Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 092
Section Code(s): 1010, 1110
Prescription Drugs
Effective Date: 01/01/2021
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	$20 copay for : • Primary Care Physician (PCP) office visits • Chiropractic spinal manipulations $40 copay for : • Specialist office visits $60 copay for : • Facility Urgent care services • Professional 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.
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	Unlimited

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab proceduresperformed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to healthmaintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar yearincludes 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 yearunder 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 $20 pcp copay; $40 specialist copay	Covered - 70% after deductible
Telemedicine Visits	Covered - 100% after $20 pcp copay; $40 specialist copay	Covered - 70% after deductible
Blue Cross Online Visits Note: Services are payable when rendered through Blue Cross OnlineVisits℠	Covered - 100% after $20 copay	Not Covered
Office Consultations	Covered - 100% after $20 pcp copay; $40 specialist 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 - 100% after $150 copay; copaywaived if admitted	Covered - 100% after $150 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Facility Urgent Care Services	Covered - 100% after $60 copay	Covered - 70% after deductible
Physician 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

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 Limited to lifetime maximum of 360 days	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

Benefits	In-Network	Out-of-Network
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

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM HumanOrgan Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designatedfacilities
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 and Substance Use Disorder Treatment	Covered - 90% after deductible	Covered - 70% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment • Telemedicine Mental Health Care • Blue Cross Online Mental Health Care	Covered - 90% after deductible Covered - 90% after deductible Covered - 90% after deductible	Covered - 70% after deductible Covered - 70% after deductible Not Covered

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

Benefits	In-Network	Out-of-Network
Applied Behavioral Analysis (ABA) Pre-authorization required **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	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 Limited to a maximum of 12 visits per member, 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
Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 90% after deductible	Covered - 70% after deductible
Private Duty Nursing Care	Not Covered	Not Covered
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 30 visits per calendar year	Covered - 90% after deductible	Covered - 70% after deductible

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Hearing Care Coverage
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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	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 ourapproved amount and the charge of the hearing aid.	Covered - 100%	Not Covered
Hearing Aid Conformity Test	Covered - 100%	Not Covered

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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 - Preferred brand drugs $80 copay - Non-Preferred brand 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 drugs $160 copay - Non-Preferred brand drugs
Specialty Drugs – 30 day supply Retail and Mail Order	$10 copay - Generic drugs $40 copay - Preferred brand drugs $80 copay - Non-Preferred brand drugs Members are restricted to a 30 day supply at both retail and mail orderand certain specialty drugs are limited to only a 15 day supply for eachfill.
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. Thisbenefit 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 theprescription will apply towards your annual out-of-pocket maximum.
Adult and childhood select preventive immunizations as recommended by theUSPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are incompliance 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	**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 forthe same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria requireprior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Mandatory maximum allowablecost 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 copayregardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requestsand 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 annualcoinsurance/copay maximum.