

Benefit Highlights

Value Blue PPOSM

| | In–Network | Out–of–Network |
|--|---|---|
| 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 by one family member, 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. | \$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 by one family member, 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 or family contract | The out–of–network annual copay dollar maximum is unlimited. Out–of–network copays do not contribute to the in–network copay dollar maximum. |
| 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. | \$3,500 per individual contract. \$4,500 per family contract (two or more members). | No out–of–pocket maximum |
| Lifetime maximum per member | \$5 million | |
| Fourth–quarter deductible carryover | 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 | | |
| 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 | Not covered | Not covered |
| Mammography | Covered – 70% after deductible | Covered – 50% after deductible |
| Physician Office Services | | |
| Office visits | Not covered | 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 – 70% after in–network deductible | Covered – 70% after in–network deductible |
| Ambulance service: medically necessary, ground transport and air ambulance | Covered – 70% after in–network deductible | Covered – 70% 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 – 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 deductible | Covered – 50% after deductible |
| Radiation therapy | Covered – 70% after deductible | Covered – 50% after deductible |
| Maternity Services | | |
| Delivery and newborn exam | Covered – 70% after deductible | Covered – 50% after deductible |
| Prenatal and postnatal exams (office visits) | Not covered | Not covered |
| Laboratory tests and pathology | Covered – 70% after deductible | Covered – 50% after deductible |
| Inpatient Hospital Care | | |
| Semi-private room: 120 days with 60-day renewal period (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 |
| Alternatives to Hospitalization | | |
| Home health care (participating providers only) | Covered – 70% after in-network deductible | |
| Hospice care: covered at a participating program up to the annual dollar maximum | Covered – 100% no deductible | |
| Outpatient Services | | |
| Outpatient physical, occupational and speech therapy: 60 consecutive days per condition | Covered – 70% after deductible | Covered – 50% after deductible |
| Chemotherapy (IV and oral) | Covered – 70% after deductible | Covered – 50% after deductible |
| Home infusion therapy (participating providers only) | Covered – 70% after in-network deductible | |
| Voluntary sterilization | Covered – 70% after deductible | Covered – 50% after deductible |
| Prosthetics (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) | Not covered | Not covered |

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| Organ Transplantation | | |
| Bone marrow transplant | 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% no deductible | |
| Mental Health and Substance Abuse Treatment | | |
| Inpatient mental health: 30 days with 60–day renewal period (BCBSM–approved facilities only) | Covered – 70% after deductible | Covered – 50% 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 – 70% after deductible | Covered – 50% after deductible |
| Prescription Drugs | | |

You are eligible for the BCBSM Affinity Rx Program, which allows you to purchase prescription drugs at the BCBSM–negotiated rate rather than at full retail price.

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.