Benefit Highlights	Value Blue Traditional℠
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.
Copays	30% of the BCBSM–approved amount
Annual copay dollar maximum	$2,500 per individual or family contract
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).
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
Mammography	Covered – 70% after deductible
Physician Office Services	
Office visits	Not covered
Outpatient presurgical second opinion consultations	Covered – 100% after deductible
Office consultations	Not covered
Emergency Services	
Medical emergencies and accidental injuries	Covered – 70% after deductible
Ambulance service: medically necessary, ground transport and air ambulance	Covered – 70% after deductible

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Benefit Highlights	Value Blue Traditional
	In–Network
Diagnostic and Radiation Services	
Ultrasound	Covered – 70% after deductible
Laboratory tests and pathology	Covered – 70% after deductible
EKGs	Covered – 70% after deductible
Diagnostic radiology and X–rays	Covered – 70% after deductible
Colonoscopies (diagnostic)	Covered – 70% after deductible
CT scans and MRIs (BCBSM–participating facilities only)	Covered – 70% after deductible
Radiation therapy	Covered – 70% after deductible
Maternity Services	
Delivery and newborn exam	Covered – 70% after deductible
Prenatal and postnatal exams (office visits)	Not covered
Laboratory tests and pathology	Covered – 70% after deductible
Inpatient Hospital Care	
Semi–private room: 120 days with 60–day renewal period (BCBSM–participating facilities only)	Covered – 70% after deductible
Inpatient consultations	Covered – 70% after deductible
Complications of pregnancy	Covered – 70% after deductible
Surgical Care – Hospital or Outpatient	
Inpatient surgical care	Covered – 70% after deductible
Outpatient surgical care	Covered – 70% after deductible
Physician surgical services	Covered – 70% after deductible
Alternatives to Hospitalization	
Home health care (participating providers only)	Covered – 70% after 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
Chemotherapy (IV and oral)	Covered – 70% after deductible
Home infusion therapy (participating providers only)	Covered – 70% after deductible
Voluntary sterilization	Covered – 70% after deductible
Prosthetics (participating providers only)	Covered – 70% after deductible
Other medical benefits	
Insulin, disposable needles and syringes dispensed with insulin and diabetic testing supplies	Covered – 70% after deductible
Outpatient diabetes management program	Covered – 70% after deductible
Contraceptives: physician–administered, prescription drugs only, devices and contraceptive injectables (Implants are not covered)	Not covered

Benefit Highlights	Value Blue Traditional
	In–Network
Organ Transplantation	
Bone marrow transplant	Covered – 70% after deductible
Kidney, cornea and skin transplants	Covered – 70% 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
Outpatient mental health	Not covered
Substance abuse – inpatient (residential) and outpatient: up to state–mandated benefit (BCBSM–approved facilities only)	Covered – 70% 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: 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.