



SM

MyBlue

My Life, My Health Plan

Plan Comparison Chart



Individual health care just got easier.

Individual coverage doesn't have to be complicated. If you're single, married, facing a layoff, considering early retirement or losing your employer-sponsored health plan, you have a lot of important decisions to make. Let the Blues make your decision about health care coverage an easy one.

MyBlue offers plans to fit every stage of your life. Available MyBlue plans include:

- **Flexible Blue IISM** — A comprehensive health plan designed for those looking to take control of their health care spending. It is Health Savings Account-qualified and has three deductible options.
- **Young Adult Blue MAXSM** — A plan designed for adults age 19 to 30 that includes low copayments, discounts on prescription drugs, and preventive medical, dental and vision benefits.
- **OneBlueSM** — A comprehensive HMO for you and your family members under age 65 offering comprehensive health care with a primary care physician who coordinates all of your care.
- **Individual Care Blue PlusSM** — A comprehensive health plan designed for you and your family members under age 65 that includes prescription drug and preventive dental and vision coverage.

MyBlue plans offer the important things on your health coverage check list, including:

- **Key benefits** — We help keep your entire body healthy with plans of varying benefit levels.
- **Reliability** — The Blues is a name you know and can trust. With more than 70 years of experience, you can count on us for security and exemplary service.
- **Large provider network** — The Blues offer unmatched access to doctors and hospitals through our industry-leading PPO provider network, and the largest HMO network of doctors and hospitals in the state.
- **Easy to manage** — Our Web resources allow you to enroll, locate BCBSM and BCN doctors and hospitals, check your coverage information and much more, easily online, 24 hours a day, seven days a week.

MyBlue plans offer more than just quality benefits. The plans are packed with complementary programs and services to help lead our members to a healthier future.

- **Exceptional wellness and care management** — Our **BlueHealthConnection[®]** program includes health coaches, targeted outreach, Web-based wellness information and an online health assessment. The program also offers case management to help you coordinate your health care and help you make more informed health care decisions. For more information, call **800-845-5982** (BCBSM) or **800-637-2972** (BCN).
- **Significant member discounts** — Members of the Michigan Blues can save money and live healthier. Score big savings and special offers on a wide variety of healthy products and services from Michigan businesses with our Healthy Blue XtrasSM program, and at companies throughout the U.S. with Blue365[®], our national savings program. From groceries and fitness gear to yoga and gym packages, Blues members can find promotions on everything needed to support a healthy, balanced lifestyle. Visit **bcbsm.com/xtras** to unlock these big savings on healthy products and services.
- **Valuable Web resources** — Our members have online access to claims information, eligibility information, doctor and hospital quality information, health education resources, *Explanation of Benefit Payments* statements, online bill pay and much more.
- **Outstanding customer service** — Our Customer Service representatives are trained to answer member questions and are just a toll-free phone call away.
- **Informative publications** — BCBSM members receive *Living Healthy* and BCN members receive *Good Health*. Both magazines are loaded with healthful tips, wellness ideas and lifestyle advice.

Young Adult Blue MAX SM (available to 19 – 30 year olds only)		Individual Care Blue Plus SM	
In-Network	Out-of-Network	In-Network	Out-of-Network
NOTE: All benefits, except preventive services and outpatient diabetes management training program, are subject to a 180-day waiting period for pre-existing conditions.		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 individual contract per calendar year.	\$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.
% Coinsurance or % Copay	30% of the BCBSM-approved amount	50% of the BCBSM-approved amount	30% of the BCBSM-approved amount	50% of the BCBSM-approved amount
Annual Coinsurance or Copay Maximum	\$2,500 per individual contract. Flat-dollar copays do not contribute to the annual coinsurance maximum.	\$3,500. Flat dollar copays do not contribute to the annual coinsurance maximum. Out-of-network coinsurance does not contribute to in-network coinsurance 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	\$5,500 per individual contract	\$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		No lifetime maximum	
Fourth Quarter deductible carryover	Not applicable		Not applicable	

Flexible Blue II SM 1500 Flexible Blue II SM 2500		Flexible Blue II SM 5000		OneBlue SM
In-Network	Out-of-Network	In-Network	Out-of-Network	In-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. Flexible Blue II 1500 is not available for group conversion.		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.		This HMO product is subject to medical underwriting. Note: For Individuals 19 years of age and older, all benefits, except preventive services and mammography screening are subject to a 180-day waiting period for pre-existing conditions.
Flexible Blue II SM 1500: \$1,500 per individual contract per calendar year. \$3,000 per family contract (two or more members) per calendar year. Flexible Blue II SM 2500: \$2,500 per individual contract per calendar year. \$5,000 per family contract (two or more members) per calendar year. Medical and drug expenses are combined to meet the integrated deductible. One or more family members may satisfy the family integrated deductible. The entire integrated deductible must be met before covered services are paid.	Flexible Blue II SM 1500: \$3,000 per individual contract per calendar year. \$6,000 per family contract (two or more members) per calendar year. Flexible Blue II SM 2500: \$5,000 per individual contract per calendar year. \$10,000 per family contract (two or more members) per calendar year. Medical and drug expenses are combined to meet the integrated deductible. One or more family members may satisfy the family integrated deductible. The entire integrated deductible must be met before covered services are paid.	\$5,000 per individual contract per calendar year. \$10,000 per family contract (two or more members) per calendar year. Medical and drug expenses are combined to meet the integrated deductible. One or more family members may satisfy the family integrated deductible. The entire integrated deductible must be met before covered services are paid.	\$10,000 per individual contract per calendar year. \$20,000 per family contract (two or more members) per calendar year. Medical and drug expenses are combined to meet the integrated deductible. One or more family members may satisfy the family integrated deductible. The entire integrated deductible must be met before covered services are paid.	\$500 per individual, per calendar year. \$1,000 per family (two or more members) per calendar year.
20% of the BCBSM-approved amount	40% of the BCBSM-approved amount	20% of the BCBSM-approved amount	40% of the BCBSM-approved amount	Fixed Dollar copay: \$5 for allergy injections, \$30 office visits, \$35 for urgent care visits, \$100 for emergency room visits. Coinsurance: 20%, 25% or 50% for specific services defined below
\$2,500 per individual contract. \$5,000 per family contract (two or more members). One or more family members may satisfy the family annual copay maximum. Prescription drug copays and flat dollar copays contribute to the annual copay maximum.	\$5000 per individual contract. \$10,000 per family contract (two or more members). One or more family members may satisfy the family annual copay maximum. Prescription drug copays and flat dollar copays contribute to the annual copay maximum.	\$800 per individual contract. \$1,600 per family contract (two or more members). One or more family members may satisfy the family annual copay maximum. Prescription drug copays and flat dollar copays contribute to the annual copay maximum.	\$1,600 per individual contract. \$3,200 per family contract (two or more members). One or more family members may satisfy the family annual copay maximum. Prescription drug copays and flat dollar copays contribute to the annual copay maximum.	Annual maximums Fixed Dollar Copay: None Annual Coinsurance Maximum: For medical services; excludes services with 50%, 25% or flat dollar copay – \$5,000 per individual per calendar year. \$10,000 per family (two or more members) per calendar year. 25% coinsurance for Inpatient Mental Health Care: \$1,000 per individual. \$2,000 per family (two or more members) per calendar year.
Flexible Blue II SM 1500: \$4,000 per individual contract. \$8,000 per family contract (two or more members). Flexible Blue II SM 2500: \$5,000 per individual contract. \$10,000 per family contract (two or more members).	Flexible Blue II SM 1500: \$8,000 per individual contract. \$16,000 per family contract (two or more members). Flexible Blue II SM 2500: \$10,000 per individual contract. \$20,000 per family contract (two or more members).	\$5,800 per individual contract. \$11,600 per family contract (two or more members).	\$11,600 per individual contract. \$23,200 per family contract (two or more members).	\$5,500 per individual, \$11,000 per family for medical services. \$1,000 per individual, \$2,000 per family for inpatient mental health services. Excludes services with 50% coinsurance and flat dollar copay.
No lifetime maximum	No lifetime maximum	No lifetime maximum	No lifetime maximum	No lifetime maximum
Not applicable	Not applicable	Not applicable	Not applicable	Applicable. Any amount you pay toward your deductible during the last three months of the calendar year will be applied to your deductible for the following calendar year. We will not apply amounts paid under other contracts toward your deductible.

Preventive Services

Preventive medical and immunizations	Covered – 100% with no deductible, copay or coinsurance. 90-day benefit waiting period applies. Includes: health maintenance exam, select laboratory services, gynecologic exam, Pap smear screening, prostate specific antigen screening, and other adult preventive services 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 Protection and Affordable Care Act.	Not covered	Covered – 100% with no deductible, copay or coinsurance per member, per calendar year. 90 day benefit waiting period applies. Includes: health maintenance exam, select laboratory services, gynecologic exam, Pap smear screening, prostate specific antigen screening, well-baby and well-child exams (6 per year, 0 -2 years; 2 per year, 2-4 years; 1 per year, 4-15 years) and other adult preventive services 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 Protection and Affordable Care Act.	Not covered
Mammography screening	Covered – 100% with no deductible copay or coinsurance. 90-day benefit waiting period applies.		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 up to four bitewing x-rays per calendar year. 90-day benefit waiting period applies.		Covered – 100% with no deductible. One dental exam, cleaning and one set of up to four bitewing x-rays 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 calendar year. Discounts available on other vision services.		Covered – 100% with no deductible. One vision exam, per member, per calendar year. Discounts available on other vision services.	

Physician Office Services

Office visits	Professional services: \$30 copay per visit with no deductible; 2 visits per calendar year. \$30 copay does not contribute to annual coinsurance maximum. Diagnostic and laboratory services performed in the physician office are subject to deductible and coinsurance, except for preventive care laboratory services.	Not covered	Covered – 70% with no deductible; 2 visits per member per calendar year	Not covered
Outpatient pre-surgical second opinion consultations	Covered – 100% before deductible	Not covered	Covered – 100% after deductible	Not covered
Office consultations	Not covered		Not covered	

Emergency and Urgent Care Services

Medical emergencies	Facility: Covered 70% after in-network deductible plus \$150 copay (waived if admitted). Professional: Covered 70% after in-network deductible.		Covered – 70% after in-network deductible for all services other than physician services. You pay \$150 for physician services (waived if admitted).	
Accidental injuries	Facility: Covered 70% before in-network deductible plus \$150 copay (waived if admitted). Professional: Covered 70% before in-network deductible		Covered – 70% after in-network deductible for all services other than physician services. You pay \$150 for physician services (waived if admitted).	
Accidental injury deductible waiver	The deductible is waived for an accidental injury and all covered services related to that injury. Coinsurance and flat-dollar copays apply.		Not applicable	
Ambulance Service: medically necessary, emergency ground transport and air ambulance	Covered – 70% after in-network deductible		Covered – 70% after in network deductible	

Flexible Blue II SM 1500 Flexible Blue II SM 2500		Flexible Blue II SM 5000		OneBlue SM
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Covered – 100% with no deductible, copay or coinsurance per member, per calendar year. 90 day benefit waiting period applies. Includes: health maintenance exam, select laboratory services, gynecologic exam, Pap smear screening, prostate specific antigen screening, Well-baby and Well-child exams (6 per year, 0 -2 years; 2 per year, 2-4 years; 1 per year, 4-15 years) and other adult preventive services 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 Protection and Affordable Care Act.	Not covered	Covered – 100% with no deductible, copay or coinsurance per member, per calendar year. 90 day benefit waiting period applies. Includes: health maintenance exam, select laboratory services, gynecologic exam, Pap smear screening, prostate specific antigen screening, Well-baby and Well-child exams (6 per year, 0 -2 years; 2 per year, 2-4 years; 1 per year, 4-15 years) and other adult preventive services 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 Protection and Affordable Care Act.	Not covered	Covered 100% with no deductible, copay or coinsurance. Includes: health maintenance exam, select laboratory services, gynecologic exam, Pap smear screening, prostate specific antigen screening, Well-baby and Well-child exams and other adult preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM and BCN that are in compliance with the provisions of the Patient Protection and Affordable Care Act.
Covered – 100% with no deductible copay or coinsurance. 90-day benefit waiting period applies.		Covered – 100% with no deductible copay or coinsurance. 90-day benefit waiting period applies.		Covered – 100% with no deductible, copay or coinsurance
Not covered		Not covered		Not offered with this product
Not covered		Not covered		Not offered with this product
Covered – 80% after deductible; 2 visits per member per calendar year.	Not covered	Covered – 80% after deductible; 2 visits per member per calendar year.	Not covered	Covered – \$30 copay; specialty care covered after deductible.
Covered – 100% after deductible	Not covered	Covered – 100% after deductible	Not covered	Covered – \$30 copay after deductible; must be referred.
Not covered		Not covered		Covered – \$30 copay after deductible; must be referred.
Covered – 80% after in-network deductible for all services other than physician services. You pay \$150 for physician services (waived if admitted).		Covered – 80% after in-network deductible for all services other than physician services. You pay \$150 for physician services (waived if admitted).		Covered – \$100 copay after deductible. Copay waived if admitted. Inpatient benefit will apply.
Covered – 80% after in-network deductible for all services other than physician services. You pay \$150 for physician services (waived if admitted).		Covered – 80% after in-network deductible for all services other than physician services. You pay \$150 for physician services (waived if admitted).		Covered - \$100 copay after deductible. Copay waived if admitted. Inpatient benefit will apply.
Not applicable		Not applicable		Not applicable
Covered – 80% after in-network deductible		Covered – 80% after in-network deductible		Covered – 80% after deductible

Emergency and Urgent Care Services (cont.)

Urgent care	Facility: Covered 70% after deductible plus \$50 copay Professional: Covered 70% after deductible	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.
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Diagnostic and Radiation Services

Laboratory tests, Pathology, EKGs, Diagnostic radiology and X-rays	Covered – 70% after deductible	Covered – 50% after deductible	Covered – 70% after deductible	Covered – 50% after deductible
Mammography (diagnostic)	Covered – 70% after deductible	Covered – 50% after deductible	Covered – 70% after deductible	Covered – 50% after deductible
Colonoscopy (diagnostic)	Covered – 70% after deductible	Covered – 50% after deductible	Covered – 70% after deductible	Covered – 50% after deductible
CT scans and MRIs (BCBSM and BCN participating facilities only)	Covered – 70% after deductible	Covered – 50% after deductible	Covered – 70% after deductible	Covered – 50% after deductible
Radiation therapy	Covered – 70% after deductible	Covered – 50% after deductible	Covered – 70% after deductible	Covered – 50% after deductible

Maternity Services

Delivery and newborn care	Not covered	Covered – 70% after deductible. Annual benefit maximum applies.	Covered – 50% after deductible. Annual benefit maximum applies.
Pre- and post-natal exams	Not covered	Not covered	

Inpatient Hospital Care

Semi-private room (BCBSM and BCN approved facilities only)	Covered – 70% after deductible, up to 180 days combined per calendar year.	Covered – 50% after deductible, up to 180 days combined per calendar year.	Covered – 70% after deductible, up to 120 days combined, with 60 day renewal.	Covered – 50% after deductible, up to 120 days combined, with 60 day renewal.
Long term acute care hospital (LTACH)	Not covered			
Skilled nursing facility (SNF)				
Inpatient consultations	Covered – 70% after deductible	Covered – 50% after deductible	Covered – 70% after deductible	Covered – 50% after deductible
Complications of pregnancy	Covered – 70% after deductible	Covered – 50% after deductible	Covered – 70% after deductible	Covered – 50% after deductible

Surgical Care – Hospital or Outpatient

Inpatient surgical care	Covered – 70% after deductible	Covered – 50% after deductible	Covered – 70% after deductible	Covered – 50% after deductible
Outpatient surgical care	Covered – 70% after deductible	Covered – 50% after deductible	Covered – 70% after deductible	Covered – 50% after deductible
Physician surgical services	Covered – 70% after deductible	Covered – 50% after deductible	Covered – 70% after deductible	Covered – 50% after deductible
Gender reassignment surgery and services	Not covered		Not covered	
Bariatric surgery and services	Not covered		Not covered	

Alternatives to Hospitalization

Home health care (BCBSM and BCN participating providers only)	Covered – 70% after in-network deductible, up to 30 visits per calendar year.	Covered – 70% after in-network deductible
Hospice care (BCBSM and BCN participating programs only)	Covered 100% after in-network deductible	Covered – 100% after in-network deductible, up to annual dollar maximum, per member per calendar year.

Flexible Blue II SM 1500 Flexible Blue II SM 2500		Flexible Blue II SM 5000		OneBlue SM
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Covered – 80% after deductible for all services other than physician services. You pay \$50 for physician services.	Covered – 60% after deductible for all services other than physician services. You pay \$50 for physician services.	Covered – 80% after deductible for all services other than physician services. You pay \$50 for physician services.	Covered – 60% after deductible for all services other than physician services. You pay \$50 for physician services.	Covered – \$35 copay with no deductible
Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible. Pre-natal ultrasound, lab and pathology covered 100%; deductible does not apply.
Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible	Covered – 60% after deductible	Covered – 100% no deductible
Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible
Covered- 80% after deductible	Covered- 60% after deductible	Covered- 80% after deductible	Covered- 60% after deductible	Covered – 80% after deductible
Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible
Not covered (optional rider available)		Not available		Covered – 100% after deductible for services provided by a physician Facility charges covered 80% after deductible.
Not covered (optional rider available)		Not available		Covered – \$30 copay for services provided by a physician
Covered – 80% after deductible, up to 120 days combined, with 60 day renewal.	Covered – 60% after deductible, up to 120 days combined, with 60 day renewal.	Covered – 80% after deductible, up to 120 days combined, with 60 day renewal.	Covered – 60% after deductible, up to 120 days combined, with 60 day renewal.	Covered – 80% after deductible; unlimited days. LTACH covered only when medically necessary and authorized by BCN. NOTE: BCN covers home health care – \$30 after deductible.
Not covered		Not covered		Covered – 80% after deductible; 45 day limit per calendar year.
Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible	Covered – 60% after deductible	Covered – 100% after deductible
Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible
Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible
Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible
Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible
Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible See member certificate for specific surgical copays.
Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible
Not covered		Not covered		Not covered
Not covered		Not covered		Covered – 50% after deductible when medically necessary and authorized by BCN.
Covered – 80% after in-network deductible		Covered – 80% after in-network deductible		Covered – \$30 copay after deductible
Covered – 100% after in-network deductible, up to annual dollar maximum, per member per calendar year.		Covered – 100% after in-network deductible, up to annual dollar maximum, per member per calendar year.		Covered – 100% after deductible

Young Adult Blue MAX SM (available to 19 – 30 year olds only)		Individual Care Blue Plus SM	
In-Network	Out-of-Network	In-Network	Out-of-Network

Outpatient Services and other benefits

Outpatient physical, occupational and speech therapy	Covered – 70% after deductible, 12 visits, all therapies combined, per calendar year.	Covered – 50% after deductible, 12 visits, all therapies combined, per calendar year.	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	Covered – 70% after deductible	Covered – 50% after deductible
Chemotherapy (oral)	Covered – 70% after deductible	Covered – 50% after deductible	Covered under prescription drug benefits	
Chiropractic spinal manipulations	Not covered		Not covered	
Home infusion therapy (BCBSM and BCN participating providers only)	Covered – 70% after in-network deductible		Covered – 70% after in-network deductible	
Voluntary sterilization	Not covered		Covered – 70% after deductible	Covered – 50% after deductible
Prosthetics (BCBSM and BCN participating providers only)	Covered – 70% after in-network deductible. Mandated only.		Covered – 70% after in-network deductible. Mandated only.	
Durable medical equipment	Not covered		Not covered	
Allergy testing and therapy	Not covered		Not covered	
Outpatient diabetes management program	Covered – 70% after deductible; includes insulin, syringes dispensed with insulin, monitors, lancets, test strips, pumps and supplies	Covered – 50% after deductible ; includes insulin, syringes dispensed with insulin, monitors, lancets, test strips, pumps and supplies	Covered – 70% after deductible; includes monitors, lancets, test strips, pumps and supplies. Insulin and syringes dispensed with insulin covered under prescription drug benefit.	Covered – 50% after deductible; includes monitors, lancets, test strips, pumps and supplies. Insulin and syringes dispensed with insulin covered under prescription drug benefit.
Outpatient diabetes training program	Covered – 100% with no deductible		Covered – 70% with no deductible	
Contraceptives: Devices and injectables. Implants are not covered.	Not covered (for the purpose of preventing pregnancy)		Covered – 70% after deductible	Covered – 50% after deductible
Oral contraceptives	Not covered (for the purpose of preventing pregnancy)		Covered under prescription drug plan	
Organ Transplantation				
Bone marrow transplants	Covered – 70% after deductible	Covered – 50% after deductible	Covered – 70% after deductible	Covered – 50% after deductible
Kidney, cornea and skin transplants	Covered – 70% after deductible	Covered – 50% after deductible	Covered – 70% after deductible	Covered – 50% after deductible
Specified organ transplant (BCBSM and BCN designated facilities only)	Covered – 100% after in-network deductible		Covered – 100% after in-network deductible	
Mental Health and Substance Abuse Treatment				
Inpatient mental health (BCBSM and BCN-approved facilities only)	Covered – 70% after deductible, up to 30 days of unused 180 inpatient hospital days, per calendar year	Covered – 50% after deductible, up to 30 days of unused 180 inpatient hospital days, per calendar year	Covered – 70% after deductible, up to 30 days of unused 120 inpatient hospital days per calendar year, 60-day renewal.	Covered – 50% after deductible, up to 30 days of unused 120 inpatient hospital days per calendar year, 60-day renewal.
Outpatient mental health	Not covered		Not covered	
Substance abuse: Inpatient (residential) and outpatient combined. (BCBSM or BCN-approved facilities only)	Covered – 70% after deductible	Covered – 50% after deductible	Covered – 70% after deductible, up to annual state-mandated benefit.	Covered – 50% after deductible, up to annual state-mandated benefit.

Flexible Blue II SM 1500 Flexible Blue II SM 2500		Flexible Blue II SM 5000		OneBlue SM
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Not covered		Not covered		Covered – \$30 copay after deductible, limited to 60 consecutive days per episode for a combination of therapies.
Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible
Covered under prescription drug benefits		Covered under prescription drug benefits	Covered under prescription drug benefits	Covered under prescription drug benefit
Not covered		Not covered		Covered if referred: \$30 copay after deductible
Covered – 80% after in-network deductible		Covered – 80% after in-network deductible		Covered – 100% after deductible
Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible	Covered – 60% after deductible	Covered – 50% after deductible
Covered – 80% after in-network deductible. Mandated only.		Covered – 80% after in-network deductible. Mandated only.		Covered – 50% with no deductible
Not covered		Not covered		Covered – 50% with no deductible
Not covered		Not covered		Covered – 50% after deductible. Allergy injections covered, \$5 copay
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.	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.	Covered – Insulin can be obtained through pharmacy benefit; applicable prescription drug copays apply.
Covered – 80% with no deductible		Covered – 80% with no deductible		Covered – BCN disease management program
Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible	Covered – 60% after deductible	Covered – Prescription drug copays apply. Your doctor will prescribe a medication or a device. Office visit copay will apply to the administration.
Covered under prescription drug plan		Covered under prescription drug plan		Covered – Prescription drug copays apply. Your doctor will prescribe a medication or a device.
Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible; subject to medical criteria.
Covered – 80% after deductible	Covered – 60% after deductible	Covered – 80% after deductible	Covered – 60% after deductible	Covered- 80% after deductible; subject to medical criteria.
Covered – 100% after in-network deductible		Covered – 100% after in-network deductible		Covered – 80% after deductible; subject to medical criteria.
Covered – 80% after deductible, up to 30 days of unused 120 inpatient hospital days per calendar year, 60-day renewal.	Covered – 60% after deductible, up to 30 days of unused 120 inpatient hospital days per calendar year, 60-day renewal.	Covered – 80% after deductible, up to 30 days of unused 120 inpatient hospital days per calendar year, 60-day renewal.	Covered – 60% after deductible, up to 30 days of unused 120 inpatient hospital days per calendar year, 60-day renewal.	Covered – 75% with no deductible up to \$1,000 per member; \$2,000 per family per calendar year; 30 days per calendar year.
Not covered		Not covered		Covered – 50%, with no deductible; 20 visits per calendar year.
Covered – 80% after deductible, up to annual state-mandated benefit.	Covered – 60% after deductible, up to annual state-mandated benefit.	Covered – 80% after deductible, up to annual state-mandated benefit.	Covered – 60% after deductible, up to annual state-mandated benefit.	Covered – 50% with no deductible. One program of treatment per year.

	Young Adult Blue MAX SM (available to 19 – 30 year olds only)		Individual Care Blue Plus SM	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drugs	Network Pharmacy	Non-network Pharmacy	Network Pharmacy	Non-network Pharmacy
Prescription drugs	Discounts at the BCBSM-negotiated rate		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	Not applicable		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 - 30 day supply)	Not covered		Covered 50% of the approved amount with \$10 minimum and \$100 maximum copay, payable with no deductible. Insulin, 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, disposable needles and syringes for diabetes management covered.
90-day retail (84- 90 day supply)	Not covered		Covered 50% of the approved amount with a minimum of \$20 and a maximum of \$200 per prescription, with no deductible. Insulin, disposable needles and syringes for diabetes management covered.	Not covered
Mail order (31 - 90 day supply)	Not covered		Covered 50% of the approved amount with a minimum of \$20 and a maximum of \$200 per prescription, with no deductible. Insulin, disposable needles and syringes for diabetes management covered.	Not covered
NOTES	The 90-day benefit waiting period for preventive services will be waived with proof of creditable coverage. Out-of-network and non-participating providers may bill members for the difference between BCBSM's approved amount and the provider's charge even when referred.		The 90-day benefit waiting period for preventive services will be waived with proof of creditable coverage. Out-of-network and non-participating 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	

Flexible Blue II SM 1500 Flexible Blue II SM 2500		Flexible Blue II SM 5000		OneBlue SM
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Non-Network Pharmacy	Network Pharmacy	Non-Network Pharmacy	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. 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.		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.		Not applicable to BCN.
Covered – \$2,500 per member, per calendar year after in-network integrated 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.		Covered – \$2,500 per member, per calendar year after in-network integrated 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.		Covered – \$2,500 per member, per calendar year. BCN's actual payment for prescription drugs (not the approved amount) will be applied to the annual benefit maximum for prescriptions.
Covered 50% of the approved amount with \$10 minimum and \$100 maximum copay, after in-network integrated deductible. Insulin, 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, disposable needles and syringes for diabetes management covered.	Covered 50% of the approved amount with \$10 minimum and \$100 maximum copay, after in-network integrated deductible. Insulin, 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, disposable needles and syringes for diabetes management covered.	\$5 generic and \$50 brand copay with contraceptives. 30-day mail order also available.
Covered 50% of the approved amount with a minimum of \$20 and a maximum of \$200 per prescription, after in-network integrated deductible. Insulin, disposable needles and syringes for diabetes management covered.	Not covered	Covered 50% of the approved amount with a minimum of \$20 and a maximum of \$200 per prescription, after in-network integrated deductible. Insulin, disposable needles and syringes for diabetes management covered.	Not covered	\$10 generic and \$100 brand copay with contraceptives
Covered 50% of the approved amount with a minimum of \$20 and a maximum of \$200 per prescription, after in-network integrated deductible. Insulin, disposable needles and syringes for diabetes management covered.	Not covered	50% of the approved amount with a minimum of \$20 and a maximum of \$200 per prescription, after in-network integrated deductible. Insulin, disposable needles and syringes for diabetes management covered.	Not covered	\$10 generic and \$100 brand copay with contraceptives.
The 90-day benefit waiting period for preventive services will be waived with proof of creditable coverage. Out-of-network and non-participating 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. Flex Blue 1500 is not available for group conversion.		The 90-day benefit waiting period for preventive services will be waived with proof of creditable coverage. Out-of-network and non-participating 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.		The pharmacy will be paid the difference of the approved amount and the copayment. Once you've reached the annual prescription drug benefit maximum, you may purchase eligible drugs and supplies from participating pharmacies at the BCN approved amount until this annual maximum is renewed next year. The annual maximum is \$2,500 per member, per calendar year. BCN's actual payment for prescription drugs (not the approved amount) will be applied to the annual benefit maximum for prescriptions.

Dental Coverage

Flexible Blue Dental Plus is optional coverage that may be purchased with Individual Care Blue Plus or Flexible Blue II plans. **Personal Blue Dental** and **Personal Blue Dental Plus** is optional coverage that may be purchased with Young Adult Blue Max and OneBlue. Members may choose a DenteMax network dentist. If a member chooses to receive care outside the DenteMax network, their out-of-pocket costs may be higher.

Flexible Blue Dental Plus SM	
Class I – Preventive services	
Oral exams, bitewing X-rays, teeth cleanings and fluoride	Covered – 75%, twice per calendar year. (90-day benefit waiting period applies)
Class II – Restorative services	
Replacement fillings and onlays, crowns, extractions and root canal therapy	Covered – 50% of the approved amount; subject to frequency limitations (90 day benefit waiting period applies)
Benefit maximum	
The benefit maximum limits the amount payable for services each calendar year. Once a member reaches the benefit maximum, services will not be paid for that member for the balance of the year. We will continue to pay claims for other eligible members until each member has reached the maximum.	\$800 per member, per calendar year
NOTE: The 90-day benefit waiting period for Class I and II services is waived with proof of creditable coverage.	

	Personal Blue Dental SM (No Out-of-Network Coverage)	Personal Blue Dental Plus SM
	In-Network	In-Network and Out-of-Network
Copays		
Class I – Preventive services	25%	25%
Class II – Basic restorative services	50%	50%
Class III – Major restorative services	50%	50%
Dollar maximums, deductibles and waiting period		
Annual maximum	\$1,250 per member for all covered services	\$1,000 per member for all covered services
Deductible (Applied to basic and major restorative services; preventive services are not subject to the deductible.)	Per calendar year \$50 single/\$100 family (two or more people)	
Waiting period	6-month waiting period is applied on the effective date of dental coverage for basic and major restorative services; preventive services are not subject to a waiting period.	

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.





Maternity Coverage

Maternity coverage is included with **IC Blue Plus**, but is optional and may be purchased with **Flexible Blue II 1500** and **2500 plans**. If the optional maternity coverage is not purchased at the same time as Flexible Blue II 1500 or 2500 (i.e., at a later date), the 180-day pre-existing condition waiting period for maternity benefits begins with the effective date of the optional maternity coverage, not the effective date of Flexible Blue II 1500 or 2500.

	Individual Care Blue PlusSM		Flexible Blue IISM 1500 Flexible Blue IISM 2500		Flexible Blue IISM 5000	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Delivery and newborn care	Covered – 70% after deductible	Covered – 50% after deductible	Covered – 80% after deductible	Covered – 60% after deductible	Not available	
Pre- and post-natal exams	Not covered	Not covered	Covered – 80% after deductible	Covered – 60% after deductible		
Annual (cal year) Benefit maximum						
Vaginal or medically-necessary C-Section	\$5,000	\$5,000	\$5,000	\$5,000		
Elective C-Section	\$7,500	\$7,500	\$7,500	\$7,500		
Pre-ex waiting period (19+ years)	180 days	180 days	180 days	180 days		

* **Maternity benefit maximum:** All maternity care and routine newborn nursery care benefits are limited to an annual benefit maximum of \$5,000 for vaginal deliveries and \$7,500 for medically necessary cesarean sections each calendar year. If a cesarean section is elective and not medically necessary, it will be limited to an annual benefit maximum of \$5,000 per calendar year. This is the most BCBSM will pay each calendar year for all hospital and physician maternity care services. Benefits will be subject to all applicable deductible and copayment requirements, annual copayment maximums and lifetime maximums.

For more details about MyBlue plans, contact your Blues-contracted agent, call 877-4MY-BLUE (877-469-2583) or visit bcbsm.com/myblue.

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 or BCN'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 or BCN; 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.

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Connect your network to ours. We'll build a healthier future together.

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MyBlueSM

My Life, My Health Plan



Flexible **Blue II**SM 1500

Flexible **Blue II**SM 2500

Flexible **Blue II**SM 5000

Young Adult **Blue MAX**SM

One**Blue**SM

Individual Care **Blue Plus**SM

Flexible **Blue Dental Plus**SM

Personal **Blue Dental**SM

Personal **Blue Dental Plus**SM

Maternity



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Blue Shield
Blue Care Network
of Michigan

Blue Cross Blue Shield of Michigan and Blue Care Network are a nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.