WESTERN MICHIGAN UNIVERSITY
Group# 07005281/0008/0009/0010/0011/0030/0031/0040
Community Blue PPOSM ASC
Effective Date: On or after January 2018
Benefits-at-a-glance for Non-Bargaining Exempt

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. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: A list of services that require approval before they are provided is available online at bcbsm.com/importantinfo. Select Approving covered services.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.
### Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$600 for one member, $1,200 for the family (when two or more members are covered under your contract) each calendar year</td>
<td>$1,200 for one member, $2,400 for the family (when two or more members are covered under your contract) each calendar year</td>
</tr>
<tr>
<td></td>
<td>Sindecuse Health Center - $300 for one member, $600 for the family (when two or more members are covered under your contract) each calendar year</td>
<td>Note: Out-of-network deductible amounts also count toward the in-network deductible.</td>
</tr>
<tr>
<td><strong>Note:</strong> Deductible may be waived for covered services performed in an in-network physician’s office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician’s office.</td>
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</tr>
</tbody>
</table>
| **Flat-dollar copays**                        | • $30 copay for office visits and office consultations with a primary care physician  
• $40 copay for office visits and office consultations with a specialist  
• $150 copay for emergency room visits  
• $50 copay for urgent care visits  | • $150 copay for emergency room visits  |
| **Coinsurance amounts (percent copays)**      | • 50% of approved amount for private duty nursing care  
• 10% of approved amount for mental health care and substance use disorder treatment  
• 10% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician’s office)  | • 50% of approved amount for private duty nursing care  
• 30% of approved amount for mental health care and substance use disorder treatment  
• 30% of approved amount for most other covered services  |
| **Note:** Coinsurance amounts apply once the deductible has been met. |
| **Annual out-of-pocket maximums** - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable | $1,500 for one member, $3,000 for the family (when two or more members are covered under your contract) each calendar year | $3,000 for one member, $6,000 for the family (when two or more members are covered under your contract) each calendar year |
| **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum. |
| **Lifetime dollar maximum**                   | None                                                                      |

### Preventive care services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures</td>
<td>100% (no deductible or copay/coinsurance), one per member per calendar year</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Note:</strong> Additional well-women visits may be allowed based on medical necessity</td>
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</tr>
</tbody>
</table>

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association. Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a “low access area” by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider’s charge.
<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynecological exam</td>
<td>100% (no deductible or copay/coinsurance), one per member per calendar year</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Note:</strong> Additional well-women visits may be allowed based on medical necessity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pap smear screening - laboratory and pathology services</td>
<td>100% (no deductible or copay/coinsurance), one per member per calendar year</td>
<td>Not covered</td>
</tr>
<tr>
<td>Voluntary sterilization for females</td>
<td>100% (no deductible or copay/coinsurance)</td>
<td>70% after out-of-network deductible</td>
</tr>
<tr>
<td>Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician</td>
<td>100% (no deductible or copay/coinsurance)</td>
<td>100% after out-of-network deductible</td>
</tr>
<tr>
<td>Contraceptive injections</td>
<td>100% (no deductible or copay/coinsurance)</td>
<td>70% after out-of-network deductible</td>
</tr>
<tr>
<td>Well-baby and child care visits</td>
<td>100% (no deductible or copay/coinsurance)</td>
<td>Not covered</td>
</tr>
<tr>
<td>- 8 visits, birth through 12 months</td>
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<td></td>
</tr>
<tr>
<td>- 6 visits, 13 months through 23 months</td>
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<td></td>
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<tr>
<td>- 6 visits, 24 months through 35 months</td>
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<td></td>
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<tr>
<td>- 2 visits, 36 months through 47 months</td>
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<td></td>
</tr>
<tr>
<td>- Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</td>
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</tr>
<tr>
<td>Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act</td>
<td>100% (no deductible or copay/coinsurance)</td>
<td>Not covered</td>
</tr>
<tr>
<td>Fecal occult blood screening</td>
<td>100% (no deductible or copay/coinsurance), one per member per calendar year</td>
<td>Not covered</td>
</tr>
<tr>
<td>Flexible sigmoidoscopy exam</td>
<td>100% (no deductible or copay/coinsurance), one per member per calendar year</td>
<td>Not covered</td>
</tr>
<tr>
<td>Prostate specific antigen (PSA) screening</td>
<td>100% (no deductible or copay/coinsurance), one per member per calendar year</td>
<td>Not covered</td>
</tr>
<tr>
<td>Routine mammogram and related reading</td>
<td>100% (no deductible or copay/coinsurance)</td>
<td>70% after out-of-network deductible</td>
</tr>
<tr>
<td><strong>Note:</strong> Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colonoscopy - routine or medically necessary</td>
<td>100% (no deductible or copay/coinsurance) for the first billed colonoscopy</td>
<td>70% after out-of-network deductible</td>
</tr>
<tr>
<td><strong>Note:</strong> Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance.</td>
<td></td>
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</tr>
</tbody>
</table>

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## Physician office services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits - must be medically necessary</td>
<td>• $30 copay for each office visit with a <strong>primary care physician</strong></td>
<td>70% after out-of-network deductible</td>
</tr>
<tr>
<td></td>
<td>• $40 copay for each office visit with a <strong>specialist</strong></td>
<td></td>
</tr>
<tr>
<td>Online visits - by physician or BCBSM selected vendor must be medically necessary</td>
<td>100% (no deductible or copay/coinsurance)</td>
<td>70% after out-of-network deductible</td>
</tr>
<tr>
<td>Outpatient and home medical care visits - must be medically necessary</td>
<td>90% after in-network deductible</td>
<td>70% after out-of-network deductible</td>
</tr>
<tr>
<td>Office consultations - must be medically necessary</td>
<td>• $30 copay for each office consultation with a <strong>primary care physician</strong></td>
<td>70% after out-of-network deductible</td>
</tr>
<tr>
<td></td>
<td>• $40 copay for each office consultation with a <strong>specialist</strong></td>
<td></td>
</tr>
<tr>
<td>Urgent care visits - must be medically necessary</td>
<td>$50 copay per urgent care visit</td>
<td>70% after out-of-network deductible</td>
</tr>
</tbody>
</table>

## Emergency medical care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital emergency room</td>
<td>$150 copay per visit (copay waived if admitted or for an accidental injury)</td>
<td>$150 copay per visit (copay waived if admitted or for an accidental injury)</td>
</tr>
<tr>
<td>Ambulance services - must be medically necessary</td>
<td>90% after in-network deductible</td>
<td>90% after in-network deductible</td>
</tr>
</tbody>
</table>

## Diagnostic services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory and pathology services</td>
<td>90% after in-network deductible</td>
<td>70% after out-of-network deductible</td>
</tr>
<tr>
<td>Diagnostic tests and x-rays</td>
<td>90% after in-network deductible</td>
<td>70% after out-of-network deductible</td>
</tr>
<tr>
<td>Therapeutic radiology</td>
<td>90% after in-network deductible</td>
<td>70% after out-of-network deductible</td>
</tr>
</tbody>
</table>

## Maternity services provided by a physician or certified nurse midwife

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal care visits</td>
<td>100% (no deductible or copay/coinsurance)</td>
<td>70% after out-of-network deductible</td>
</tr>
<tr>
<td>Postnatal care visit</td>
<td>100% (no deductible or copay/coinsurance)</td>
<td>70% after out-of-network deductible</td>
</tr>
<tr>
<td>Delivery and nursery care</td>
<td>90% after in-network deductible</td>
<td>70% after out-of-network deductible</td>
</tr>
</tbody>
</table>

## Hospital care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies</td>
<td>90% after in-network deductible</td>
<td>70% after out-of-network deductible</td>
</tr>
</tbody>
</table>

**Note:** Nonemergency services must be rendered in a **participating** hospital.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
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</thead>
<tbody>
<tr>
<td>Inpatient consultations</td>
<td>90% after in-network deductible</td>
<td>70% after out-of-network deductible</td>
</tr>
</tbody>
</table>

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### Benefits

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
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</thead>
<tbody>
<tr>
<td>Chemotherapy</td>
<td>90% after in-network deductible</td>
<td>70% after out-of-network deductible</td>
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</tbody>
</table>

### Alternatives to hospital care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing care - must be in a participating skilled nursing facility</td>
<td>90% after in-network deductible</td>
<td>90% after in-network deductible</td>
</tr>
</tbody>
</table>

  Limited to a maximum of 120 days per member per calendar year.

| Hospice care | 100% (no deductible or copay/coinsurance) | 100% (no deductible or copay/coinsurance) |

Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a participating hospice program only, limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)

| Home health care: |
| • must be medically necessary |
| • must be provided by a participating home health care agency | 90% after in-network deductible | 90% after in-network deductible |

| Infusion therapy: |
| • must be medically necessary |
| • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) |
| • may use drugs that require preauthorization - consult with your doctor | 90% after in-network deductible | 90% after in-network deductible |

### Surgical services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility</td>
<td>90% after in-network deductible</td>
<td>70% after out-of-network deductible</td>
</tr>
</tbody>
</table>

| Presurgical consultations | 100% (no deductible or copay/coinsurance) | 70% after out-of-network deductible |

| Voluntary sterilization for males | 90% after in-network deductible | 70% after out-of-network deductible |

**Note:** For voluntary sterilizations for females, see "Preventive care services."

| Voluntary abortions | 90% after in-network deductible | 70% after out-of-network deductible |

### Human organ transplants

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specified human organ transplants - must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)</td>
<td>100% (no deductible or copay/coinsurance)</td>
<td>100% (no deductible or copay/coinsurance) - in designated facilities only</td>
</tr>
</tbody>
</table>

| Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) | 90% after in-network deductible | 70% after out-of-network deductible |

| Specified oncology clinical trials | 90% after in-network deductible | 70% after out-of-network deductible |

**Note:** BCBSM covers clinical trials in compliance with PPACA.

| Kidney, cornea and skin transplants | 90% after in-network deductible | 70% after out-of-network deductible |
## Mental health care and substance use disorder treatment

**Note:** Some mental health and substance use disorder services are considered by BCBSM to be comparable to an office visit or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit or medical online visit, we will process the claim under your office visit or medical online visit benefit.

**Note:** BCBSM will cover mental health services performed - MD, DO, Fully Licensed Psychologists, Licensed Professional Counselor (LPC), and Clinical Licensed Master's Social Workers (CLMSWs), Limited Licensed Psychologists (LLPs), Social Workers who have the following social work degrees/certifications: MMSW and MMSW.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient mental health care and inpatient substance use disorder</td>
<td>90% after in-network deductible</td>
<td>70% after out-of-network deductible</td>
</tr>
<tr>
<td>treatment</td>
<td></td>
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</tr>
<tr>
<td>Residential psychiatric treatment facility:</td>
<td>90% after in-network deductible</td>
<td>70% after out-of-network deductible</td>
</tr>
<tr>
<td>• covered mental health services must be performed in a residential</td>
<td></td>
<td></td>
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<tr>
<td>psychiatric treatment facility</td>
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<td></td>
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<tr>
<td>• treatment must be preauthorized</td>
<td></td>
<td></td>
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<tr>
<td>• subject to medical criteria</td>
<td></td>
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</tr>
<tr>
<td>Outpatient mental health care:</td>
<td>90% after in-network deductible</td>
<td>70% after in-network deductible</td>
</tr>
<tr>
<td>• Facility and clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Online visits - by physician or BCBSM selected vendor must be</td>
<td>$30 copay per visit</td>
<td>70% after out-of-network deductible</td>
</tr>
<tr>
<td>medically necessary</td>
<td></td>
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<tr>
<td>• Physician's office</td>
<td>90% after in-network deductible</td>
<td>70% after out-of-network deductible</td>
</tr>
<tr>
<td>Outpatient substance use disorder treatment - in approved facilities</td>
<td>90% after in-network deductible</td>
<td>70% after out-of-network deductible</td>
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<tr>
<td>only</td>
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<td>(in-network cost-sharing will apply if there is</td>
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<td></td>
<td>no PPO network)</td>
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## Autism spectrum disorders, diagnoses and treatment

**Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.

<table>
<thead>
<tr>
<th>Benefits</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Applied behavioral analysis (ABA) treatment - when rendered by an</td>
<td>90% after in-network deductible</td>
<td>90% after in-network deductible</td>
</tr>
<tr>
<td>approved board-certified behavioral analyst - is covered through age</td>
<td></td>
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</tr>
<tr>
<td>18, subject to preauthorization</td>
<td></td>
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</tr>
<tr>
<td>Note: Diagnosis of an autism spectrum disorder and a treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>recommendation for ABA services must be obtained by a BCBSM approved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>autism evaluation center (AAEC) prior to seeking ABA treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient physical therapy, speech therapy, occupational therapy,</td>
<td>90% after in-network deductible</td>
<td>70% after out-of-network deductible</td>
</tr>
<tr>
<td>nutritional counseling for autism spectrum disorder</td>
<td>Physical, speech and occupational therapy with</td>
<td></td>
</tr>
<tr>
<td></td>
<td>an autism diagnosis is</td>
<td></td>
</tr>
<tr>
<td></td>
<td>unlimited</td>
<td></td>
</tr>
<tr>
<td>Other covered services, including mental health services, for autism</td>
<td>90% after in-network deductible</td>
<td>70% after out-of-network deductible</td>
</tr>
<tr>
<td>spectrum disorder</td>
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</tbody>
</table>
## Other covered services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
</table>
| **Outpatient Diabetes Management Program (ODMP)**                       | • 90% after in-network deductible for diabetes medical supplies  
• 100% (no deductible or copay/coinsurance) for diabetes self-management training | 70% after out-of-network deductible               |
| **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. |                                                 |                                                 |
| **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs. |                                                 |                                                 |
| **Allergy testing and therapy**                                         | 100% (no deductible or copay/coinsurance)       | 70% after out-of-network deductible            |
| **Chiropractic spinal manipulation and osteopathic manipulative therapy** | 100% (no deductible or copay/coinsurance)       | 70% after out-of-network deductible            |
|                                                                        | Limited to a **combined** 12-visit maximum per member per calendar year |                                                 |
| **Outpatient physical, speech and occupational therapy - provided for rehabilitation** | 90% after in-network deductible                  | 70% after out-of-network deductible            |
| **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered. |                                                 |                                                 |
|                                                                        | Limited to a **combined** 60-visit maximum per member per calendar year |                                                 |
| **Durable medical equipment**                                           | 90% after in-network deductible                  | 90% after in-network deductible                |
| **Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM. |                                                 |                                                 |
| **Prosthetic and orthotic appliances**                                  | 90% after in-network deductible                  | 90% after in-network deductible                |
| **Private duty nursing care**                                           | 50% after in-network deductible                  | 50% after in-network deductible                |
| **Massage therapy - covered with a prescription from a M.D, D.O., Chiropractor, Physician Assistant or, Nurse Practitioner prior to receipt of services, and preformed by a licensed Massage Therapist (with no diagnostic restrictions)** | $70 visit maximum subject to 90% after in-network deductible | $70 visit maximum subject to 70% after out-of-network deductible |
| **Note:** Limited to 12 visits per member, per calendar year. Separate from physical, occupational, and speech therapy visit maximums. |                                                 |                                                 |
| **Glucose monitor, diabetic test strips and lancets**                   | 100% (no deductible or copay/coinsurance)       | 100% (no deductible or copay/coinsurance)      |

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association. Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.
WESTERN MICHIGAN UNIVERSITY
Group# 007005281/0004/0009/0010/0011/0030/0031/0040

BCBSM Preferred RX Program

Effective Date: On or after January 2018

Benefits-at-a-glance for Non-Bargaining Exempt

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/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Specialty Pharmaceutical Drugs - The mail order pharmacy for specialty drugs is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at bcbsm.com/pharmacy. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the same annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

<table>
<thead>
<tr>
<th>Benefits</th>
<th>90-day retail network pharmacy</th>
<th><em>In-network mail order provider</em></th>
<th>In-network pharmacy (not part of the 90-day retail network)</th>
<th>Out-of-network pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 - Generic or select prescribed over-the-counter drugs</td>
<td>1 to 30-day period</td>
<td>You pay $10 copay</td>
<td>You pay $10 copay</td>
<td>You pay $10 copay plus an additional 25% of BCBSM approved amount for the drug</td>
</tr>
<tr>
<td></td>
<td>31 to 83-day period</td>
<td>No coverage</td>
<td>You pay $20 copay</td>
<td>No coverage</td>
</tr>
<tr>
<td></td>
<td>84 to 90-day period</td>
<td>You pay $25 copay</td>
<td>You pay $20 copay</td>
<td>No coverage</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Benefits</th>
<th>90-day retail network pharmacy</th>
<th>* In-network mail order provider</th>
<th>In-network pharmacy (not part of the 90-day retail network)</th>
<th>Out-of-network pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 2 - Preferred brand-name</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>drugs</td>
<td>1 to 30-day period</td>
<td>You pay $40 copay</td>
<td>You pay $40 copay</td>
<td>You pay $40 copay</td>
</tr>
<tr>
<td></td>
<td>31 to 83-day period</td>
<td>No coverage</td>
<td>You pay $80 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>84 to 90-day period</td>
<td>You pay $100 copay</td>
<td>You pay $80 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 to 30-day period</td>
<td>You pay $80 copay</td>
<td>You pay $80 copay</td>
<td></td>
</tr>
<tr>
<td>Tier 3 - Non Preferred brand-name drugs</td>
<td>31 to 83-day period</td>
<td>No coverage</td>
<td>You pay $160 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>84 to 90-day period</td>
<td>You pay $200 copay</td>
<td>You pay $160 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 to 30-day period</td>
<td>You pay 15% of the approved amount, but no more than $150</td>
<td>You pay 15% of the approved amount, but no more than $150</td>
<td></td>
</tr>
<tr>
<td>Tier 4 - Generic and preferred brand-name specialty drug</td>
<td>31 to 83-day period</td>
<td>No coverage</td>
<td>No coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>84 to 90-day period</td>
<td>No coverage</td>
<td>No coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 to 30-day period</td>
<td>You pay 25% of the approved amount, but no more than $300</td>
<td>You pay 25% of the approved amount, but no more than $300</td>
<td></td>
</tr>
<tr>
<td>Tier 5 - Nonpreferred brand-name specialty drugs</td>
<td>31 to 83-day period</td>
<td>No coverage</td>
<td>No coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>84 to 90-day period</td>
<td>No coverage</td>
<td>No coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 to 30-day period</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>Sindecuse Pharmacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 - Generic or select prescribed over-the-counter drugs</td>
<td>31 to 83-day period</td>
<td>No coverage</td>
<td>No coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>84 to 90-day period</td>
<td>No coverage</td>
<td>No coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 to 30-day period</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>Sindecuse Pharmacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 2 - Preferred brand-name</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>drugs</td>
<td>31 to 83-day period</td>
<td>Not applicable</td>
<td>No coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>84 to 90-day period</td>
<td>Not applicable</td>
<td>You pay $22.50 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 to 30-day period</td>
<td>Not applicable</td>
<td>You pay $30 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>31 to 83-day period</td>
<td>Not applicable</td>
<td>No coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>84 to 90-day period</td>
<td>Not applicable</td>
<td>You pay $67.50 copay</td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>90-day retail network pharmacy</td>
<td>* In-network mail order provider</td>
<td>In-network pharmacy (not part of the 90-day retail network)</td>
<td>Out-of-network pharmacy</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------</td>
<td>---------------------------------</td>
<td>----------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>Sindecuse Pharmacy</strong>&lt;br&gt;Tier 3 - Nonpreferred brand-name drugs&lt;br&gt;1 to 30-day period</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>You pay $60 copay</td>
<td>Not applicable</td>
</tr>
<tr>
<td>31 to 83-day period</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>No coverage</td>
<td>Not applicable</td>
</tr>
<tr>
<td>84 to 90-day period&lt;br&gt;1 to 30-day period</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>You pay 15% of the approved amount, but not more than $120</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Sindecuse Pharmacy</strong>&lt;br&gt;Tier 4 - Generic and preferred brand-name specialty drugs&lt;br&gt;31 to 83-day period</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>No coverage</td>
<td>Not applicable</td>
</tr>
<tr>
<td>84 to 90-day period&lt;br&gt;1 to 30-day period</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>You pay 25% of the approved amount, but not more than $240</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Sindecuse Pharmacy</strong>&lt;br&gt;Tier 5 - Nonpreferred brand-name specialty drugs&lt;br&gt;31 to 83-day period</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>No coverage</td>
<td>Not applicable</td>
</tr>
<tr>
<td>84 to 90-day period</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>No coverage</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

*BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.*

## Covered services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>90-day retail network pharmacy</th>
<th>* In-network mail order provider</th>
<th>In-network pharmacy (not part of the 90-day retail network)</th>
<th>Out-of-network pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>FDA-approved drugs&lt;br&gt;100% of approved amount less plan copay/coinsurance</td>
<td>100% of approved amount less plan copay/coinsurance</td>
<td>100% of approved amount less plan copay/coinsurance</td>
<td>75% of approved amount less plan copay/coinsurance</td>
<td></td>
</tr>
<tr>
<td>State-controlled drugs&lt;br&gt;100% of approved amount less plan copay/coinsurance</td>
<td>100% of approved amount less plan copay/coinsurance</td>
<td>100% of approved amount less plan copay/coinsurance</td>
<td>75% of approved amount less plan copay/coinsurance</td>
<td></td>
</tr>
<tr>
<td>FDA-approved <strong>generic</strong> and select <strong>brand-name</strong> prescription preventive drugs, supplements and vitamins as required by PPACA&lt;br&gt;100% of approved amount</td>
<td>100% of approved amount</td>
<td>100% of approved amount</td>
<td>75% of approved amount</td>
<td></td>
</tr>
<tr>
<td>Other FDA-approved <strong>brand-name</strong> prescription preventive drugs, supplements and vitamins as required by PPACA&lt;br&gt;100% of approved amount less plan copay/coinsurance</td>
<td>100% of approved amount less plan copay/coinsurance</td>
<td>100% of approved amount less plan copay/coinsurance</td>
<td>75% of approved amount less plan copay/coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Benefits</th>
<th>90-day retail network pharmacy</th>
<th>* In-network mail order provider</th>
<th>In-network pharmacy (not part of the 90-day retail network)</th>
<th>Out-of-network pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 Patient Protection and Affordable Care Act</td>
<td>100% of approved amount</td>
<td>Not covered</td>
<td>100% of approved amount</td>
<td>75% of approved amount</td>
</tr>
<tr>
<td>FDA-approved <strong>generic</strong> and select <strong>brand name</strong> prescription contraceptive medication (non-self-administered drugs are not covered) - including prescriptions received from Sindecuse Pharmacy</td>
<td>100% of approved amount</td>
<td>100% of approved amount</td>
<td>100% of approved amount</td>
<td>75% of approved amount</td>
</tr>
<tr>
<td>Other FDA-approved <strong>brand name</strong> prescription contraceptive medication (non-self-administered drugs are not covered) - including prescriptions received from Sindecuse Pharmacy</td>
<td>100% of approved amount</td>
<td>100% of approved amount less plan copay/coinsurance</td>
<td>Member pays 100% of approved amount **Sindecuse Pharmacy--100% of approved amount less plan copay/coinsurance</td>
<td>75% of approved amount less plan copay/coinsurance</td>
</tr>
<tr>
<td>Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs</td>
<td>100% of approved amount less plan copay/coinsurance</td>
<td>100% of approved amount less plan copay/coinsurance</td>
<td>100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug</td>
<td>75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug</td>
</tr>
<tr>
<td>Note: Needles and syringes have no copay/coinsurance.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic test strips and lancets</td>
<td>100% of approved amount</td>
<td>100% of approved amount</td>
<td>100% of approved amount</td>
<td>75% of approved amount</td>
</tr>
<tr>
<td>Diabetic Drugs - including prescriptions received from Sindecuse Pharmacy</td>
<td>100% of approved amount</td>
<td>100% of approved amount</td>
<td>100% of approved amount</td>
<td>75% of approved amount less plan copay</td>
</tr>
</tbody>
</table>

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

**Features of your prescription drug plan**

**Custom Drug List**

A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.

- **Tier 1 (generic)** - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment.
- **Tier 2 (preferred brand)** - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance.
- **Tier 3 (nonpreferred brand)** - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.
- **Tier 4 (generic and preferred brand-name specialty)** - Tier 4 includes covered specialty drugs listed as generic drugs (Tier 1) or preferred brand-name drugs (Tier 2) from the Custom Drug List. These drugs have a proven record for safety and effectiveness, and offer the best value to our members. They have the lowest specialty drug copay/coinsurance.
- **Tier 5 (nonpreferred brand-name specialty)** - Tier 5 includes covered specialty drugs listed as nonpreferred brand name (Tier 3). These drugs may not have a proven record for safety or their clinical value may not be as high as the specialty drugs in Tier 4. They have the highest specialty drug copay/coinsurance.
Features of your prescription drug plan

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug interchange and generic copay/coinsurance waiver</td>
<td>BCBSM's drug interchange and generic copay/coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/coinsurance. In select cases BCBSM may waive the initial copay/coinsurance after your prescription HSA been rewritten. BCBSM will notify you if you are eligible for a waiver.</td>
</tr>
<tr>
<td>Mandatory maximum allowable cost drugs</td>
<td>If your prescription is filled by any type of 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 nonformulary brand-name drug with a generic equivalent from BCBSM and writes &quot;Dispense as Written&quot; or &quot;DAW&quot; on the prescription order, You pay only your applicable copay.  <strong>Note:</strong> This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.</td>
</tr>
<tr>
<td>Over-the-counter drugs</td>
<td>Excludes benefits for certain over-the-counter drugs.</td>
</tr>
<tr>
<td>Dosage and quantity of drugs</td>
<td>Your prescription drug coverage has eliminated authorization requirements for select prescription drugs, and dosages and quantities of drugs.</td>
</tr>
<tr>
<td>Erectile dysfunction drugs</td>
<td>Limited to no more than 9 doses in a 30-day period.</td>
</tr>
</tbody>
</table>
WESTERN MICHIGAN UNIVERSITY

Group# 007005281/0008/0009/0010/0011/0030/0031/0040

Dental Coverage

Effective Date: On or after January 2018

Benefits-at-a-glance for Non-Bargaining Exempt

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. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Network access information

With Blue Dental PPO Plus, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.¹

Blue Dental PPO network- Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 438,000 dentist locations² nationwide. PPO dentists agree to accept our approved amount as full payment for covered services - members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit mibluedentist.com or call 1-888-826-8152.

1 Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.
2 A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.

Blue Par SelectSM arrangement- Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services - members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit mibluedentist.com.

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Member's responsibility (deductible, coinsurance and dollar maximums)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$30 per member limited to a maximum of $60 per family per calendar year</td>
</tr>
<tr>
<td>• Applies to Class II and Class III services only</td>
<td></td>
</tr>
<tr>
<td>Class I services</td>
<td>None (covered at 100%)</td>
</tr>
<tr>
<td>Class II services</td>
<td>10%</td>
</tr>
<tr>
<td>Class III services</td>
<td>50%</td>
</tr>
<tr>
<td>Class IV services</td>
<td>40%</td>
</tr>
<tr>
<td>Annual maximum for Class I, II and III services</td>
<td>$2,500 per member</td>
</tr>
<tr>
<td>Lifetime maximum for Class IV services</td>
<td>$2,500 per member</td>
</tr>
</tbody>
</table>

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.
### Class I services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral exams</td>
<td>100% of approved amount</td>
</tr>
<tr>
<td>A set (up to 4 films) of bitewing x-rays</td>
<td>100% of approved amount</td>
</tr>
<tr>
<td>Panoramic or full-mouth x-rays</td>
<td>100% of approved amount</td>
</tr>
<tr>
<td>Dental prophylaxis (teeth cleaning)</td>
<td>100% of approved amount</td>
</tr>
<tr>
<td>Pit and fissure sealants - for members age 19 and younger</td>
<td>100% of approved amount</td>
</tr>
<tr>
<td>Palliative (emergency) treatment</td>
<td>100% of approved amount</td>
</tr>
<tr>
<td>Fluoride treatments</td>
<td>100% of approved amount</td>
</tr>
<tr>
<td>Space maintainers - missing posterior (back) primary teeth - for members under age 19</td>
<td>100% of approved amount</td>
</tr>
</tbody>
</table>

### Notes:
- Twice per calendar year
- Once every 60 months
- Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
- Once per quadrant per lifetime
- Once every 24 months per quadrant
- Three times per tooth per calendar year after six months from original restoration

### Class II services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fillings - permanent (adult) teeth</td>
<td>90% of approved amount after deductible</td>
</tr>
<tr>
<td>Fillings - primary (child) teeth</td>
<td>90% of approved amount after deductible</td>
</tr>
<tr>
<td>Onlays and inlays restorations - permanent teeth - for members age 12 and older</td>
<td>90% of approved amount after deductible</td>
</tr>
<tr>
<td>Recementation of crowns, veneers, inlays, onlays and bridges</td>
<td>90% of approved amount after deductible</td>
</tr>
<tr>
<td>Oral surgery, except simple extractions</td>
<td>90% of approved amount after deductible</td>
</tr>
<tr>
<td>Root canal treatment - permanent tooth</td>
<td>90% of approved amount after deductible</td>
</tr>
<tr>
<td>Scaling and root planing</td>
<td>90% of approved amount after deductible</td>
</tr>
<tr>
<td>Full mouth occlusal adjustments</td>
<td>90% of approved amount after deductible</td>
</tr>
<tr>
<td>Occlusal biteguards</td>
<td>90% of approved amount after deductible</td>
</tr>
<tr>
<td>General anesthesia or IV sedation</td>
<td>90% of approved amount after deductible</td>
</tr>
<tr>
<td>Repairs and adjustments of a partial or complete denture</td>
<td>90% of approved amount after deductible</td>
</tr>
<tr>
<td>Relining or rebasing of a partial or complete denture</td>
<td>90% of approved amount after deductible</td>
</tr>
<tr>
<td>Tissue conditioning</td>
<td>90% of approved amount after deductible</td>
</tr>
</tbody>
</table>

### Notes:
- Replacement fillings covered after 24 months or more after initial filling
- Replacement fillings covered after 12 months or more after initial filling
- Once every 60 months per tooth
- Once every 12 months for tooth with one or more canals
- Once every 24 months per quadrant
- Once every 12 months
- When medically necessary and performed with oral surgery
- Six months or more after denture is delivered
- Once per arch in any 36 consecutive months
- Once per arch in any 36 consecutive months

### Class III services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removable dentures (complete and partial)</td>
<td>50% of approved amount after deductible</td>
</tr>
<tr>
<td>Bridges (fixed partial dentures) - for members age 16 and older</td>
<td>50% of approved amount after deductible</td>
</tr>
</tbody>
</table>

### Notes:
- Once every 60 months
- Once every 60 months after original was delivered
### Benefits Coverage

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endosteal implants - for members age 16 or older who are</td>
<td>50% of approved amount after deductible</td>
</tr>
<tr>
<td>covered at the time of the actual implant placement</td>
<td><strong>Note:</strong> Once per tooth per lifetime when</td>
</tr>
<tr>
<td></td>
<td>implant placement is for teeth numbered 2</td>
</tr>
<tr>
<td></td>
<td>through 15 and 18 through 31</td>
</tr>
<tr>
<td>Crowns - permanent teeth - for members age 12 and older</td>
<td>50% of approved amount after deductible</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Once every 60 months per tooth</td>
</tr>
</tbody>
</table>

**Class IV services - Orthodontic services for dependents under age 19**

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor treatment for tooth guidance appliances</td>
<td>60% of approved amount</td>
</tr>
<tr>
<td>Minor treatment to control harmful habits</td>
<td>60% of approved amount</td>
</tr>
<tr>
<td>Interceptive and comprehensive orthodontic treatment</td>
<td>60% of approved amount</td>
</tr>
<tr>
<td>Post-treatment stabilization</td>
<td>60% of approved amount</td>
</tr>
<tr>
<td>Cephalometric film (skull) and diagnostic photos</td>
<td>60% of approved amount</td>
</tr>
</tbody>
</table>

**Note:** For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination **before** treatment begins.
WESTERN MICHIGAN UNIVERSITY
Group# 007005281/0008/0009/0010/0011/0030/0031/0040

Vision Coverage
Effective Date: On or after January 2018
Benefits-at-a-glance for Non-Bargaining Exempt

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. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call 1-800-877-7195 or log on to the VSP Web site at vsp.com.

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

<table>
<thead>
<tr>
<th>Member's responsibility (copays)</th>
<th>VSP network doctor</th>
<th>Non-VSP provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye exam</td>
<td>$10 copay</td>
<td>$10 copay applies to charge</td>
</tr>
<tr>
<td>Prescription glasses (lenses and/or frames)</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Medically necessary contact lenses</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Note: No copay is required for prescribed contact lenses that are not medically necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual benefit maximum</td>
<td>BCBSM will pay up to a benefit maximum of $400 per member, whether obtained from a VSP or Non-VSP provider in any period of 24 consecutive months. You are responsible for any provider charges over the $400 amount.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eye exam</th>
<th>VSP network doctor</th>
<th>Non-VSP provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits</td>
<td>$10 copay</td>
<td>Reimbursement up to $50 less $10 copay (member responsible for any difference)</td>
</tr>
<tr>
<td>Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

One eye exam in any period of 24 consecutive months
# Lenses and frames

<table>
<thead>
<tr>
<th>Benefits</th>
<th>VSP network doctor</th>
<th>Non-VSP provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard</strong> lenses (must not exceed 60 mm in diameter) prescribed and dispatched by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Standard lenses</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>$400 allowance combined for lenses, frames, and contact lenses, or any combination thereof</td>
<td>One pair of lenses, with or without frames, in any period of 24 <strong>consecutive</strong> months</td>
<td>One frame in any period of 24 <strong>consecutive</strong> months</td>
</tr>
</tbody>
</table>

**Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.

---

# Contact Lenses

<table>
<thead>
<tr>
<th>Benefits</th>
<th>VSP network doctor</th>
<th>Non-VSP provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Elective contact lenses that <strong>improve</strong> vision (prescribed, but do not meet criteria of medically necessary)</td>
<td>Contact lenses up to the allowance in any period of 24 <strong>consecutive</strong> months</td>
<td>Contact lenses up to the allowance in any period of 24 <strong>consecutive</strong> months</td>
</tr>
<tr>
<td>$400 allowance combined for lenses, frames, and contact lenses, or any combination thereof</td>
<td>Contact lenses up to the allowance in any period of 24 <strong>consecutive</strong> months</td>
<td>Contact lenses up to the allowance in any period of 24 <strong>consecutive</strong> months</td>
</tr>
</tbody>
</table>