Care Physician (PCP) office visits $40 copay for: • Specialist office visits $20 copay for: • Chiropractic spinal manipulations $60 copay for: • Urgent care services $150 copay for • Facility medical emergency	$150 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.
Out-of-Pocket Maximum	$2,500 per member $5,000 per family Includes Deductible, Coinsurance and Copays	$2,500 per member $5,000 per family Includes Coinsurance
Lifetime Maximum	Unlimited	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	Covered - 100%	Covered - 70% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Covered – 100% after deductible
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

Office Visits	Covered - 100% after $20 PCP copay; $40 specialist copay	Covered - 70% after deductible
Office Consultation	Covered - 100% after $20 PCP copay; $40 specialist copay	Covered - 70% after deductible
Pre-Surgical Consultation	Covered - 100%	Covered - 70% after deductible

Emergency Medical Care

Hospital Emergency Room Qualified medical emergency	Covered - 100% after $150 copay; copay waived if admitted	Covered - 100% after $150 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Urgent Care Services	Covered – 100% after $60 copay	Covered - 70% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 90% after deductible	Covered - 90% after deductible

Diagnostic 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 Visits	Covered - 100%	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 Four 90-day periods	Covered - 100%	Covered - 100%
Home Health Care	Covered - 90% after deductible	Covered - 70% after deductible
Skilled Nursing Limited to a maximum of 120 days per calendar year	Covered - 90% after deductible	Covered - 70% after deductible

Surgical Services

Surgery (includes related surgical services)	Covered - 90% after deductible	Covered - 70% after deductible
Bariatric Surgery	Covered - 50% after deductible	Covered - 50% 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 Care and Substance Abuse Treatment Services

Inpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 90% after deductible	Covered - 70% after deductible
Outpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 90% after deductible	Covered - 70% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

Applied Behavioral Analysis (ABA) Limited to a visit maximum of: 30 units (7.5 hrs per week) birth through age 6 24 units (6 hrs per week) age 7 - 12 18 units (4.5 hrs per week) age 13 - 18	Covered - 90% after deductible	Covered - 70% after deductible
Physical, Occupational and Speech Therapy Limited to a combined maximum of 30 visits per calendar year	Covered - 90% after deductible	Covered - 70% after deductible
Nutritional Counseling	Covered - 90% after deductible	Covered - 70% after deductible

Other Services

Cardiac Rehabilitation	Covered - 90% after deductible	Covered - 70% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 12 visits per calendar year	Covered – 100% after $20 copay	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	Not Covered	Not Covered
Allergy Testing and Therapy	Covered - 90% after deductible	Covered - 70% after deductible

Therapy Services

Physical, Occupational and Speech Therapy Limited to a combined maximum of 30 visits per calendar year	Covered - 90% after deductible	Covered - 70% after deductible

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

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. BCBSM provides administrative claims services only. Your employer is financially responsible for claims.

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	$10 copay -Generic drugs $40 copay – Preferred brand name drugs $80 copay – Non-Preferred brand name drugs Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Mail Order - 90 day supply	$20 copay -Generic drugs $80 copay – Preferred brand name drugs $160 copay – Non-Preferred brand name drugs
Specialty Drugs – 30 day supply Retail and Mail Order	$20 copay -Generic drugs $40 copay – Preferred brand name drugs $80 copay – Non-Preferred brand name drugs Member are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.
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	Covered
Weight Loss Drugs	Not Covered
Impotency Drugs	Not Covered
Infertility Drugs	Covered
Diabetic Supplies	Not Covered

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. Some over-the-counter medications may be covered under step therapy guidelines. 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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