Keep Fit℠

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

	In-Network	Out-of-Network
	NOTE: For all members 19 years of age and older, all benefits, except preventive, are subject to a 180-day waiting period for pre-existing conditions.	
Benefit Highlights		
Annual deductible	**Individual plan**	
	Inpatient services (facility and professional):	
	$1,500, $2,500, $5,000, $7,500 or $10,000 per individual contract per calendar year.	$3,000, $5,000, $10,000, $15,000 or $20,000 per individual contract per calendar year.
	Outpatient and emergency services (facility and professional):	
	$5,000, $6,000, $8,500, $11,000 or $13,500 per individual contract per calendar year.	$10,000, $12,000, $17,000, $22,000 or $27,000 per individual contract per calendar year.
	Family plan (two or more members)	
	Inpatient services (facility and professional):	
	$3,000, $5,000, $10,000, $15,000 or $20,000 per family contract per calendar year.	$6,000, $10,000, $20,000, $30,000 or $40,000 per family contract per calendar year.
	Outpatient and emergency services (facility and professional):	
	$10,000, $12,000, $17,000, $22,000 or $27,000 per family contract per calendar year.	$20,000, $24,000, $34,000, $44,000 or $54,000 per family contract per calendar year.
	NOTE: *If one family member receives medical services (inpatient or outpatient), he or she must meet entire family deductible before any services are paid. Individual deductible does not apply to family plans.*	
Coinsurance	**Inpatient services (facility and professional):**	
	30% of the BCBSM-approved amount	50% of the BCBSM-approved amount
	Outpatient and emergency services (facility and professional):	
	No coinsurance	
Annual coinsurance maximum **NOTE:** Prescription drug copays and flat-dollar copays do not contribute to the annual coinsurance maximum.	**Individual plan**	
	Inpatient services (facility and professional):	
	$3,500 per individual contract per calendar year.	$7,000 per individual contract per calendar year.
	Outpatient and emergency services (facility and professional):	
	Not applicable	
	Family plan (two or more members)	
	Inpatient services (facility and professional):	
	$7,000 per family contract per calendar year.	$14,000 per family contract per calendar year.
	Outpatient and emergency services (facility and professional):	
	Not applicable.	Not applicable. *Out-of-network coinsurance does not contribute to in-network coinsurance maximum.*
	NOTE: *If one family member receives medical services (inpatient or outpatient), he or she must meet entire family deductible before any services are paid; he or she will then pay the 30% coinsurance until the family coinsurance maximum is met. Individual deductible and coinsurance maximums do not apply to family plans.*	

Keep Fit℠

	In-Network	Out-of-Network
Annual out-of-pocket maximum: **NOTE:** Members may satisfy the contract annual out-of-pocket maximum by meeting only the Inpatient deductible and coinsurance maximum, only the outpatient deductible or a combination of inpatient and outpatient.	**Individual plan**	
	$5,000, $6,000, $8,500, $11,000 or $13,500 per individual contract per calendar year.	$10,000, $12,000, $17,000, $22,000 or $27,000 per individual contract per calendar year.
	Family plan (two or more members)	
	$10,000, $12,000, $17,000, $22,000 or $27,000 per family contract per calendar year.	$20,000, $24,000, $34,000, $44,000 or $54,000 per family contract per calendar year.
	NOTE: *If one family member receives medical services (inpatient or outpatient), he or she must meet entire family deductible before any services are paid, he or she will then pay the 30% coinsurance until the family coinsurance maximum is met. At that point, the annual out-of-pocket maximum is met for the family. The individual out-of-pocket maximum does not apply to family plans.*	
Lifetime maximum per member	No lifetime maximum	
Fourth-quarter deductible carryover	Not applicable	
Preventive Services		
Preventive medical and immunizations	Covered – 100% with no deductible, coinsurance or flat dollar copay **Includes:** health maintenance exam, select laboratory services, gynecologic exam, Pap smear 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
Mammography screening	Covered – 100% with no deductible, coinsurance or flat dollar copay	
Wellness Incentives		
Vanishing deductible	If selected health criteria are met by the subscriber (single contract) or subscriber and spouse (family contract), and an online health risk appraisal is submitted to BCBSM, your contract's deductible will be reduced in subsequent years. Details are available at **bcbsm.com.**	Not available
Fitness reward	If you earn the vanishing deductible, you will receive a fitness-related reward. Details are available at **bcbsm.com.**	Not available

	In-Network	Out-of-Network
Physician Office Services		
Office visits (medically-necessary)	**Professional services:** $40 copay per visit with no outpatient deductible, 2 visits per member per calendar year. $40 copay does not contribute to the contract's inpatient annual coinsurance maximum or outpatient deductible. Diagnostic and laboratory services performed in a physician's office are subject to the contract's outpatient deductible, except for preventive care laboratory services. After 2 office visits, additional office visits and diagnostic and laboratory services performed in the physician's office are paid by the member. After the contract's annual out-of-pocket maximum is met, up to 5 additional office visits per member per calendar year are covered. Professional services and diagnostic and laboratory services performed in the physician's office will be covered at $40 copay per visit.	Not covered
Outpatient pre-surgical second opinion consultations	Included in the office visit benefit. Visits count toward the office visit limit.	Not covered
Office consultations	Not covered	
Emergency and Urgent Care Services		
Emergency services in an emergency room	**Facility**: Covered – 100% after outpatient deductible plus $250 copay (copay waived if admitted) **Professional:** Covered – 100% after outpatient deductible	
Accidental injuries	**Facility:** Covered – 70% before inpatient deductible. Covered – 100% before outpatient deductible plus $250 copay (copay waived if admitted) **Professional:** Covered – 70% before inpatient deductible. Covered – 100% before outpatient deductible	
Accidental injury deductible waiver	The inpatient and outpatient deductible is waived for an accidental injury and all covered services related to that injury. Coinsurance and flat-dollar copays apply. **For emergency services and accidental injuries:** If member visits an emergency room for a non-qualified medical emergency or accidental injury, the member will be responsible for payment of the facility services. Professional services will be processed as an outpatient office visit.	
Ambulance service: medically necessary, emergency ground transport and air ambulance	Covered – 100% after outpatient deductible	
Urgent care services	**Facility:** Covered – 100% after outpatient deductible plus $75 copay **Professional:** Covered – 100% after outpatient deductible	

Keep Fit℠

	In-Network	Out-of-Network
Diagnostic and Radiation Services		
Ultrasounds, laboratory tests, pathology, EKGs, diagnostic radiology and X-rays	Covered – 70% after inpatient deductible Covered – 100% after outpatient deductible	Covered – 50% after inpatient deductible Covered – 100% after outpatient deductible
Mammography (diagnostic)	Covered – 70% after inpatient deductible Covered – 100% after outpatient deductible	Covered – 50% after inpatient deductible Covered – 100% after outpatient deductible
Colonoscopy (diagnostic)	Covered – 70% after inpatient deductible Covered – 100% after outpatient deductible	Covered – 50% after inpatient deductible Covered – 100% after outpatient deductible
CT scans and MRIs (BCBSM participating facilities only)	Covered – 70% after inpatient deductible Covered – 100% after outpatient deductible	Covered – 50% after inpatient deductible Covered – 100% after outpatient deductible
Radiation therapy	Covered – 70% after inpatient deductible Covered – 100% after outpatient deductible	Covered – 50% after inpatient deductible Covered – 100% after outpatient deductible
Maternity Services		
Delivery and newborn care	Not covered	
Pre- and post-natal exams	Not covered	
Inpatient Hospital Care		
Semi-private room (BCBSM-approved facilities only), long term acute care hospital and skilled nursing facility	Covered – 70% after inpatient deductible, up to 180 days combined, per member per calendar year	Covered – 50% after inpatient deductible, up to 180 days combined, per member per calendar year
Inpatient consultations	Covered – 70% after inpatient deductible	Covered – 50% after inpatient deductible
Complications of pregnancy	Covered – 70% after inpatient deductible Covered – 100% after outpatient deductible	Covered – 50% after inpatient deductible Covered – 100% after outpatient deductible
Surgical Care - Hospital or outpatient		
Surgical care	Covered – 70% after inpatient deductible Covered – 100% after outpatient deductible	Covered – 50% after inpatient deductible Covered – 100% after outpatient deductible
Physician surgical services	Covered – 70% after inpatient deductible Covered – 100% after outpatient deductible	Covered – 50% after inpatient deductible Covered – 100% after outpatient deductible
Gender reassignment surgery and services	Not covered	
Bariatric surgery and services	Not covered	

	In-Network	Out-of-Network
Alternatives to Hospitalization		
Home health care (BCBSM participating providers only)	Covered – 100% after outpatient deductible up to 30 visits per member per calendar year	
Hospice care (BCBSM participating programs only)	Covered – 100% after inpatient or outpatient deductible	
Outpatient Services and Other Benefits		
Outpatient physical, occupational and speech therapy	Covered – 100% after outpatient deductible, 12 visits per member per calendar year, all therapies combined	Covered – 100% after outpatient deductible, 12 visits per member per calendar year, all therapies combined
Spinal manipulations	Not covered	
Orthotics	Not covered	
Chemotherapy (IV)	Covered – 70% after inpatient deductible Covered – 100% after outpatient deductible	Covered – 50% after inpatient deductible Covered – 100% after outpatient deductible
Home infusion therapy (BCBSM participating providers only)	Covered – 100% after outpatient deductible	
Voluntary sterilization	Not covered	
Prosthetics: mandated only (BCBSM participating providers only)	Covered – 100% after outpatient deductible, mandated only	
Durable medical equipment	Not covered	
Allergy testing and therapy	Not covered	
Outpatient diabetes management program (monitors, lancets, test strips, pumps and supplies, etc.)	Covered – 100% after outpatient deductible. Insulin and syringes dispensed with insulin covered under prescription drug benefit.	Covered – 100% after outpatient deductible. Insulin and syringes dispensed with insulin covered under prescription drug benefit.
Outpatient diabetes training program	Covered – 100% after outpatient deductible	Covered – 100% after outpatient deductible
Contraceptives (oral medications, devices, injectables) and implants	Not covered	
Organ Transplantation		
Bone marrow transplants	Covered – 70% after inpatient deductible Covered – 100% after outpatient deductible	Covered – 50% after inpatient deductible Covered – 100% after outpatient deductible
Kidney, cornea and skin transplants	Covered – 70% after inpatient deductible Covered – 100% after outpatient deductible	Covered – 50% after inpatient deductible Covered – 100% after outpatient deductible
Specified organ transplant (BCBSM designated facilities only)	Covered – 70% after inpatient deductible Covered – 100% after outpatient deductible	

Keep Fit℠

	In-Network	Out-of-Network
Mental Health and Substance Abuse Treatment		
Inpatient mental health (BCBSM-approved facilities only)	Covered – 70% after inpatient deductible, up to 30 days of unused 180 inpatient hospital days, per member per calendar year	Covered – 50% after inpatient deductible, up to 30 days of unused 180 inpatient hospital days, per member per calendar year
Outpatient mental health	Not covered	
Substance abuse: inpatient (residential) and outpatient services (BCBSM-approved facilities only)	Covered – 70% after inpatient deductible Covered – 100% after outpatient deductible	Covered – 50% after inpatient deductible Covered – 100% after outpatient deductible
Prescription Drugs		
Prescription drug deductible	$1,000 per individual contract, $2,000 per family contract	Not covered
Tier 1 - generic and specialty drugs	**Generic:** Covered – $10 copay per prescription, before prescription drug deductible **Specialty:** Covered – 50% copay per prescription, before prescription drug deductible. $100 minimum per prescription, no dollar maximum. 30-day supply limit.	Not covered
Tier 2 - formulary brand and specialty	**Brand:** Covered – 50% copay per prescription, after prescription drug deductible. $25 minimum per prescription, no dollar maximum. **Specialty:** Covered – 50% copay per prescription, after prescription drug deductible. $250 minimum per prescription, no dollar maximum. 30-day supply limit.	Not covered
Tier 3 - all non-formulary and specialty	Member pays 100%. Specialty @ 30-day supply limit. Member may purchase their prescriptions at the BCBSM-negotiated rate.	Not covered
Chemotherapy (oral)	Covered – Tier 1, 2 or 3, as applicable	Not covered
Contraceptives (oral, devices, injectables or implants)	Not covered, medically-necessary or to prevent pregnancy	Not covered
Outpatient diabetes management program (insulin and syringes dispensed with insulin)	Covered – Tier 1, 2 or 3, as applicable	Not covered

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, admissions and hospitalizations; dental care, dental implants or treatment to the teeth except as specifically stated in your benefit plan; hearing aids; infertility services or related drugs; 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 specifically stated in your benefit plan; 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; voluntary abortions or sterilizations including vasectomies and vasectomy reversals; sleep studies and surgeries; medications, drugs or hormones to stimulate growth; genetic testing, except for the purpose of organ transplantation and bone marrow transplantation; RK, PRK, or LASIK; 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 coinsurance 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.

Keep Fit℠

Blue Cross Blue Shield of Michigan

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

bcbsm.com/myblue

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

A Healthier Michigan

news.bcbsm.com | aHealthierMichigan.org | twitter.com/bcbsm
twitter.com/healthiermi | facebook.com/bcbsm | youtube.com/bcbsmnews

CB 11991 JUL 11

112779INDB