



## PPO Versatile Plan 2 with RX Plan 7

### Benefits-at-a-Glance

### WmHIP

#### In-Network

#### Out-of-Network

#### Deductible, Copays/Coinsurance and Dollar Maximums

<b>Deductible - per calendar year</b>	\$250 per member \$500 per family	\$ 500 per member \$1,000 per family
<b>Copays/Coinsurance</b> • Fixed Dollar Copays	\$10 copay for: <ul style="list-style-type: none"> <li>• Office visits</li> <li>• Urgent Care Visits</li> <li>• Routine physical exams</li> <li>• Well baby and child care visits</li> </ul> \$25 copay for: <ul style="list-style-type: none"> <li>• Non-emergency visits in emergency room</li> </ul>	\$25 copay for: <ul style="list-style-type: none"> <li>• Non-emergency visits in emergency room</li> </ul>
• Percent Coinsurance	10%	30% <b>Note:</b> Services without a network are covered at the in-network level.
<b>Out-of-Pocket Maximum – per calendar year</b> • Percent Coinsurance <i>Excludes Deductible</i>	\$1,000 per member \$2,000 per family	\$2,000 per member \$4,000 per family
<b>Lifetime Maximum</b>		Unlimited

#### Preventive Services – limited to \$500 per member per calendar year maximum

Health Maintenance Exam – beginning age 16, one per calendar year; includes related X-rays, EKG, and lab procedures performed as part of the physical exam	Covered – 100% after \$10 copay	Not Covered
Annual Gynecological Exam - one per calendar year <i>Does not contribute to annual dollar maximum</i>	Covered – 100% after \$10 copay	Not Covered
Pap Smear Screening – one per calendar year; laboratory services only. <i>Does not contribute to annual maximum</i>	Covered – 100%	Not Covered
Prostate Specific Antigen (PSA) Screening - one per calendar year. <i>Does not contribute to annual maximum</i>	Covered – 100%	Not Covered
Fecal Occult Blood Test – one per calendar year, <i>Does not contribute to annual dollar maximum</i>	Covered – 100%	Not Covered
Endoscopic Exams – one per calendar year <i>Does not contribute to annual dollar maximum</i>	Covered – 100%	Not Covered
Well-Baby and Child Care - through age 15; 6 visits birth through age 1, 2 visits per year age 2 through 3, 1 visit per year age 4 through 15	Covered – 100% after \$10 copay	Not Covered
Immunizations - pediatric and adult <i>Does not contribute to annual dollar maximum</i>	Covered – 100%	Not Covered

#### Mammograms

Mammography Screening – one per calendar year <i>Does not contribute to annual dollar maximum</i>	Covered – 100%	Not Covered
--	----------------	-------------

#### Physician Office Services

Office Visits Includes: <ul style="list-style-type: none"> <li>• Primary Care Physicians and Specialists</li> <li>• Presurgical consultations</li> <li>♦ Initial visit to determine pregnancy</li> </ul>	Covered – 100% after \$10 copay One copay applies to the office visit exam and all services performed during the office visit (e.g., lab, x-rays, etc.)	Covered – 70% after deductible
Urgent Care Visits	Covered – 100% after \$10 copay	Covered – 70% after deductible



**In-Network**

**Out-of-Network**

**Emergency Medical Care**

Hospital Emergency Room Qualified Medical Emergency & First Aid Services	Covered – 90% after deductible	Covered – 90% after deductible
Non-Emergency use of the Emergency Room	Covered - \$25 copay then 90% after deductible	Covered - \$25 copay then 90% 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
Independent Laboratory	Covered – 100%, deductible waived	Covered – 70% after deductible
Other Diagnostic Tests, X-rays, Laboratory & Pathology	Covered – 90% after deductible	Covered – 70% after deductible
Radiation Therapy	Covered – 90% after deductible	Covered – 70% after deductible

**Maternity Services Provided by a Physician**

Pre-Natal and Post-Natal 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
Chemotherapy	Covered – 90% after deductible	Covered – 70% after deductible

**Alternatives to Hospital Care**

Skilled Nursing Facility	Covered – 90% after deductible	Covered – 90% after deductible
	Limited to 120 days per calendar year	
Hospice Care	Covered – 90% after deductible	Covered – 90% after deductible
Home Health Care	Covered – 90% after deductible	Covered – 90% after deductible

**Outpatient Surgical Services**

Surgery – includes related surgical services	Covered – 90% after deductible	Covered – 70% after deductible
Dental surgery and related anesthesia for the removal of wisdom teeth	Covered – 90% after deductible	Covered – 90% after deductible
Voluntary Abortion	Not Covered	Not Covered
Voluntary Sterilization – <i>excludes reversal sterilization</i>	Covered – 90% after deductible	Covered – 70% after deductible

**Human Organ Transplants**

Specified Organ Transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered - 100%	Not Covered
	Unlimited dollar maximum per transplant type	
Kidney, Cornea, Bone Marrow and Skin	Covered – 90% after deductible	Covered – 70% after deductible

**Mental Health Care and Substance Abuse Treatment**

Inpatient Mental Health Care <i>Does not contribute to out-of-pocket maximum</i>	Covered – 90% after deductible	Covered – 70% after deductible
	Limited to a lifetime maximum of 45 days (Combined with inpatient substance abuse care)	
Inpatient Substance Abuse Care <i>Does not contribute to out-of-pocket maximum</i>	Covered – 90% after deductible	Covered – 90% after deductible
	Limited to a lifetime maximum of 45 days (Combined with inpatient substance abuse care)	
Outpatient Mental Health Care <i>Does not contribute to out-of-pocket maximum</i>	Covered – 90% after deductible	Covered – 70% after deductible
	Limited to 50 visits per calendar year	
Outpatient Substance Abuse Care <i>Does not contribute to out-of-pocket maximum</i>	Covered – 90% after deductible	Covered – 90% after deductible
	Limited to annually adjusted state dollar maximum	



**In-Network**

**Out-of-Network**

**Other Services**

Cardiac Rehabilitation	Covered – 90% after deductible	Covered – 70% after deductible
Acupuncture - Performed by MD, DO and other select provider specialties	Covered – 90% after deductible	Covered – 70% after deductible
Allergy Testing and Therapy	Covered – 90% after deductible	Covered – 70% after deductible
Chiropractic Care	Covered – 90% after deductible	Covered – 90% after deductible
	Limited to 24 spinal manipulation visits per calendar year	
Outpatient Physical, Speech and Occupational Therapy	Covered – 90% after deductible	Covered – 70% after deductible
	Limited to 60 combined visits per calendar year. Services are covered when performed in the outpatient department of the hospital, or approved freestanding facility. Physical therapy is also covered in an independent therapist’s office.	
Massage Therapy rendered by MD, DO, or Chiropractor	Covered – 90% after deductible	Covered – 70% after deductible
	Limited to 24 visits per calendar year	
Durable Medical Equipment/Medical Supplies	Covered – 90% after deductible	Covered – 90% after deductible
Prosthetic and Orthotic Appliances	Covered – 90% after deductible	Covered – 90% after deductible
Private Duty Nursing	Covered – 90% after deductible	Covered – 90% after deductible
Hearing Aids	Covered – 100% of the approved amount. Hearing aids must be purchased from an approved hearing aid provider.	

**Prescription Drugs**

<b>Retail – 34 day supply</b>	<p>\$ 0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children’s Claritin, Claritin RediTabs and Claritin-D)            \$ 5 copay – Generic drugs            \$30 copay – Brand name drugs</p> <p>Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member’s copay.</p>
<b>Mail Order - 90-day supply</b>	<p>\$ 0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children’s Claritin, Claritin RediTabs and Claritin-D)            \$10 copay – Generic drugs            \$60 copay – Brand name drugs</p>
<b>Additional Services</b> Oral & Injectable Contraceptives Smoking Cessation Drugs Weight Loss Drugs Impotency Drugs Infertility Drugs	<p>Covered          Covered          Covered          Covered – limited to 12 doses per month          Covered</p>

**This is intended as an easy-to-read guide. It is not a contract. An official description of benefits is contained in applicable Blue Cross Blue Shield of Michigan coverage documents.**