Flexible Blue II℠ (1500)

An *extended* plan from Blue Cross Blue Shield of Michigan.

	In-Network	Out-of-Network
	NOTES: · For individuals 19 years of age and older, all benefits, except preventive services, are subject to a 180-day waiting period for pre-existing conditions. · To be eligible for coverage, the following services require approval before they are provided: inpatient acute care, rehabilitation services, radiology, mental health and substance abuse, skilled nursing facilities and human organ transplant 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.	
Benefit Highlights		
Annual deductible	$1,500 per individual contract per calendar year. $3,000 per family contract (two or more members) per calendar year. Medical and drug expenses are combined to meet the integrated deductible. *If one family member receives medical services, he or she must meet entire family deductible before any services are paid. Individual deductible does not apply to family plans.*	$3,000 per individual contract per calendar year. $6,000 per family contract (two or more members) per calendar year. Medical and drug expenses are combined to meet the integrated deductible. *If one family member receives medical services, he or she must meet entire family deductible before any services are paid. Individual deductible does not apply to family plans.*
Coinsurance	20% of the BCBSM-approved amount	40% of the BCBSM-approved amount
Annual coinsurance maximum	$2,500 per individual contract. $5,000 per family contract (two or more members). *If one family member receives medical services, he or she must meet entire family deductible before any services are paid; he or she will then pay the 20% coinsurance until the family coinsurance maximum is met. Individual deductible and individual coinsurance maximums do not apply to family plans.* Prescription drug copays and flat-dollar copays contribute to the annual coinsurance maximum.	$5,000 per individual contract. $10,000 per family contract (two or more members). *If one family member receives medical services, he or she must meet entire family deductible before any services are paid; he or she will then pay the 40% coinsurance until the family coinsurance maximum is met. Individual deductible and individual coinsurance maximums do not apply to family plans.* Prescription drug copays and flat-dollar copays contribute to the annual coinsurance maximum.
Annual out-of-pocket maximum: The annual out-of-pocket maximum limits the amount members are responsible for paying each calendar year. Once the annual out-of-pocket maximum is met, most services are payable at 100% of the BCBSM-approved amount.	$4,000 per individual contract. $8,000 per family contract (two or more members).	$8,000 per individual contract. $16,000 per family contract (two or more members).
Lifetime maximum (per member)	No lifetime maximum	
Fourth-quarter deductible carryover	Not applicable	

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	In-Network	Out-of-Network
Preventive Services		
Preventive medical and immunizations: Includes health maintenance exam, select laboratory services, gynecologic exam, 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) 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 Protections and Affordable Care Act.	Covered – 100% with no deductible, copay or coinsurance. 90-day benefit waiting period applies.	Not covered
Mammography screening	Covered – 100% with no deductible, copay or coinsurance. 90-day benefit waiting period applies.	
Preventive dental	Not covered	
Preventive vision (VSP network provider only)	Not covered	
Physician Office Services		
Office visits	Covered – 80% after 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 – 80% 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 – 80% after in-network deductible	
Urgent Care	Covered – 80% after deductible for all services other than physician services. You pay $50 for physician services.	60% after deductible for all services other than physicians services. You pay $50 for physician services.
Diagnostic and Radiation Services		
Laboratory tests and pathology	Covered – 80% after deductible	Covered – 60% after deductible
EKGs	Covered – 80% after deductible	Covered – 60% after deductible
Diagnostic radiology and X-rays	Covered – 80% after deductible	Covered – 60% after deductible
Colonoscopies (diagnostic)	Covered – 80% after deductible	Covered – 60% after deductible
CT scans and MRIs (BCBSM participating facilities only)	Covered – 80% after deductible	Covered – 60% after deductible
Radiation therapy	Covered – 80% after deductible	Covered – 60% after deductible
Maternity Services		
Delivery and newborn routine care	Not covered (optional rider available)	
Pre and postnatal exams	Not covered (optional rider available)	
Inpatient Hospital Care		
Semi-private room: 120 days with 60-day renewal (BCBSM-approved facilities only)	Covered – 80% after deductible	Covered – 60% after deductible
Inpatient consultations	Covered – 80% after deductible	Covered – 60% after deductible
Complications of pregnancy	Covered – 80% after deductible	Covered – 60% after deductible

	In-Network	Out-of-Network
Surgical Care – Hospital or Outpatient		
Inpatient surgical care	Covered – 80% after deductible	Covered – 60% after deductible
Outpatient surgical care	Covered – 80% after deductible	Covered – 60% after deductible
Physician surgical services	Covered – 80% after deductible	Covered – 60% after deductible
Gender reassignment surgery and services	Not covered	
Bariatric surgery and services	Not covered	
Alternatives to Hospitalization		
Home health care (BCBSM-participating providers only)	Covered – 80% after in-network deductible	
Hospice care (BCBSM-participating programs only)	Covered – 100% after in-network deductible	
Outpatient Services		
Outpatient physical, occupational and speech therapy	Not covered	
Chemotherapy (IV)	Covered – 80% after deductible	Covered – 60% after deductible
Chemotherapy (oral)	Covered under prescription drug benefit	
Home infusion therapy (BCBSM-participating providers only)	Covered – 80% after in-network deductible	
Voluntary sterilization*	Covered – 80% after deductible	Covered – 60% after deductible
Prosthetics: mandated only (BCBSM-participating providers only)	Covered – 80% after in-network deductible	
Other medical benefits		
Outpatient diabetes management program	Covered – 80% after deductible; includes monitors, lancets, test strips, pumps and supplies. Insulin and syringes dispensed with insulin covered under prescription drug benefit.	Covered – 60% after deductible; includes monitors, lancets, test strips, pumps and supplies. Insulin and syringes dispensed with insulin covered under prescription drug benefit.
Outpatient diabetes management training program	Covered – 80% after deductible	
Contraceptives: devices and contraceptive injectables (implants are not covered)*	Covered – 80% after deductible	Covered – 60% after deductible
Organ Transplantation		
Bone marrow transplants	Covered – 80% after deductible	Covered – 60% after deductible
Kidney, cornea and skin transplants	Covered – 80% after deductible	Covered – 60% after deductible
Specified organ transplant: (BCBSM-designated facilities only)	Covered – 100% after in-network deductible	
Mental Health and Substance Abuse Treatment		
Inpatient mental health (BCBSM-approved facilities only)	Covered – 80% after deductible, up to 30 days of unused 120 inpatient hospital days per calendar year with 60 day renewal.	Covered – 60% after deductible, up to 30 days of unused 120 inpatient hospital days per calendar year with 60 day renewal.
Outpatient mental health	Not covered	
Substance abuse: inpatient (residential) **and outpatient** (BCBSM-approved facilities only)	Covered – 80% after deductible	Covered – 60% after deductible

*For new members starting on Aug. 1, 2012, or after, in-network benefits are covered at 100% of the BCBSM approved amount (for women only).

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	In-Network	Out-of-Network
	Network Pharmacy	Non-network Pharmacy
Prescription Drugs		
For individuals 19 years of age and older, prescription drug benefits are subject to a 180-day waiting period for pre-existing conditions. Covered after the in-network integrated deductible. Medical and drug expenses combine to meet the integrated deductible. Prescription drug copays contribute to the annual copay dollar maximum.		
Annual maximum	None	
Retail (1-30 day supply)	Covered – 50% of the approved amount with $10 minimum and $100 maximum copay, after in-network integrated deductible. Insulin and disposable needles and syringes for diabetes management covered.	Members must pay the pharmacist the full cost of the drug. After the in-network integrated deductible, BCBSM will reimburse 80% 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. Insulin and disposable needles and syringes for diabetes management covered.
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, after in–network integrated deductible. Insulin and disposable needles and syringes for diabetes management covered.	Not covered
Mail order (31-90 day supply)	Covered – 50% of the approved amount with a minimum of $20 and a maximum of $200 per prescription, after in–network integrated deductible. Insulin and disposable needles and syringes for diabetes management covered.	Not covered

NOTES: Flexible Blue II 1500 is not available for group conversion.

- Voluntary sterilization and contraceptives: For new members starting on Aug. 1, 2012, or after, in-network benefits are covered at 100% of the BCBSM approved amount (for women only).
- A 90-day benefit waiting period applies to preventive medical and mammography screening. The waiting period will be waived with proof of creditable coverage.
- 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.
- Maternity coverage and 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; sleep studies and surgeries; 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, supplies or services as a result ofwar 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. In the event of a conflict between this document and the applicable certificate and riders, the certificate and riders will rule. 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.

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.