Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

WESTERN MICHIGAN UNIVERSITY
MSEA
007005281
Community Blue PPO℠ ASC
Effective Date: On or after January 2023
Benefits-at-a-glance

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.

Provider Networks
Your health care benefits include three provider networks or tiers

- **Tier 1:** Sindecuse Health Center and WMU-Unified Clinic. Members will experience the least out-of-pocket costs when services are provided at Sindecuse Health Center and WMU-Unified Clinic. This network will consist of Sindecuse Health Center and WMU-Unified Clinic. Tier 1 is considered In-network and unless otherwise noted, benefits will remain the same as Tier 2.
- **Tier 2:** BCBSM PPO In-network Facility and Professional Providers. When services are performed by a provider who is part of BCBSM's PPO In-network, members will experience greater out-of-pocket costs than services provided under Tier 1
- **Tier 3:** Out-of-network Facility and Professional Providers. Members are subject to the greatest out-of-pocket expenses when treatment is received from out-of-network providers without an authorized referral or in absence of an emergency situation

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

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Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Deductible	$450 for one member, $900 for the family (when two or more members are covered under your contract) each calendar year **Note:** Level 1 deductible amounts also count toward the level 2 deductible. **Note:** Deductible may be waived for covered services performed in an Level 1 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.	$900 for one member, $1,800 for the family (when two or more members are covered under your contract) each calendar year **Note:** Level 2 deductible amounts also count toward the level 1 deductible. **Note:** Deductible may be waived for covered services performed in an Level 2 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.	$1,800 for one member, $3,600 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the level 1 and level 2 deductibles.
Flat-dollar copays	• $25 copay for office visits and office consultations with a **primary care physician** • $40 copay for office visits and office consultations with a **specialist** • $25 copay for medical online visits • $40 copay for urgent care visits • $150 copay for emergency room visits	• $25 copay for office visits and office consultations with a **primary care physician** • $40 copay for office visits and office consultations with a **specialist** • $25 copay for medical online visits • $40 copay for urgent care visits • $150 copay for emergency room visits	• $150 copay for emergency room visits
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 30% 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 select covered services	• 30% 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 select covered services	• 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
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	$2,000 for one member, $4,000 for the family (when two or more members are covered under your contract) each calendar year	$2,000 for one member, $4,000 for the family (when two or more members are covered under your contract) each calendar year	$4,000 for one member, $8,000 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		

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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. 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.

Preventive care services

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance) **Note:** Additional well-women visits may be allowed based on medical necessity.	100% (no deductible or copay/coinsurance) **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
	One per member per calendar year		
Gynecological exam	100% (no deductible or copay/coinsurance) **Note:** Additional well-women visits may be allowed based on medical necessity.	100% (no deductible or copay/coinsurance) **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
	Two per member per calendar year		
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
	One per member per calendar year		
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
	• 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		
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	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
	One per member per calendar year		
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
	One per member per calendar year		

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Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	Not covered
	One per member per calendar year		
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your Level 1 deductible and coinsurance.	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your Level 2 deductible and coinsurance, if applicable.	70% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year		
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your Level 1 deductible and coinsurance.	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your Level 2 deductible and coinsurance.	70% after out-of-network deductible
	One per member per calendar year		

Physician office services

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Office visits - must be medically necessary	• $25 copay for each office visit with a **primary care physician** • $40 copay for each office visit with a **specialist**	• $25 copay for each office visit with a **primary care physician** • $40 copay for each office visit with a **specialist**	70% after out-of-network deductible
Online visits - by physician or **BCBSM** selected vendor must be medically necessary	• $25 copay for online visits	$25 copay per online visit	70% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Office consultations - must be medically necessary	• $25 copay for each office consultation with a **primary care physician** • $40 copay for each office consultation with a **specialist**	• $25 copay for each office consultation with a **primary care physician** • $40 copay for each office consultation with a **specialist**	70% after out-of-network deductible
Urgent care visits - must be medically necessary	$40 copay per urgent care visit	$40 copay per urgent care visit	70% after out-of-network deductible

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Benefits	PPO Network		Tier 3 - Out-of-Network
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Emergency medical care

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Hospital emergency room	$150 copay per visit (copay waived if admitted or for an accidental injury)	$150 copay per visit (copay waived if admitted or for an accidental injury)	$150 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	90% after Level 2 in-network deductible

Diagnostic services

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Laboratory and pathology services	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Diagnostic tests and x-rays	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Therapeutic radiology	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Prenatal care visits	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Delivery and nursery care	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible

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Hospital care

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
	Unlimited days		
Inpatient consultations	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Chemotherapy	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible

Alternatives to hospital care

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Skilled nursing care - must be in a **participating** skilled nursing facility	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	90% after Level 2 in-network deductible
	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)	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 Level 1 in-network deductible	90% after Level 2 in-network deductible	90% after Level 2 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 Level 1 in-network deductible	90% after Level 2 in-network deductible	90% after Level 2 in-network deductible

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Surgical services

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see "**Preventive care services.**"	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Voluntary abortions	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible

Human organ transplants

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities **only**
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Kidney, cornea and skin transplants	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible

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Behavioral Health Services (Mental Health and Substance Use Disorder)

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: MSSW and MMSW

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Inpatient mental health care and **inpatient** substance use disorder treatment	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
	Unlimited days		
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment **must** be preauthorized • subject to medical criteria	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	90% after Level 2 in-network deductible in participating facilities **only**
• Online visits - by physician or **BCBSM** selected vendor must be medically necessary	$25 copay per online visit	$25 copay per online visit	70% after out-of-network deductible
• Physician's office	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	70% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

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Autism spectrum disorders, diagnoses and treatment

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Applied behavior analysis (ABA) treatment - when rendered by an approved licensed behavior analyst - subject to preauthorization **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.	Not covered	90% after in-network deductible	90% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not covered	90% after in-network deductible	70% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited		
Other covered services, including mental health services, for autism spectrum disorder	Not covered	90% after in-network deductible	70% after out-of-network deductible

Other covered services

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Outpatient Diabetes Management Program (ODMP) **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.	• 90% after Level 1 in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	• 90% after Level 2 in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	70% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	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)	100% (no deductible or copay/coinsurance)	70% after out-of-network deductible
	Limited to a **combined** 12-visit maximum per member per calendar year		

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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. 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.

Benefits	PPO Network		Tier 3 - Out-of-Network
	Tier 1 - Sindecuse Health Center and WMU-Unified Clinic	Tier 2 - BCBSM PPO In-Network Providers	
Outpatient physical, speech and occupational therapy - provided for rehabilitation	90% after Level 1 in-network deductible	90% after Level 2 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 **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.	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	90% after Level 2 in-network deductible
Prosthetic and orthotic appliances	90% after Level 1 in-network deductible	90% after Level 2 in-network deductible	90% after Level 2 in-network deductible
Private duty nursing care	70% after Level 1 in-network deductible	70% after Level 2 in-network deductible	50% after out-of-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 performed by a licensed Massage Therapist (with no diagnostic restrictions) **Note:** Limited to 9 visits per member, per calendar year. Separate from physical, occupational, and speech therapy visit maximums.	$70 visit maximum subject to 90% after Level 1 in-network deductible	$70 visit maximum subject to 90% after Level 2 in-network deductible	$70 visit maximum subject to 70% after out-of-network deductible
Glucose monitor, diabetic test strips and lancets	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)

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WESTERN MICHIGAN UNIVERSITY
MSEA
007005281
BCBSM Preferred RX Program
Effective Date: On or after January 2023
Benefits-at-a-glance

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.

Prescription Drug Discount Program - Prescription drug manufacturers provide coupon programs for certain medications. Your benefit plan requires you to take advantage of BCBSM-approved coupon programs for select medications. This benefit may lower the cost-sharing typically required for these drugs. Your out-of-pocket expense will be no more than your benefit cost-sharing. When a manufacturer 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 to reflect your true out-of-pocket cost.

This program may be discontinued at any time if it is no longer supported by the vendor.

Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Pharmacy, 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. AllianceRx Walgreens Pharmacy will handle mail order prescriptions only for specialty drugs. You may obtain specialty drugs through a Walgreens retail pharmacy as well as long as the drug is available at that location. You may want to call ahead to confirm availability at the location. ***If you go to a non-AllianceRx Walgreens Pharmacy, you may be responsible for 100% of the cost of the specialty drug.*** Other mail order prescription medications can continue to be sent to the OptumRx home delivery pharmacy. (OptumRx 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 AllianceRx Walgreens 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 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The 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

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Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay $10 copay	You pay $10 copay	You pay $10 copay	You pay $10 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $20 copay	No coverage	No coverage
	84 to 90-day period	You pay $25 copay	You pay $20 copay	No coverage	No coverage
Preferred brand-name drugs	1 to 30-day period	You pay $40 copay	You pay $40 copay	You pay $40 copay	You pay $40 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $80 copay	No coverage	No coverage
	84 to 90-day period	You pay $100 copay	You pay $80 copay	No coverage	No coverage
Nonpreferred brand-name drugs**	1 to 30-day period	You pay $80 copay	You pay $80 copay	You pay $80 copay	You pay $80 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $160 copay	No coverage	No coverage
	84 to 90-day period	You pay $200 copay	You pay $160 copay	No coverage	No coverage
Generic and preferred brand-name specialty drugs	1 to 30-day period	You pay 15% of the approved amount, but no more than $150	You pay 15% of the approved amount, but no more than $150	You pay 15% of the approved amount, but no more than $150	You pay 15% of the approved amount, but no more than $150 plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage
Nonpreferred brand-name specialty drugs	1 to 30-day period	You pay 25% of the approved amount, but no more than $300	You pay 25% of the approved amount, but no more than $300	You pay 25% of the approved amount, but no more than $300	You pay 25% of the approved amount, but no more than $300 plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage
Sindecuse Pharmacy Generic or select prescribed over-the-counter drugs	1 to 30-day period	Not applicable	Not applicable	You pay $10 copay	Not applicable
	31 to 83-day period	Not applicable	Not applicable	No coverage	Not applicable
	84 to 90-day period	Not applicable	Not applicable	You pay $22.50 copay	Not applicable

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Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Sindecuse Pharmacy Preferred brand-name drugs	1 to 30-day period	Not applicable	Not applicable	You pay $40 copay	Not applicable
	31 to 83-day period	Not applicable	Not applicable	No coverage	Not applicable
	84 to 90-day period	Not applicable	Not applicable	You pay $90 copay	Not applicable
Sindecuse Pharmacy Nonpreferred brand-name drugs	1 to 30-day period	Not applicable	Not applicable	You pay $80 copay	Not applicable
	31 to 83-day period	Not applicable	Not applicable	No coverage	Not applicable
	84 to 90-day period	Not applicable	Not applicable	You pay $180 copay	Not applicable
Sindecuse Pharmacy Generic and preferred brand-name specialty drugs	1 to 30-day period	Not applicable	Not applicable	You pay 15% of the approved amount, but not more than $150	Not applicable
	31 to 83-day period	Not applicable	Not applicable	No coverage	Not applicable
	84 to 90-day period	Not applicable	Not applicable	Not applicable	Not applicable
Sindecuse Pharmacy Nonpreferred brand-name specialty drugs	1 to 30-day period	Not applicable	Not applicable	You pay 25% of the approved amount, but not more than $300	Not applicable
	31 to 83-day period	Not applicable	Not applicable	No coverage	Not applicable
	84 to 90-day period	Not applicable	Not applicable	Not applicable	Not applicable

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

Covered services

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

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Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
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	100% of approved amount	No coverage	100% of approved amount	75% of approved amount
FDA-approved **generic** and select **brand name** prescription contraceptive medication (non-self-administered drugs are not covered) - including prescriptions received from Sindecuse Pharmacy	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs are not covered) - including prescriptions received from Sindecuse Pharmacy	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug
Diabetic test strips and lancets	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Diabetic Drugs - including prescriptions received from Sindecuse Pharmacy	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount less plan copay

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

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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. • **Generic drug tier** - This tier 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. • **Preferred brand-name drug tier** - This tier includes non-specialty preferred brand-name drugs. These drugs are more expensive then generic and members pay more for them • **Nonpreferred brand-name drug tier** - This tier includes non-specialty brand-name drugs for which there's either a generic alternative or a more cost-effective preferred brand-name drug available. Members pay more for these nonpreferred brand-name drugs. • **Generic and preferred specialty drug tier** - This tier includes generic and preferred brand-name specialty drugs that are used to treat difficult health conditions. These drugs are generally more cost-effective than nonpreferred specialty drugs. • **Nonpreferred specialty drug tier** - This tier includes nonpreferred brand-name, specialty drugs that are used to treat difficult health conditions. Members pay more for nonpreferred specialty drugs because there are cost-effective generic or preferred drugs available.
Mandatory maximum allowable cost drugs	If your prescription is filled by an in-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/coinsurance regardless of whether you or your physician requests the brand-name drug. **Exception:** If your physician requests and receives authorization for a nonpreferred 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/coinsurance. **Note:** This MAC difference will not be applied toward your annual in-network deductible, your annual coinsurance, or your annual out-of-pocket maximum, if applicable.
Over-the-counter drugs	Excludes benefits for certain over-the-counter drugs.
Quantity of drugs	Your prescription drug coverage has eliminated authorization requirements for select prescription drugs, and quantities of drugs.
Erectile dysfunction drugs	Limited to no more than **6 doses** in a **30-day** period.

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Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

WESTERN MICHIGAN UNIVERSITY
MSEA
007005281
Dental Coverage
Effective Date: On or after January 2023
Benefits-at-a-glance

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Coverage determination: Claims are subject to dental necessity verification and availability of dental benefits when they are processed, as well as the terms and conditions of the applicable BCBSM certificates and riders.

Network access information
With Blue Dental PPO, 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.

Blue Dental PPO network- Blue Dental members have unmatched access to PPO (in-network) dentists through the Blue Dental PPO network, which offers more than 535,000 dentist locations* nationwide. PPO dentists agree to accept our approved amount as full payment for covered services, and 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.**

**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 is two dentist locations.*

Blue Par Select℠ arrangement- Most non-PPO(out-of-network) 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, and 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)

Benefits	Coverage
Deductible • Applies to Class II and Class III services only	$30 per member limited to a maximum of $60 per family per calendar year
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services	None (covered at 100%)
• Class II services	10%
• Class III services	50%
• Class IV services	40%

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Benefits	Coverage
Dollar maximums • Annual maximum for Class I, II and III services	$2,500 per member
• Lifetime maximum for Class IV services	$2,500 per member

Class I services

Benefits	Coverage
Oral exams	100% of approved amount **Note:** Twice per calendar year
A set (up to 4 films) of bitewing x-rays	100% of approved amount **Note:** Twice per calendar year
Panoramic or full-mouth x-rays	100% of approved amount **Note:** Once every 60 months
Prophylaxis (cleaning)	100% of approved amount **Note:** Twice per calendar year
Sealants - for members age 19 and younger	100% of approved amount **Note:** Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Emergency palliative treatment	100% of approved amount
Fluoride treatments	100% of approved amount **Note:** Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	100% of approved amount **Note:** Once per quadrant per lifetime

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	90% of approved amount after deductible **Note:** Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	90% of approved amount after deductible **Note:** Replacement fillings covered after 12 months or more after initial filling
Onlays and inlays restorations - permanent teeth - for members age 12 and older	90% of approved amount after deductible **Note:** Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	90% of approved amount after deductible **Note:** Three times per tooth per calendar year after six months from original restoration
Oral surgery	90% of approved amount after deductible
Root canal treatment	90% of approved amount after deductible **Note:** Once per tooth per lifetime; retreatment of previous root canal therapy (after 12 months from the date of the original therapy) once per tooth per lifetime.
Scaling and root planing	90% of approved amount after deductible **Note:** Once every 24 months per quadrant
Full mouth occlusal adjustments	90% of approved amount after deductible
Occlusal biteguards	90% of approved amount after deductible **Note:** Once every 12 months
General anesthesia or IV sedation	90% of approved amount after deductible **Note:** When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	90% of approved amount after deductible **Note:** Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	90% of approved amount after deductible **Note:** Once per arch in any 36 consecutive months

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Benefits	Coverage
Tissue conditioning	90% of approved amount after deductible **Note:** Once per arch in any 36 consecutive months

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	50% of approved amount after deductible **Note:** Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	50% of approved amount after deductible **Note:** Once every 60 months
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount after deductible **Note:** Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31
Crowns - permanent teeth - for members age 12 and older	50% of approved amount after deductible **Note:** Once every 60 months per tooth

Class IV services

Benefits	Coverage
Minor treatment for tooth guidance appliances	60% of approved amount
Minor treatment to control harmful habits	60% of approved amount
Interceptive and comprehensive orthodontic treatment	60% of approved amount
Post-treatment stabilization	60% of approved amount
Cephalometric film (skull) and diagnostic photos	60% of approved amount

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.

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Blue Cross Blue Shield of Michigan

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WESTERN MICHIGAN UNIVERSITY
MSEA
007005281
Vision Coverage
Effective Date: On or after January 2023
Benefits-at-a-glance

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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

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	$10 copay	$10 copay applies to charge
Prescription glasses (lenses and/or frames)	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)	Member responsible for difference between benefit maximum and provider's charge
Medically necessary contact lenses **Note:** No copay is required for prescribed contact lenses that are not medically necessary.	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)	Member responsible for difference between benefit maximum and provider's charge
Annual benefit maximum	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 for standard lenses, frames and contact lenses. You are responsible for any provider charges over the $400 amount.	

Eye exam

Benefits	VSP network doctor	Non-VSP provider
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.	$10 copay	Reimbursement up to $50 less $10 copay (member responsible for any difference)
	One eye exam in any period of 24 **consecutive** months	

ADM DC26MEVIS;ADM PLANYR JAN;ASCMOD 10442MED;ASCMOD 10444DRG;ASCMOD 4386 MED;ASCMOD 8886 VIS;ASCMOD 8887 DEN;BLUE DENTAL;BLUE VISION;BVC $10;BVFLE;CB ASC;CB-AMB ASC;CB-ECMP-ASC;CB-ET $150 ASC;CB-MTC $0 ASC;CB-OPMIN 2K ASC;CB-OPMON 4K ASC;CB-OV $30 ASC;CBD $250-IN ASC;CBD $500-ON ASC;CBOLV 30 ASC;CCB ASC;CDC-DC 26-ME;DC 26-ME ASC;DO-PPO;PD-ESN ASC;PDRX ASC;PKE39;RX-VCP ASC;SP10408015%253K;XBPPE ASC

Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed 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.	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)
	One pair of lenses, with or without frames, in any period of 24 **consecutive** months	
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)
	One frame in any period of 24 **consecutive** months	

Contact Lenses

Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)
	Contact lenses up to the benefit maximum in any period of 24 consecutive months	
Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)	Reimbursement up to benefit maximum (member responsible for any amount above the benefit maximum)
	Contact lenses up to the benefit maximum in any period of 24 consecutive months	

ADM DC26MEVIS;ADM PLANYR JAN;ASCMOD 10442MED;ASCMOD 10444DRG;ASCMOD 4386 MED;ASCMOD 8886 VIS;ASCMOD 8887 DEN;BLUE DENTAL;BLUE VISION;BVC $10;BVFLE;CB ASC;CB-AMB ASC;CB-ECMP-ASC;CB-ET $150 ASC;CB-MTC $0 ASC;CB-OPMIN 2K ASC;CB-OPMON 4K ASC;CB-OV $30 ASC;CBD $250-IN ASC;CBD $500-ON ASC;CBOLV 30 ASC;CCB ASC;CDC-DC 26-ME;DC 26-ME ASC;DO-PPO;PD-ESN ASC;PDRX ASC;PKE39;RX-VCP ASC;SP10408015%253K;XBPPE ASC