### Western Michigan Health Insurance Pool:
**GRCC Versatile 1 PPO, RX1**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

<table>
<thead>
<tr>
<th><strong>Coverage Period:</strong></th>
<th>Beginning on or after 01/01/2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage for:</strong></td>
<td>Individual / Family</td>
</tr>
<tr>
<td><strong>Plan Type:</strong></td>
<td>PPO</td>
</tr>
</tbody>
</table>

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**Group Number 71565 001, 002**

**Questions:** Call the number on the back of your BCBSM ID card or visit us at [www.bcbsm.com](http://www.bcbsm.com). If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [http://www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call the number on the back of your BCBSM ID card to request a copy.

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**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsm.com](http://www.bcbsm.com) or by calling 877 752-1233.

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<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>What is the overall deductible?</td>
<td>$250 Individual/ $500 Family</td>
<td>$500 Individual/ $1,000 Family</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>$1,250 Individual/ $2,500 Family</td>
<td>$2,500 Individual/ $5,000 Family</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Co-pays, premiums, balance-billed charges, and health care this plan doesn’t cover.</td>
<td></td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td></td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. For a list of in-network providers, see <a href="http://www.bcbsm.com">www.bcbsm.com</a> or call the number on the back of your BCBSM ID card.</td>
<td></td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No.</td>
<td></td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
<td></td>
</tr>
</tbody>
</table>
- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use a In-Network Provider</th>
<th>Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$10 co-pay</td>
<td>30% co-insurance after deductible</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Primary care visit to treat an injury or illness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$10 co-pay</td>
<td>30% co-insurance after deductible</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>10% co-insurance after deductible for Chiropractor</td>
<td>10% co-insurance after deductible for Chiropractor</td>
<td>Limited to a maximum of 24 visits per member per calendar year</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/ immunization</td>
<td>No charge</td>
<td>Not Covered</td>
<td>---none---</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% co-insurance after deductible</td>
<td>30% co-insurance after deductible</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% co-insurance after deductible</td>
<td>30% co-insurance after deductible</td>
<td>---none---</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic or prescribed over-the-counter drugs</td>
<td>$10 co-pay for retail 30-day supply, $20 co-pay for mail order 90-day supply</td>
<td>$10 co-pay plus an additional 25% of BCBSM approved amount</td>
<td>For information on women's contraceptive coverage, contact your employer. Mail order drugs are not covered out-of-network.</td>
</tr>
<tr>
<td></td>
<td>Formulary (preferred) brand-name drugs</td>
<td>$40 co-pay for retail 30-day supply, $80 co-pay for mail order 90-day supply</td>
<td>$40 co-pay plus an additional 25% of BCBSM approved amount</td>
<td>Mail order drugs are not covered out-of-network.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your cost if you use a</td>
<td>Limitations &amp; Exceptions</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>prescription drug coverage <em>(if applicable)</em>, contact your employer.</td>
<td>Nonformulary (nonpreferred) brand-name drugs</td>
<td>In-Network Provider $40 co-pay for retail 30-day</td>
<td>Mail order drugs are not covered out-of-network.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>supply, $80 co-mail order 90-day supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-of-Network Provider $40 co-pay plus an</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>additional 25% of BCBSM approved amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% co-insurance after deductible</td>
<td>---none---</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% co-insurance after deductible</td>
<td>---none---</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>10% co-insurance after deductible</td>
<td>---none---</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% co-insurance after deductible</td>
<td>---none---</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$10 co-pay</td>
<td>---none---</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% co-insurance after deductible</td>
<td>---none---</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>10% co-insurance after deductible</td>
<td>---none---</td>
<td></td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$10 co-pay</td>
<td>---none---</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>10% co-insurance after deductible</td>
<td>---none---</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$10 co-pay</td>
<td>---none---</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>10% co-insurance after deductible</td>
<td>---none---</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>10% co-insurance after deductible</td>
<td>---none---</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your cost if you use a</td>
<td>Limitations &amp; Exceptions</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>----------------------------------------</td>
<td>-----------------------------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% co-insurance after deductible</td>
<td>30% co-insurance after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% co-insurance after deductible</td>
<td>30% co-insurance after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% co-insurance after deductible</td>
<td>30% co-insurance after deductible</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Delivery and all inpatient services</td>
<td>---none---</td>
<td>Physical, Occupational, and Speech therapy are limited to a combined maximum of 60 visits per member, per calendar year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>10% co-insurance after deductible</td>
<td>30% co-insurance after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% co-insurance after deductible</td>
<td>30% co-insurance after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% co-insurance after deductible</td>
<td>30% co-insurance after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% co-insurance after deductible</td>
<td>30% co-insurance after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>10% co-insurance after deductible</td>
<td>30% co-insurance after deductible</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
</tbody>
</table>

|                                            |                                        | 10% co-insurance after deductible      | 30% co-insurance after deductible                                                       |
|                                            |                                        | 10% co-insurance after deductible      | 30% co-insurance after deductible                                                       |
|                                            |                                        | 10% co-insurance after deductible      | 30% co-insurance after deductible                                                       |
|                                            |                                        | 10% co-insurance after deductible      | 30% co-insurance after deductible                                                       |
## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental Care (Adult)
- Infertility treatment
- Long-term care
- Routine eye care
- Routine foot care
- Weight loss programs

### Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See http://provider.bcbs.com
- Hearing aids
- If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, co-payments, or co-insurance, or benefits not otherwise covered.
- Private-duty nursing
Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 877 752-1233. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Blue Cross® and Blue Shield® of Michigan, a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association, by calling 877 752-1233. Or, you can contact Michigan Office of Financial and Insurance Regulation at [www.michigan.gov/ofir](http://www.michigan.gov/ofir) or 1-877-999-6442. For group health coverage subject to ERISA, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Language Access Services
For assistance in a language below, please call 877 752-1233.

SPANISH (Español): Para ayuda en español, llame al número de servicio al cliente 877 752-1233 que se encuentra en este aviso ó en el reverso de su tarjeta de identificación.

TAGALOG (Tagalog): Para sa tulong sa wikang Tagalog, mangyaring tumawag sa numero ng serbisyo sa mamimili 877 752-1233 na nakalagay sa likod ng iyong pagkakakilanlan kard o sa paunawang ito.

CHINESE (中文): 要获取中文帮助，请致电您的身份识别卡背面或本通知提供的客户服务877 752-123 号码。

NAVAJO (Dine): Taa’dineji’keego shii’kaa’ahdool’wool ninizin’goo 877 752-1233, beesh behane’e naal’tsoos bikii sin’dahiiigii binii’deehgo eeh’doodago di’naal’tsoo bikaiigii bichi’hoodillnii.
About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much insurance protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Please note: Coverage Examples are calculated based on individual coverage.

Having a baby (normal delivery)

- Amount owed to providers: $7,540
- Plan pays $6,420
- You pay $1,120

Sample care costs:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges</td>
<td>$2,700</td>
</tr>
<tr>
<td>(mother)</td>
<td></td>
</tr>
<tr>
<td>Routine obstetric</td>
<td>$2,100</td>
</tr>
<tr>
<td>care</td>
<td></td>
</tr>
<tr>
<td>Hospital charges</td>
<td>$900</td>
</tr>
<tr>
<td>(baby)</td>
<td></td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other</td>
<td>$40</td>
</tr>
<tr>
<td>preventive</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$7,540</td>
</tr>
</tbody>
</table>

Patient pays:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Co-pays</td>
<td>$20</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$700</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$150</td>
</tr>
<tr>
<td>Total</td>
<td>$1,120</td>
</tr>
</tbody>
</table>

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays $4,450
- You pay $950

Sample care costs:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment &amp; Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits &amp; Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td>Total</td>
<td>$5,400</td>
</tr>
</tbody>
</table>

Patient pays:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Co-pays</td>
<td>$500</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>$120</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$80</td>
</tr>
<tr>
<td>Total</td>
<td>$950</td>
</tr>
</tbody>
</table>
Questions and answers about the Coverage Examples:

**What are some of the assumptions behind the Coverage Examples?**

- Costs don’t include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

**What does a Coverage Example show?**

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

**Does the Coverage Example predict my own care needs?**

✔️ No. Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor’s advice, your age, how serious your condition is, and many other factors.

**Does the Coverage Example predict my future expenses?**

✘ No. Coverage Examples are **not** cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

**Can I use Coverage Examples to compare plans?**

✔️ Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

**Are there other costs I should consider when comparing plans?**

✔️ Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you’ll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call the number on the back of your BCBSM ID card or visit us at [www.bcbsm.com](http://www.bcbsm.com). If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [http://www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call the number on the back of your BCBSM ID card to request a copy.