Individual Care **Blue** Plus℠

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

	In-Network	Out-of-Network
	NOTE: 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. Individual Care Blue Plus is not available for group conversion.	
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 calendar 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)	No lifetime maximum	
Fourth-quarter deductible carryover	Not applicable	
Preventive Services		
Preventive medical care 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	Covered – 100% with no deductible. One dental exam, cleaning and one set of bitewing x-rays (up to four) 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. Discounts available on other vision services.	

	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 deductible for all services other than physician services. You pay $50 for physician services.	Covered – 50% after deductible for all services other than physician services. You pay $50 for physician services.
Diagnostic and Radiation Services		
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 deductible	Covered – 50% after deductible
Radiation therapy	Covered – 70% after deductible	Covered – 50% after deductible
Maternity Services		
Delivery and newborn routine care	Covered – 70% after deductible.	Covered – 50% after deductible.
Pre and postnatal exams	Not covered	
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
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	

	In-Network	Out-of-Network
Alternatives to Hospitalization		
Home health care: (BCBSM-participating providers only)	Covered – 70% after in-network deductible	
Hospice care (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)	Covered – 70% after deductible	Covered – 50% after deductible
Chemotherapy (oral)	Covered under prescription drug benefit	
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		
Outpatient diabetes management program	Covered – 70% after deductible; includes monitors, lancets, tests strips, pumps and supplies. Insulin and syringes dispensed with insulin covered under prescription drug benefit.	Covered – 50% after deductible; includes monitors, lancets, tests strips, pumps and supplies. Insulin and syringes dispensed with insulin covered under prescription drug benefit.
Outpatient diabetes training program	Covered – 70% after deductible	
Contraceptives: 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: (BCBSM-designated facilities only)	Covered – 100% after in-network deductible	
Mental Health and Substance Abuse Treatment		
Inpatient mental health (BCBSM-approved facilities only)	Covered – 70% after deductible, up to 30 days of unused 120 inpatient hospital days per calendar year with 60-day renewal.	Covered – 50% 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 – 70% after deductible	Covered – 50% after deductible

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	In-Network	Out-of-Network
Prescription Drugs		
	Network Pharmacy	**Non-network Pharmacy**
	For individuals 19 years of age and older, 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	None	
Retail (1-30 day supply)	Covered – 50% of the approved amount with $10 minimum and $100 maximum copay with no deductible. Insulin and disposable needles and syringes for diabetes management covered.	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. 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, with no deductible. Insulin and disposable needles and syringes for diabetes managment 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, with no deductible. Insulin and disposable needles and syringes for diabetes management covered.	Not covered

NOTES: Individual Care Blue Plus is not available for group conversion.

- The 90-day benefit waiting period for preventive medical care, mammography screening and preventive dental 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.
- 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.

Blue Cross Blue Shield of Michigan

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