Individual Care **Blue** Plus℠

An individual health plan from Blue Cross Blue Shield of Michigan.

	In-Network	Out-of-Network
	NOTE: All benefits, except preventive services, are subject to a 180-day waiting period for pre-existing conditions.	
Benefit Highlights		
Annual deductible	$1,000 per individual contract per calendar year. $2,000 per family contract (two or more members) per calendar year. Two or more members must meet the family deductible. If the individual deductible has been met, but not the family deductible, we will pay covered services only for that member. Covered services for the remaining family members will be paid when the full family deductible has been met.	$2,000 per individual contract per calendar year. $4,000 per family contract (two or more members) per calendar year. Two or more members must meet the family deductible. If the individual deductible has been met, but not the family deductible, we will pay covered services only for that member. Covered services for the remaining family members will be paid when the full family deductible has been met.
Copays	30% of the BCBSM-approved amount	50% of the BCBSM-approved amount
Annual copay dollar maximum	$2,500 per individual contract. $5,000 per family contract (two or more members). Prescription drug copays and flat-dollar copays do not contribute to the annual copay dollar maximum.	$5,000 per individual contract. $10,000 per family contract (two or more members). Prescription drug copays and flat-dollar copays do not contribute to the annual copay dollar maximum.
Annual out-of-pocket maximum: The annual out-of-pocket maximum limits the amount members are responsible for paying each year. Once the annual out-of-pocket maximum is met, most services are payable at 100% of the BCBSM-approved amount.	$3,500 per individual contract. $7,000 per family contract (two or more members).	$7,000 per individual contract. $14,000 per family contract (two or more members).
Lifetime maximum (per member)	$5 million	
Fourth-quarter deductible carryover	Not applicable	
Preventive Services		
Preventive medical care: Includes health maintenance exam, routine laboratory and radiology, fecal occult blood screening, flexible sigmoidoscopy, gynecological exam, childhood immunizations (through age 15), Pap smear screening, prostate specific antigen screening, well-baby and well-child exams (6 visits per year through age 1; 2 visits per year, ages 2 through 3; 1 visit per year, ages 4 through 15).	Covered – 100% with no deductible, up to a combined maximum of $500 per member, per calendar year. 90-day benefit waiting period applies.	Not covered
Mammography screening	Covered – 100% with no deductible. 90-day benefit waiting period applies.	
Preventive dental	Covered – 100% with no deductible. One dental exam, cleaning and bitewing per member, per calendar year. 90-day benefit waiting period applies.	
Preventive vision (VSP network provider only)	Covered – 100% with no deductible. One vision exam, per member, per calendar year	

	In-Network	Out-of-Network
Physician Office Services		
Office visits	Covered – 70% with no deductible; 2 visits, per member, per calendar year	Not covered
Outpatient presurgical second opinion consultations	Covered – 100% after deductible	Not covered
Office consultations	Not covered	
Emergency and Urgent Care Services		
Medical emergencies and accidental injuries	Covered – 70% after in-network deductible for all services other than physician services. You pay $150 for physician services (waived if admitted).	
Ambulance service: medically necessary, emergency ground transport and air ambulance	Covered – 70% after in-network deductible	
Urgent care	Covered – 70% after in-network deductible for all services other than physician services. You pay $50 for physician services.	
Diagnostic and Radiation Services		
Ultrasound	Covered – 70% after deductible	Covered – 50% after deductible
Laboratory tests and pathology	Covered – 70% after deductible	Covered – 50% after deductible
EKGs	Covered – 70% after deductible	Covered – 50% after deductible
Diagnostic radiology and X-rays	Covered – 70% after deductible	Covered – 50% after deductible
Colonoscopies (diagnostic)	Covered – 70% after deductible	Covered – 50% after deductible
CT scans and MRIs (BCBSM-participating facilities only)	Covered – 70% after in-network deductible	
Radiation therapy	Covered – 70% after deductible	Covered – 50% after deductible
Maternity Services		
Delivery and newborn exam	Covered – 70% after deductible. Annual benefit maximum applies.	Covered – 50% after deductible. Annual benefit maximum applies.
Pre and postnatal exams (office visits)	Not covered	
Annual benefit maximum: This is the maximum amount BCBSM will pay for covered maternity services per calendar year. Benefits are subject to all applicable deductible and copay requirements and to the copay and lifetime maximums mentioned elsewhere in your certificate.	$5,000 per calendar year for vaginal deliveries and elective or non-medically necessary cesarean deliveries $7,500 per calendar year for medically necessary cesarean deliveries	
Inpatient Hospital Care		
Semi-private room: 120 days with 60-day renewal (BCBSM-approved facilities only)	Covered – 70% after deductible	Covered – 50% after deductible
Inpatient consultations	Covered – 70% after deductible	Covered – 50% after deductible
Complications of pregnancy	Covered – 70% after deductible	Covered – 50% after deductible

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Surgical Care – Hospital or Outpatient		
Inpatient surgical care	Covered – 70% after deductible	Covered – 50% after deductible
Outpatient surgical care	Covered – 70% after deductible	Covered – 50% after deductible
Physician surgical services	Covered – 70% after deductible	Covered – 50% after deductible
Gender reassignment surgery and services	Not covered	
Bariatric surgery and services	Not covered	
Alternatives to Hospitalization		
Home health care: up to the annual maximum (BCBSM-participating providers only)	Covered – 70% after in-network deductible	
Hospice care: up to the annual dollar maximum (BCBSM-participating programs only)	Covered – 100% after in-network deductible	
Outpatient Services		
Outpatient physical, occupational and speech therapy	Covered – 70% after deductible; 12 visits total, all therapies combined, per member, per calendar year	Covered – 50% after deductible; 12 visits total, all therapies combined, per member, per calendar year
Chemotherapy (IV and oral)	Covered – 70% after deductible	Covered – 50% after deductible
Home infusion therapy (BCBSM-participating providers only)	Covered – 70% after in-network deductible	
Voluntary sterilization	Covered – 70% after deductible	Covered – 50% after deductible
Prosthetics: mandated only (BCBSM-participating providers only)	Covered – 70% after in-network deductible	
Other Medical Benefits		
Insulin, disposable needles and syringes dispensed with insulin, diabetic testing supplies	Covered – 70% after deductible	Covered – 50% after deductible
Outpatient diabetes management program	Covered – 70% after deductible	Covered – 50% after deductible
Contraceptives: physician-administered, prescription drugs only, devices and contraceptive injectables (implants are not covered)	Covered – 70% after deductible	Covered – 50% after deductible
Organ Transplantation		
Bone marrow transplants	Covered – 70% after deductible	Covered – 50% after deductible
Kidney, cornea and skin transplants	Covered – 70% after deductible	Covered – 50% after deductible
Specified organ transplant: $1 million lifetime maximum per transplant type, included in the $5 million lifetime maximum. (BCBSM-designated facilities only)	Covered – 100% after in-network deductible	

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Mental Health and Substance Abuse Treatment		
Inpatient mental health (BCBSM-approved facilities only)	Covered – 70% after deductible, 30 days with 60-day renewal	Covered – 50% after deductible, 30 days with 60-day renewal
Outpatient mental health	Not covered	Not covered
Substance abuse: inpatient (residential) and outpatient, up to state-mandated benefit (BCBSM-approved facilities only)	Covered – 70% after deductible	Covered – 50% after deductible
Prescription Drugs		
	Network Pharmacy	**Non-network Pharmacy**
	Prescription drug benefits are subject to a 180-day waiting period for pre-existing conditions. Medical and drug expenses do not combine to meet the annual deductible. Prescription drug copays do not contribute to the annual copay dollar maximum.	
Annual maximum	Covered – $2,500 per member, per calendar year with no deductible, retail and mail order combined. Members who exhaust the annual maximum may purchase prescription drugs at the BCBSM-negotiated rate for the remainder of the calendar year.	
Retail (1-34 day supply)	Covered – 50% of the approved amount with $10 minimum and $100 maximum copay, with no deductible	Members must pay the pharmacist the full cost of the drug. BCBSM will reimburse 75% of the BCBSM-approved amount for covered drugs, less the copay and the difference between the non-network pharmacy's charge and the BCBSM-approved amount for the drug. No deductible required.
90-day retail (84-90 day supply)	Covered – 50% of the approved amount with a minimum of $20 and a maximum of $200 per prescription, with no deductible	Not covered
Mail order (35-90 day supply)	Covered – 50% of the approved amount with a minimum of $20 and a maximum of $200 per prescription, with no deductible	Not covered

NOTES:
- The 90-day waiting period for preventive medical care, mammography screening and preventive dental will be waived with proof of creditable coverage.
- Individual Care Blue Plus is not available to group conversion.
- Out-of-network and nonparticipating providers may bill members for the difference between BCBSM's approved amount and the provider's charge, even when referred.
- Flexible Blue Dental Plus℠ coverage may be purchased separately with this plan.

Exclusions and Limitations: Conditions covered by workers' compensation or similar law; services or supplies not specifically listed as covered under your benefit plan; services received before your effective date or after coverage ends; services you wouldn't have to pay for if you did not have this coverage; services or supplies that are not medically necessary; physical exams for insurance, employment, sports or school; any amounts in excess of BCBSM's approved amount; cosmetic surgery; dental care, dental implants or treatment to the teeth except as specifically stated in your benefit plan; hearing aids; infertility services; private duty nursing; eyeglasses or contact lenses; telephone, facsimile machine or any other type of electronic consultation; educational services, except as specifically provided or arranged by BCBSM; nutritional counseling; care or treatment furnished in a nonparticipating hospital, except as specifically stated in your benefit plan; personal comfort items; custodial care; services or supplies supplied to any person not covered under your benefit plan; services while confined in a hospital or other facility owned or operated by state or federal government, unless required by law; services provided by a professional provider to a family member; services provided by any person who ordinarily resides in the covered person's home or who is a family member; any drug, medicine or device that is not FDA–approved, unless required by law; vitamins, dietary products and any other nonprescription supplements; dental services, except for dental injury; appliances or supplies; war or any act of war, whether declared or not; communication or travel time, lodging or transportation, except as stated in your benefit plan; foot care services, except as stated in your benefit plan; health clubs or health spas, aerobic and strength conditioning, work hardening programs and related material and products for these programs; hair prosthesis, hair transplants or implants; experimental treatments, except as stated in your benefit plan; weight loss programs; and alternative medicines or therapies.

This document is intended to be an easy–to–read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. A complete description of benefits is contained in the applicable Blue Cross Blue Shield of Michigan certificate and riders. Payment amounts are based on the BCBSM–approved amount, less any applicable deductible and/or copay amounts required by the plan. All covered benefits are subject to a pre–existing conditions waiting period, unless noted otherwise. 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.