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): 210, 211
Division Code(s): 3020, 3120
PPO - ENHANCED HSA 2000 210 211, Rx 84, Hearing
Effective Date: 01/01/2026
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 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 $5,000 per family	$4,000 per member $8,000 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.
Annual out-of-pocket maximums The full family out of pocket maximum must be met before it is considered satisfied.	$3,000 per member $6,000 per family Includes Deductible, Coinsurance and Copays	$6,000 per member $12,000 per family 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 includes 3D Mammography	Covered - 100%	Covered - 80% 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 - 80% 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

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after deductible	Covered - 80% after deductible
Telemedicine Visits	Covered - 100% after deductible	Covered - 80% after deductible
Virtual Care - Online Medical Visits Note: Online Medical visits by a non-BCBSM selected vendor are not covered.	Covered - 100% after deductible	Not Covered
Office Consultations	Covered - 100% after deductible	Covered - 80% after deductible
Pre-Surgical Consultations	Covered - 100% after deductible	Covered - 80% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after deductible	Covered - 100% after deductible
Non-Emergency use of the Emergency Room	Covered - 100% after deductible	Covered - 80% after deductible
Facility Urgent Care Services	Covered - 100% after deductible	Covered - 80% after deductible
Physician 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

Benefits	In-Network	Out-of-Network
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

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

Hospital Care

Benefits	In-Network	Out-of-Network
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

Benefits	In-Network	Out-of-Network
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

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 100% after deductible	Covered - 80% after deductible
Bariatric Surgery	Covered - 100% after deductible	Covered - 80% after deductible
Oral Surgery Wisdom teeth extractions	Covered - 100% after deductible	Covered - 100% after deductible after in-network deductible
Sterilization - male reproductive organs excludes reversal sterilization	Covered - 100% after deductible	Covered - 80% after deductible
Sterilization - female reproductive organs excludes reversal sterilization	Covered - 100%	Covered - 80% after deductible
Expanded Abortion Services **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 In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100% after deductible	Covered - 80% after deductible
Kidney, Cornea, Bone Marrow and Skin	Covered - 100% after deductible	Covered - 80% 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 - 100% after deductible	Covered - 80% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 100% after deductible	Covered - 80% after deductible
Telemedicine Mental Health Care	Covered - 100% after deductible	Covered - 80% after deductible
Virtual Care - Online Mental Health Visits Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered.	Covered - 100% after deductible	Not Covered

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out-of-Network
Applied Behavior Analysis (ABA) Prior authorization required **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 - 100% after deductible	Covered - 80% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 100% after deductible	Covered - 80% after deductible
Nutritional Counseling	Covered - 100% after deductible	Covered - 80% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 100% after deductible	Covered - 80% after deductible
Chiropractic Spinal Manipulation Services Limited to a maximum of 24 visits per member 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
Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 100% after deductible	Covered - 80% after deductible
Private Duty Nursing Care	Covered - 80% after deductible	Covered - 80% after deductible
Allergy Testing and Therapy	Covered - 100% after deductible	Covered - 80% after deductible
Facility Clinic Visit	Covered - 100% after deductible	Covered - 80% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 100% after deductible	Covered - 80% after deductible

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Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 210, 211
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 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): 210, 211
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 $5,000 per family
Retail - 30-day supply	$20 copay after deductible - Generic drugs 20% coinsurance after deductible - Preferred brand drugs $80 maximum 20% coinsurance after deductible - Non-Preferred brand drugs $100 maximum 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 20% coinsurance after deductible - Preferred brand drugs $160 maximum 20% coinsurance after deductible - Non-Preferred brand drugs $200 maximum
Specialty Drugs **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: $20 copay after deductible - Generic drugs 20% coinsurance after deductible - Preferred brand drugs $80 maximum 20% coinsurance after deductible - Non-Preferred brand drugs $100 maximum Members are restricted to a 30-day supply and certain specialty drugs are limited to only a 15-day supply for each fill.

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 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 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. • 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.

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. 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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