

# Flexible **Blue** II<sup>SM</sup> (1500)

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



In-Network	Out-of-Network
<b>NOTE:</b> All benefits, except preventive services, are subject to a 180-day waiting period for pre-existing conditions.	

Benefit Highlights		
<b>Annual deductible</b>	\$1,500 per individual contract per calendar year. \$3,000 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.	\$3,000 per individual contract per calendar year. \$6,000 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.
<b>Copays</b>	20% of the BCBSM-approved amount	40% of the BCBSM-approved amount
<b>Annual copay dollar maximum</b>	\$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. Prescription drug copays and flat-dollar copays contribute to the 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 annual copay dollar maximum. Prescription drug copays and flat-dollar copays contribute to the annual copay dollar maximum.
<b>Annual out-of-pocket maximum:</b> 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.	\$4,000 per individual contract. \$8,000 per family contract (two or more members).	\$8,000 per individual contract. \$16,000 per family contract (two or more members).
<b>Lifetime maximum (per member)</b>	\$5 million	
<b>Fourth-quarter deductible carryover</b>	Not applicable	
Preventive Services		
<b>Preventive medical care:</b> Includes health maintenance exam, routine laboratory and radiology, fecal occult blood screening, flexible sigmoidoscopy, gynecological exam, childhood immunizations (through age 15), 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).	Covered – 100% with no deductible, up to a combined maximum of \$500 per member, per calendar year. 90-day benefit waiting period applies.	Not covered
<b>Mammography screening</b>	Covered – 100% with no deductible. 90-day benefit waiting period applies.	
<b>Preventive dental</b>	Not covered	
<b>Preventive vision (VSP network provider only)</b>	Not covered	

	In-Network	Out-of-Network
<b>Physician Office Services</b>		
<b>Office visits</b>	Covered – 80% after deductible; 2 visits, per member, per calendar year	Not covered
<b>Outpatient presurgical second opinion consultations</b>	Covered – 100% after deductible	Not covered
<b>Office consultations</b>	Not covered	
<b>Emergency and Urgent Care Services</b>		
<b>Medical emergencies and accidental injuries</b>	Covered – 80% after in-network deductible for all services other than physician services. You pay \$150 for physician services (waived if admitted).	
<b>Ambulance service: medically necessary, emergency ground transport and air ambulance</b>	Covered – 80% after in-network deductible	
<b>Urgent care</b>	Covered – 80% after in-network deductible for all services other than physician services. You pay \$50 for physician services.	
<b>Diagnostic and Radiation Services</b>		
<b>Ultrasound</b>	Covered – 80% after deductible	Covered – 60% after deductible
<b>Laboratory tests and pathology</b>	Covered – 80% after deductible	Covered – 60% after deductible
<b>EKGs</b>	Covered – 80% after deductible	Covered – 60% after deductible
<b>Diagnostic radiology and X-rays</b>	Covered – 80% after deductible	Covered – 60% after deductible
<b>Colonoscopies (diagnostic)</b>	Covered – 80% after deductible	Covered – 60% after deductible
<b>CT scans and MRIs (BCBSM-participating facilities only)</b>	Covered – 80% after in-network deductible	
<b>Radiation therapy</b>	Covered – 80% after deductible	Covered – 60% after deductible
<b>Maternity Services</b>		
<b>Delivery and newborn exam</b>	Not covered (optional rider available)	
<b>Pre and postnatal exams (office visits)</b>	Not covered (optional rider available)	
<b>Inpatient Hospital Care</b>		
<b>Semi-private room: 120 days with 60-day renewal (BCBSM-approved facilities only)</b>	Covered – 80% after deductible	Covered – 60% after deductible
<b>Inpatient consultations</b>	Covered – 80% after deductible	Covered – 60% after deductible
<b>Complications of pregnancy</b>	Covered – 80% after deductible	Covered – 60% after deductible
<b>Surgical Care – Hospital or Outpatient</b>		
<b>Inpatient surgical care</b>	Covered – 80% after deductible	Covered – 60% after deductible
<b>Outpatient surgical care</b>	Covered – 80% after deductible	Covered – 60% after deductible
<b>Physician surgical services</b>	Covered – 80% after deductible	Covered – 60% after deductible
<b>Gender reassignment surgery and services</b>	Not covered	
<b>Bariatric surgery and services</b>	Not covered	

	In-Network	Out-of-Network
<b>Alternatives to Hospitalization</b>		
Home health care: up to the annual maximum (BCBSM-participating providers only)	Covered – 80% after in-network deductible	
Hospice care: up to the annual dollar maximum (BCBSM-participating programs only)	Covered – 100% after in-network deductible	
<b>Outpatient Services</b>		
Outpatient physical, occupational and speech therapy	Not covered	Not covered
Chemotherapy (IV and oral)	Covered – 80% after deductible	Covered – 60% after deductible
Home infusion therapy (BCBSM-participating providers only)	Covered – 80% after in-network deductible	
Voluntary sterilization	Covered – 80% after deductible	Covered – 60% after deductible
Prosthetics: mandated only (BCBSM-participating providers only)	Covered – 80% after in-network deductible	
<b>Other medical benefits</b>		
Insulin, disposable needles and syringes dispensed with insulin, 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
<b>Organ Transplantation</b>		
Bone marrow transplants	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	
<b>Mental Health and Substance Abuse Treatment</b>		
Inpatient mental health (BCBSM-approved facilities only)	Covered – 80% after deductible, 30 days with 60-day renewal	Covered – 60% after deductible, 30 days with 60-day renewal
Outpatient mental health	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

# 1500 Flexible Blue II<sup>SM</sup>

	In-Network	Out-of-Network
<b>Prescription Drugs</b>		
	<b>Network Pharmacy</b>	<b>Non-network Pharmacy</b>
	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.	
<b>Annual maximum</b>	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. These expenses will not contribute to the in-network integrated deductible or annual copay dollar maximum.	
<b>Retail (1-34 day supply)</b>	Covered – 50% of the approved amount with \$10 minimum and \$100 maximum copay, after in-network integrated deductible	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.
<b>90-day retail (84-90 day supply)</b>	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
<b>Mail order (35-90 day supply)</b>	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

**NOTES:**

- The 90-day benefit waiting period for preventive services will be waived with proof of creditable coverage.
- Flexible Blue II 1500 is not available to group conversion.
- 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.
- Maternity coverage and Flexible Blue Dental Plus<sup>SM</sup> 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.

# HealthReform

From the Blues Office of National Health Reform

## You pay **nothing** for preventive health services

Your health plan covers the preventive services listed here in full. That means you can get checkups, vaccines, screenings and more without paying out-of-pocket at your doctor's office. That's right—you don't need to contribute a copay and you don't have to meet your deductible first when you get these services from a provider in our network.

Why? Because visiting your provider regularly for checkups can help keep you healthy and prevent serious and costly medical conditions.

The listed services are covered at 100 percent when you get them from a provider in our network, and when the main purpose of your visit is to get preventive care. These services are not considered preventive when they are part of a visit about an existing illness or injury, or if you get services that are not listed during the same visit.

### Covered Exams

- Annual OB/GYN Exam
- Health Maintenance Exam (HME) The following categories will be covered as part of your HME exam when appropriate:
  - Discussions with your doctor about taking aspirin for the prevention of cardiovascular disease (aspirin not payable)
  - Discussions with your doctor about the prevention of iron deficiency anemia for at-risk 6 to 12 month old babies
  - Discussions with your doctor about breast and ovarian cancer susceptibility, genetic risk assessment and BRCA mutation testing
  - Discussions with your doctor about chemoprevention when at high risk for breast cancer
  - Discussions with your doctor about taking a daily supplement containing 0.4 to 0.8 mg of folic acid for women planning or capable of pregnancy (folic acid not payable as a medical benefit)
  - Discussions with your doctor about dental tooth decay or cavity prevention in preschool children (oral fluoride not payable as a preventive benefit)
  - Depression screening
  - High blood pressure screening
  - Screening major depressive disorders in adolescents
  - Obesity screening for adults and children
  - Sexually transmitted infection counseling if sexually active
  - Autism screening
  - Developmental surveillance
  - Psychosocial and behavioral assessment
  - Alcohol and drug use assessment
  - Oral health (basic check of child's mouth/teeth by primary care provider/pediatrician)
  - Anticipatory guidance

*The information in this document is based on BCBSM and BCN's current understanding of the Patient Protection and Affordable Care Act (PPACA) and is not intended to impart legal advice. Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to revise and update the information in this document as it becomes available. This document is intended as an educational tool only and does not replace a more rigorous review of the law's applicability to individual circumstances and should not be relied upon as legal or compliance advice. Analysis of the law is ongoing and additional guidance is expected from the Department of Health and Human Services. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members are encouraged to consult with their benefit administrators for specific details.*

## Covered Counseling

- Tobacco use and tobacco-caused disease counseling for pregnant women and adults
- Alcohol behavioral counseling interventions
- Diet behavioral counseling in primary care for adults with cholesterol-related hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease
- Recommended interventions during pregnancy and after birth to promote breastfeeding

## Your prescription carrier will cover the following medication:

- Topical gonorrhea prophylactic medication

## Covered Immunizations

- Influenza (flu)
- Influenza type B
- Pneumococcal (pneumonia)
- Tetanus, diphtheria, pertussis
- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Measles, mumps, rubella, and varicella (MMR or MMRV)
- Meningococcal (meningitis)
- Zoster (shingles)
- Rotavirus
- Inactivated polio
- Varicella (chicken-pox)

## Covered Screenings

- Abdominal aortic aneurysm (one-time screening for smokers)
- Asymptomatic Bacteriuria — Bacterial urinary infection with no symptoms in pregnant women
- Mammography for breast cancer
- Colorectal cancer
- Congenital hypothyroidism
- Lipid disorders, such as cholesterol or cardiovascular screening
- Osteoporosis for postmenopausal women
- Phenylketonuria (PKU) (newborn test)
- Rh (D) incompatibility (pregnancy related blood test)
- Sickle cell disease
- Type 2 diabetes
- Cervical cancer or dysplasia
- Vision
- Hearing
- Newborn metabolic/hemoglobin
- Hematocrit or hemoglobin (blood test)
- Lead
- Tuberculin test (skin test)
- Sexually Transmitted Infections
  - Chlamydia
  - Gonorrhea
  - Syphilis
  - Aids/HIV
  - Hepatitis B
  - Hepatitis C
  - Herpes
  - Human Papillomavirus (HPV)

Blue Cross Blue Shield of Michigan and Blue Care Network follow the recommendations of national medical societies on service frequencies, age requirements and gender guidance when such requirements are not specifically outlined in the law. All health plans will be updated if the federal regulator issues further guidance that requires the plans to be revised.

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