Blue Cross Blue Shield of Michigan
Independent licensee of the Blue Cross and Blue Shield Association

WESTERN MICHIGAN UNIVERSITY

Health Insurance Benefits Summary

Service	Community Blue[SM] PPO	
	In-Network	Out-of-Network
Health Maintenance Exam **(1)**	Covered – 100%, one per calendar year, includes select chest X-ray, EKG and select lab procedures *	Not Covered
Annual Gynecological Exam **(1)**	Covered – 100%, one per calendar year *	Not Covered
Pap Smear Screening – laboratory services only **(1)**	Covered – 100%, one per calendar year *	Not Covered
Well-Baby and Child Care	Covered – 100% * • 6 visits per year through age 1 • 2 visits per year, age 2 through age 3 • 1 visit per year, age 4 through 15	Not Covered
Immunizations	Covered – 100%, up through age 16 *	Not Covered
Fecal Occult Blood Screening	Covered – 100%, one per calendar year *	Not Covered
Flexible Sigmoidoscopy Exam	Covered – 100%, one per calendar year *	Not Covered
Prostate Specific Antigen (PSA) Screening **(1)**	Covered – 100%, one per calendar year *	Not Covered
**** Limited to $750 per member per calendar year.***		
Mammography Screening **(1)**	Covered – 100% after deductible	Covered – 80% after deductible
	One per calendar year, no age restrictions	
Office Visits **(1)**	Covered – $15 copay	Covered – 80% after deductible, must be medically necessary
Outpatient and Home Visits	Covered – 100% after deductible	Covered – 80% after deductible, must be medically necessary
Office Consultations **(1)**	Covered – $15 copay	Covered – 80% after deductible, must be medically necessary
Urgent Care Visits	Covered – $15 copay	Covered – 80% after deductible, must be medically necessary
Hospital Emergency Room – approved diagnosis	Covered – $50 copay, waived if admitted or for an accidental injury	Covered – $50 copay, waived if admitted or for an accidental injury
Ambulance Services – medically necessary	Covered – 100% after deductible	Covered – 100% after deductible
Diagnostic Services		
Laboratory and Pathology Tests	Covered – 100% after deductible	Covered – 80% after deductible
Diagnostic Tests and X-rays	Covered – 100% after deductible	Covered – 80% after deductible
Radiation Therapy	Covered – 100% after deductible	Covered – 80% after deductible
Maternity Services Provided by a Physician		
Pre-Natal and Post-Natal Care	Covered – 100%, includes care provided by a Certified Nurse Midwife	Covered – 80% after deductible, includes care provided by a Certified Nurse Midwife
Delivery and Nursery Care	Covered – 100%, after deductible includes delivery care provided by a Certified Nurse Midwife	Covered – 80% after deductible, includes delivery care provided by a Certified Nurse Midwife
Hospital Care		
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 100% after deductible	Covered – 80% after deductible
	Unlimited Days	
Inpatient Consultations	Covered – 100% after deductible	Covered – 80% after deductible
Chemotherapy	Covered – 100% after deductible	Covered – 80% after deductible

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Alternatives to Hospital Care		
Skilled Nursing Care	Covered – 100% after deductible	Covered – 100% after deductible
	Up to 120 days per calendar year	
Hospice Care	Covered – 100%	Covered – 100%
	Limited to the lifetime dollar maximum which is adjusted annually by the state	
Home Health Care	Covered – 100% after deductible,	Covered – 100% after deductible
	Unlimited Visits	
Surgical Services		
Surgery – includes related surgical services	Covered –100% after deductible	Covered – 80% after deductible
Voluntary Sterilization	Covered – 100% after deductible	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%	Covered – in designated facilities only
	Up to $1.5 million maximum per transplant type	
Bone Marrow – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504); specific criteria applies	Covered – 100% after deductible	Covered – 80% after deductible
Kidney, Cornea and Skin	Covered – 100% after deductible	Covered – 80% after deductible
Mental Health Services and Substance Abuse Treatment		
Inpatient Mental Health Care and Substance Abuse Care	Covered – 80% after deductible	Covered – 80% after deductible
	60 days per calendar year	
Outpatient Mental Health Care	Facility and Clinic: Covered – 80% after deductible Private Practice: Covered –80%, after deductible MSWs and CSWs covered.	Facility and Clinic: Covered – 80% after deductible Private Practice: Covered –80%, after deductible MSWs and CSWs covered.
	50 visits per calendar year	
Outpatient Substance Abuse Care – in approved facilities	Covered – 80% after deductible	Covered – 80% after deductible
	Up to the state-dollar amount which is adjusted annually.	
Other Services		
Allergy Testing and Therapy	Covered – 100%	Covered – 80% after deductible
Chiropractic Spinal Manipulation	Covered – 100%	Covered – 80% after deductible
	Up to 24 visits per calendar year	
Outpatient Physical Therapy and Occupational Therapy	Covered – 100% after deductible	Covered – 80% after deductible
	Up to 60 visits per calendar year	
Speech Therapy	Covered – 100% after deductible	Covered – 80% after deductible
Durable Medical Equipment	Covered – 100% after deductible	Covered – 100% after deductible
Prosthetic and Orthotic Appliances	Covered – 100% after deductible	Covered – 100% after deductible
Private Duty Nursing	Covered – 50% after deductible	Covered – 50% after deductible
Special Services		
Pay Subscriber Claims	Not Applicable Covered – 100% to Provider	Participating TRADITIONAL Provider: Covered – 80% after deductible, no balance bill Non-Participating TRADITIONAL/PPO Provider: Covered – 80% after deductible plus balance bill
BCBSM Medical Policy	BCBSM Medical Policy applies	BCBSM Medical Policy applies

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Multiple surgery rules and other inclusive procedures on pay subscriber claims	BCBSM Medical Policy applies	BCBSM Medical policy applies. Multiple surgery rules pay the highest cost service and may reject or pay at 50% any additional procedure. The member may be balance billed.
Infertility Diagnosis	Covered – 100%, after deductible	Covered – 80% after deductible
TMJ Bite Splints	Covered – 100% after deductible	Covered – 80% after deductible
Injection of Tendon or Ligament	Covered – 100% after deductible Trigger Point Injections Covered	Covered – 80% after deductible Trigger Point Injections Covered
Removal of Ear Wax	Covered – 100% after deductible	Covered – 80% after deductible
Audiology	Covered – 100%, after deductible for testing procedures performed by a MD or DO, or under the Physician's direct supervision if performed by an Audiologist. Routine screening services and services paid directly to the Audiologist are not covered.	Covered – 80% after deductible, for testing procedures performed by a MD or DO, or under the Physician's direct supervision if performed by an Audiologist. Routine screening services and services paid directly to the Audiologist are not covered.
Christian Science Practitioners	Not Covered	Not Covered
Massage Therapy performed by a Massage Therapist	Covered - Limited to 12 visits annually with a maximum $70 per visit, after in-network deductible.	
Light Box Therapy	Not Covered	Not Covered
Acupuncture by an Acupuncturist	Covered - Limited to 12 visits annually with a maximum $70 per visit, after in-network deductible.	

Prescription Drugs

Brand or Generic	Covered – under three (3) tier copay Tier 1– Generic - $15 Tier 2 – Formulary Brand - $25 Tier 3 – Nonformulary Brand - $35	Non-participating pharmacy claims will be paid at 75%

Deductible, Copays and Dollar Maximums

Deductible – per calendar year	$150 per member, $300 family	$250 per member, $500 family
Copays • Fixed Dollar Copays	$15 for office visits and $50 for emergency room visits	$50 for emergency room visits
• Percent Copays	20% for mental health care and substance abuse care, 50% for private duty nursing	20% for general services, mental health care and substance abuse care, 50% for private duty nursing* Note: Services without a network are covered at the in-network level
Copay Dollar Maximums • Fixed Dollar Copays	None	None
• Percent Copays – excludes mental health care, substance abuse care and private duty nursing copays	Not Applicable	$2,000 per member, $4,000 family, per calendar year
Dollar Maximums	$5 million lifetime per member for all covered services and as noted above for individual services	

*Note: If you receive care from a nonparticipating provider, even if you are referred, you may be billed for the difference between the approved amount and the provider's charge.
**Revised 09-08-05

VISION PLAN

Service	Community Blue PPO
Vision Services	
Examination	$10 Copay, then 100%
Single Vision Lenses	$15 Copay, then 100%
Bifocal Lenses	$15 Copay, then 100%
Trifocal Lenses	$15 Copay, then 100%
Progressive Lenses	$15 Copay, then 100%
Contact Lenses, medically necessary	$200 Maximum
Frames	$100 Maximum
Benefit Frequency	
Examinations	24 months
Lenses	24 months
Frames	24 months
Contacts	24 months

DENTAL PLAN

Service	Community Blue PPO
Benefit Attributes	
Annual Deductible	$0
Annual Plan Maximum	$2,500
Lifetime Orthodontia Plan Maximum	$2,500
Diagnostic and Preventive Services	
Diagnostic and Preventive	90%
Oral Exams	90% (2 per benefit period)
X-Rays	90% (Bitewings – 1 every 6 months; Full Mouth – 1 every 36 months)
Prophylaxis Treatments	90% (1 every 6 months)
Fluoride Treatments	90%
Space Maintainers	90% (for members under the age of 19)
Sealants	Not Covered
Basic Services	
Oral Surgery: Extractions and Other Surgical Procedures	90%
Restorative: Amalgam, Synthetic Porcelain and Plastic Restorations (Fillings)	90%
Endodontic Treatment	90%
Periodontic Treatment	90%
Major Services	
Crowns, Jackets and Cast Restoration Benefits	50%
Prosthodontic Benefits (Fixed Bridges, Partial/Complete Dentures, Single tooth implant)	50% (Replacement of dentures & bridges after 5 years if unserviceable)
Orthodontia Services	
Orthodontia	60% ($2,500 lifetime maximum)

This is intended to be an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificate and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan.

(1)Also see Sindecuse Health Center Services.

WMU Health Services Plan
Available to Community Blue PPO Participants at
Sindecuse Health Center and WMU Unified Clinics

Sindecuse Health Center Services

Office Visits Includes: -Health Maintenance Exams -Office Consultations -Annual Gynecological Exams -Pap Smear Screening -Prostate Specific Antigen (PSA) Screening -Mammography Screening Referrals	Covered – 100%
Urgent Care Facility	Covered – 100%
Physical Therapy	Covered – 100%
Physical Therapy Supplies	Covered – 100% if under $30, 90% if over $30
Allergy Services - injections	Covered – 100%
Prescription Drugs	Covered – with a three (3) tier copay Tier 1 – Generic - $10 Tier 2 – Formulary Brand - $20 Tier 3 – Nonformulary Brand - $30

Unified Clinics Services

Vision Services offered through Kalamazoo Optometry at the WMU Unified Clinics.

- Address: WMU Unified Clinics, 1000 Oakland Drive, 4th floor.
- The vision package is payable once every 24 months and includes:
- No Deductibles
- 100% coverage of vision exams
- $150 coverage towards the purchase of frames
- $15 copay for glass lenses
- $200 coverage toward contact lenses

For more information or to schedule an appointment, please call Kalamazoo Optometry at 269-382-6755.

Services in the following clinical areas are available at no cost to PPO plan members at the level of service as defined by each provider.

- Geriatric Assessment Center
- Child Trauma Center
- Women's Heath Center
- Low Vision Clinic
- Audiology Services
- Speech and Language Services
- Voice Services – for adults with a physician's referral