# PPO Premier with RX Plan 6
# Benefits-at-a-Glance
# WmHIP

| | In-Network | Out-of-Network |
|---|---|---|
| **Deductible, Copays/Coinsurance and Dollar Maximums** | | |
| **Deductible - per calendar year** | Not Applicable | $250 per member<br>$500 per family |
| **Copays/Coinsurance**<br>• Fixed Dollar Copays | $5 copay for:<br>• Office visits<br>• Urgent Care Visits<br>$25 copay for:<br>• Non-emergency visits in emergency room | $25 copay for:<br>• Non-emergency visits in emergency room |
| • Percent Coinsurance | Not Applicable | 20%<br>**Note**: Services without a network are covered at the in-network level. |
| **Out-of-Pocket Maximum – per calendar year**<br>• Percent Coinsurance<br>*Excludes Deductible* | Not Applicable | $2,000 per member<br>$4,000 per family |
| **Lifetime Maximum** | Unlimited | |
| **Preventive Services – limited to $500 per member per calendar year maximum** | | |
| Health Maintenance Exam – beginning age 16, one per calendar year; includes related X-rays, EKG, and lab procedures performed as part of the physical exam | Covered – 100% | Not Covered |
| Annual Gynecological Exam - one per calendar year<br>*Does not contribute to annual dollar maximum* | Covered – 100% | Not Covered |
| Pap Smear Screening – one per calendar year; laboratory services only. *Does not contribute to annual maximum* | Covered – 100% | Not Covered |
| Prostate Specific Antigen (PSA) Screening - one per calendar year. *Does not contribute to annual maximum* | Covered – 100% | Not Covered |
| Fecal Occult Blood Test – one per calendar year,<br>*Does not contribute to annual dollar maximum* | Covered – 100% | Not Covered |
| Endoscopic Exams – one per calendar year<br>*Does not contribute to annual dollar maximum* | Covered – 100% | Not Covered |
| Well-Baby and Child Care - through age 15<br>6 visits birth through age 1, 2 visits per year age 2 through 3, 1 visit per year age 4 through 15 | Covered – 100% | Not Covered |
| Immunizations - pediatric and adult<br>*Does not contribute to annual dollar maximum* | Covered – 100% | Not Covered |
| Hearing Exam – one per calendar year | Covered – 100% | Not Covered |
| **Mammograms** | | |
| Mammography Screening – one per calendar year<br>*Does not contribute to annual dollar maximum* | Covered – 100% | Not Covered |
| **Physician Office Services** | | |
| Office Visits<br>Includes:<br>• Primary Care Physicians and Specialists<br>• Pre-surgical consultations<br>♦ Initial visit to determine pregnancy | Covered – 100% after $5 copay<br><br>One copay applies to the office visit exam and all services performed during the office visit (e.g., lab, x-rays, etc.) | Covered – 80% after deductible |
| Urgent Care Visits | Covered – 100% after $5 copay | Covered – 80% after deductible |

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| **Emergency Medical Care** | | |
| Hospital Emergency Room<br>Qualified Medical Emergency & First Aid Services | Covered – 100% | Covered – 100% |
| Non-Emergency use of the Emergency Room | Covered – 100% after $25 copay | Covered – 100% after $25 copay |
| Ambulance Services – medically necessary transport | Covered – 100% | Covered – 100% |
| **Diagnostic Services** | | |
| MRI, MRA, PET and CAT Scans and Nuclear Medicine | Covered – 100% | Covered – 80% after deductible |
| Other Diagnostic Tests, X-rays, Laboratory & Pathology | Covered – 100% | Covered – 80% after deductible |
| Radiation Therapy | Covered – 100% | Covered – 80% after deductible |
| **Maternity Services Provided by a Physician** | | |
| Pre-Natal and Post-Natal Care | Covered – 100% | Covered – 80% after deductible |
| Delivery and Nursery Care | Covered – 100% | Covered – 80% after deductible |
| **Hospital Care** | | |
| Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies | Covered – 100% | Covered – 80% after deductible |
| | Unlimited days | |
| Inpatient Medical Care | Covered – 100% | Covered – 80% after deductible |
| Chemotherapy | Covered – 100% | Covered – 80% after deductible |
| **Alternatives to Hospital Care** | | |
| Skilled Nursing Facility | Covered – 100% | Covered – 100% |
| | Limited to 120 days per calendar year | |
| Hospice Care | Covered – 100% | Covered – 100% |
| Home Health Care | Covered – 100% | Covered – 100% |
| **Outpatient Surgical Services** | | |
| Surgery – includes related surgical services | Covered – 100% | Covered – 80% after deductible |
| Dental surgery and related anesthesia for the removal of wisdom teeth | Covered – 100% | Covered – 80% after deductible |
| Voluntary Abortion | Not Covered | Not Covered |
| Voluntary Sterilization – *excludes reversal sterilization* | Covered – 100% | Covered – 80% after deductible |
| **Human Organ Transplants** | | |
| Specified Organ Transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504) | Covered - 100% | Not Covered |
| | Unlimited dollar maximum per transplant type | |
| Kidney, Cornea, Bone Marrow and Skin | Covered – 100% | Covered – 80% after deductible |
| **Mental Health Care and Substance Abuse Treatment** | | |
| Inpatient Mental Health Care | Covered – 100% | Covered – 80% after deductible |
| Inpatient Substance Abuse Care | Covered – 100% | Covered – 80% after deductible |
| Outpatient Mental Health Care | Covered – 100% | Covered – 80% after deductible |
| Outpatient Substance Abuse Care | Covered – 100% | Covered – 80% after deductible |

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|---|---|---|

## Other Services

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|---|---|---|
| Cardiac Rehabilitation | Covered – 100% | Covered – 80% after deductible |
| Acupuncture - Performed by MD, DO, and other select provider specialties | Covered – 100% | Covered – 80% after deductible |
| Allergy Testing and Therapy | Covered – 100% | Covered – 80% after deductible |
| Chiropractic Spinal Manipulation | Covered – 100% | Covered – 80% after deductible |
| | Limited to 24 visits per calendar year | |
| Outpatient Physical, Speech and Occupational Therapy | Covered – 100% | Covered – 80% after deductible |
| | Limited to 60 combined visits per calendar year. Services are covered when performed in the outpatient department of the hospital, or approved freestanding facility. Physical therapy is also covered in an independent therapist's office. | |
| Massage Therapy rendered by MD, DO or Chiropractor<br>Hot/Cold Packs rendered by Chiropractor | Covered – 100% | Covered – 80% after deductible |
| | Limited to 24 visits per calendar year | |
| Durable Medical Equipment/Medical Supplies | Covered – 100% | Covered – 100% |
| Prosthetic and Orthotic Appliances | Covered – 100% | Covered – 100% |
| Private Duty Nursing<br>*Does not contribute to out-of-pocket maximum* | Covered – 90% | Covered – 90% |
| Hearing Aids | Covered – 100% of the approved amount. Hearing aid must be purchased from an approved hearing aid provider. | |

## Prescription Drugs

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|---|---|
| **Retail –** *34 day supply* | $ 0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D)<br>$ 10 copay – Generic drugs<br>$40 copay – Brand name drugs<br><br>Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay. |
| **Mail Order** - *90-day supply* | $ 0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D)<br>$20 copay – Generic drugs<br>$80 copay – Brand name drugs |
| **Additional Services:**<br>Oral & Injectable Contraceptives<br>Smoking Cessation Drugs<br>Weight Loss Drugs<br>Impotency Drugs<br>Infertility Drugs | <br>Covered<br>Covered<br>Covered<br>Covered – limited to 12 doses per month<br>Covered |

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