

Benefit Highlights

Flexible Blue 2500SM

| | In-Network | Out-of-Network |
|--|--|---|
| Annual deductible | \$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. Your 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. Your entire integrated deductible must be met before covered services are paid. |
| Copays | 20% of the BCBSM-approved amount | 40% of the BCBSM-approved amount |
| Annual copay dollar maximum | \$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 dollar maximum. | \$5,000 per individual contract. \$10,000 per family contract (two or more members). One or more family members may satisfy the family deductible. |
| Annual out-of-pocket maximum: The annual out-of-pocket maximum limits the amount you will be 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. | \$5,000 per individual contract. \$10,000 per family contract (two or more members). | \$10,000 per individual contract. \$20,000 per family contract (two or more members). |
| Lifetime maximum per member | \$5 million | |
| Fourth-quarter deductible carryover | Not applicable | Not applicable |
| Preventive Services | | |
| Includes: health maintenance exam, routine laboratory and radiology, fecal occult blood screening, flexible sigmoidoscopy, gynecological exam, childhood immunizations (0 – 18 years), Pap smear screening, prostate specific antigen screening, well-baby and well-child exams | Covered – 100% with no deductible, up to a combined maximum of \$500 per member, per calendar year. | Not covered |
| Mammography | Covered – 100% with no deductible | Covered – 100% with no deductible |
| Physician Office Services | | |
| Office visits | Covered – 80% after deductible; 2 per member, per calendar year | Not covered |
| Outpatient presurgical second opinion consultations | Covered – 100% after deductible | Not covered |
| Office consultations | Not covered | Not covered |
| Emergency Services | | |
| Medical emergencies and accidental injuries | Covered – 80% after in-network deductible | Covered – 80% after in-network deductible |
| Ambulance service: medically necessary, ground transport and air ambulance | Covered – 80% after in-network deductible | Covered – 80% after in-network deductible |



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association



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| Diagnostic and Radiation Services | | |
| Ultrasound | Covered – 80% after deductible | Covered – 60% after deductible |
| 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 exam | Not covered (optional coverage available) | Not covered (optional coverage available) |
| Prenatal and postnatal exams (office visits) | Not covered (optional coverage available) | Not covered (optional coverage available) |
| Laboratory tests and pathology | Covered – 80% after deductible | Covered – 60% after deductible |
| Inpatient Hospital Care | | |
| Semi-private room: 120 days with 60-day renewal period (BCBSM-participating 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 |
| 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 |
| Alternatives to Hospitalization | | |
| Home health care (participating providers only) | Covered – 80% after in-network deductible | |
| Hospice care: covered at a participating program up to the annual dollar maximum | Covered – 100% after in-network deductible | |
| Outpatient Services | | |
| Outpatient physical, occupational and speech therapy: 60 consecutive days per condition | Not covered | Not covered |
| Chemotherapy (IV and oral) | Covered – 80% after deductible | Covered – 60% after deductible |
| Home infusion therapy (participating providers only) | Covered – 80% after in-network deductible | |
| Voluntary sterilization | Covered – 80% after deductible | Covered – 60% after deductible |
| Prosthetics (participating providers only) | Covered – 80% after in-network deductible | |
| Other medical benefits | | |
| Insulin, disposable needles and syringes dispensed with insulin and diabetic testing supplies | Covered – 80% after deductible | Covered – 60% after deductible |
| Outpatient diabetes management program | Covered – 80% after deductible | Covered – 60% after deductible |
| Contraceptives: physician-administered, prescription drugs only, devices and contraceptive injectables (Implants are not covered) | Covered – 80% after deductible | Covered – 60% after deductible |

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| | In-Network | Out-of-Network |
| Organ Transplantation | | |
| Bone marrow transplant | Covered – 80% after deductible | Covered – 60% after deductible |
| Kidney, cornea and skin transplants | Covered – 80% after deductible | Covered – 60% 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 | |
| Mental Health and Substance Abuse Treatment | | |
| Inpatient mental health (BCBSM–approved facilities only) | Covered – 80% after deductible | Covered – 60% after deductible |
| Outpatient mental health | Not covered | Not covered |
| Substance abuse – inpatient (residential) and outpatient: up to state–mandated benefit (BCBSM–approved facilities only) | Covered – 80% after deductible | Covered – 60% after deductible |

| Prescription Drugs | | |
|------------------------------------|---|---|
| | Network Pharmacy | Non-Network Pharmacy |
| Annual maximum | Covered – \$2,500 per member, per calendar year after in-network integrated deductible, retail and mail order combined. If you exhaust your annual maximum, you 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 a minimum of \$10 and a maximum of \$100 per prescription, after in-network integrated deductible | You must pay the pharmacist the full cost of the drug. BCBSM will reimburse you 80% of the BCBSM–approved amount for covered drugs obtained in the United States, less your copay, after the in-network integrated deductible. You are responsible for the difference between the non-network pharmacy's charge and the BCBSM–approved amount for the drug. |
| 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. You must have been on the medication under BCBSM coverage for at least 60 out of the previous 120 days before becoming eligible for the 90–day retail supply | 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, after in-network integrated deductible | Not covered |

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| Other Prescription Drug Benefits | | |
| Specialty drugs | Covered – after in–network integrated deductible, copays apply. Specialty drugs are available at many retail pharmacies as well as by mail order through Option Care. A list of covered specialty drugs may be found on bcbsm.com . If you have any questions about specialty drugs, please call Option Care at 866–515–1355. | Not covered |
| Contraceptives: self–administered prescription drugs only | Covered – after in–network integrated deductible. Prescription drug copay applies. | Covered – after in–network integrated deductible. Prescription drug copay applies. |
| Drugs prescribed for cosmetic purposes | Not covered | Not covered |
| Elective drugs | Not covered | Not covered |
| Prescription drugs ordered on the Internet | Not covered | Not covered |
| Vaccines given solely to resist infectious diseases | Not covered | Not covered |
| Notes | | |
| Dispense as written | If you, or your physician, requests a brand–name drug when a generic equivalent is available, you must pay the difference in cost between the BCBSM–approved amount for the brand–name drug dispensed and the maximum allowable cost for the generic, plus your applicable copay. Exception: If your physician requests and receives authorization for a formulary brand–name drug from BCBSM and writes “Dispense as Written” or “DAW” on the prescription, you pay only your applicable copay. | |
| Prior authorization | A process that requires a physician to obtain approval from BCBSM before select prescription drugs are covered. | |
| Step therapy | An automated part of the prior authorization process that applies criteria to select prior authorization medications to determine if a less costly drug may be used for the same drug therapy. | |

Note: Out–of–network (nonparticipating) providers may bill you for the difference between BCBSM’s approved amount and the provider’s charge, even if you are referred.

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 the 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.