

## Benefit Highlights

# Individual Care Blue PPO<sup>SM</sup>

	In-Network	Out-of-Network
<b>Annual deductible</b>	None	None
<b>Copays</b>	30% of the BCBSM-approved amount	50% of the BCBSM-approved amount
<b>Annual copay dollar maximum</b>	\$2,500 per individual or family contract (two or more members), per calendar year. Prescription drug copays do not contribute to the annual copay dollar maximum.	The out-of-network annual copay dollar maximum is unlimited. Prescription drug copays do not contribute to the in-network copay dollar maximum.
<b>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.</b>	\$2,500 per individual or family contract (two or more members)	No out-of-pocket maximum
<b>Lifetime maximum per member</b>	\$5 million	
<b>Fourth-quarter deductible carryover</b>	Not applicable	Not applicable
<b>Preventive Services</b>		
<b>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</b>	Covered – 100% up to a combined maximum of \$500 per member, per calendar year	Not covered
<b>Mammography</b>	Covered – 100%	Covered – 100%
<b>Physician Office Services</b>		
<b>Office visits</b>	Covered – 70%; 2 per member, per calendar year	Not covered
<b>Outpatient presurgical second opinion consultations</b>	Covered – 100%	Not covered
<b>Office consultations</b>	Not covered	Not covered
<b>Emergency Services</b>		
<b>Medical emergencies and accidental injuries</b>	Covered – 70%	Covered – 70%
<b>Ambulance service: medically necessary, ground transport and air ambulance</b>	Covered – 70%	Covered – 70%



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

**MyBlue**<sup>SM</sup>  
My Life, My Health Plan

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<b>Diagnostic and Radiation Services</b>		
Ultrasound	Covered – 70%	Covered – 50%
Laboratory tests and pathology	Covered – 70%	Covered – 50%
EKGs	Covered – 70%	Covered – 50%
Diagnostic radiology and X–rays	Covered – 70%	Covered – 50%
Colonoscopies (diagnostic)	Covered – 70%	Covered – 50%
CT scans and MRIs (BCBSM–participating facilities only)	Covered – 70%	Covered – 50%
Radiation therapy	Covered – 70%	Covered – 50%
<b>Maternity Services</b>		
Delivery and newborn exam	Covered – 70%	Covered – 50%
Prenatal and postnatal exams (office visits)	Not covered	Not covered
Laboratory tests and pathology	Covered – 70%	Covered – 50%
<b>Inpatient Hospital Care</b>		
Semi–private room: 120 days with 60–day renewal period (BCBSM–approved facilities only)	Covered – 70%	Covered – 50%
Inpatient consultations	Covered – 70%	Covered – 50%
Complications of pregnancy	Covered – 70%	Covered – 50%
<b>Surgical Care – Hospital or Outpatient</b>		
Inpatient surgical care	Covered – 70%	Covered – 50%
Outpatient surgical care	Covered – 70%	Covered – 50%
Physician surgical services	Covered – 70%	Covered – 50%
<b>Alternatives to Hospitalization</b>		
Home health care (participating providers only)		Covered – 70%
Hospice care: covered at a participating program up to the annual dollar maximum		Covered – 100%
<b>Outpatient Services</b>		
Outpatient physical, occupational and speech therapy: 60 consecutive days per condition	Covered – 70%	Covered – 50%
Chemotherapy (IV and oral)	Covered – 70%	Covered – 50%
Home infusion therapy (participating providers only)		Covered – 70%
Voluntary sterilization	Covered – 70%	Covered – 50%
Prosthetics (participating providers only)		Covered – 70%
<b>Other medical benefits</b>		
Insulin, disposable needles and syringes dispensed with insulin, diabetic testing supplies	Covered – 70%	Covered – 50%
Outpatient diabetes management program	Covered – 70%	Covered – 50%
Contraceptives: physician–administered, prescription drugs only, devices and contraceptive injectables (Implants are not covered)	Covered – 70%	Covered – 50%

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<b>Organ Transplantation</b>		
Bone marrow transplant	Covered – 70%	Covered – 50%
Kidney, cornea and skin transplants	Covered – 70%	Covered – 50%
Specified organ transplant: \$1 million lifetime maximum per transplant type, included in the \$5 million lifetime maximum (BCBSM–designated facilities only)	Covered – 100%	
<b>Mental Health and Substance Abuse Treatment</b>		
Inpatient mental health: 30 days with 60–day renewal period (BCBSM–approved facilities only)	Covered – 70%	Covered – 50%
Outpatient mental health	Not covered	Not covered
Substance abuse – inpatient (residential) and outpatient: up to state–mandated benefit (BCBSM–approved facilities only)	Covered – 70%	Covered – 50%

## Prescription Drugs

	Network Pharmacy	Non–Network Pharmacy
Annual maximum	Covered – \$2,500 per member, per calendar year. 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. Prescription drug copays are not applied toward the annual copay dollar maximum.	You must pay the pharmacist the full cost of the drug. BCBSM will reimburse you 75% of the BCBSM–approved amount for covered drugs obtained in the United States, less your 50% network copay. You are responsible for the difference between the non–network pharmacy’s charge and the BCBSM–approved amount for the drug. Prescription drug copays are not applied toward the annual copay dollar maximum.
90–day retail (84 – 90 day supply)	Not covered	Not covered
Mail order (35 – 90 day supply)	Not covered	Not covered

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	Network Pharmacy	Non–Network Pharmacy
<b>Other Prescription Drug Benefits</b>		
<b>Specialty drugs</b>	Covered – prescription drug copay applies. 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 <b>bcbsm.com</b> . If you have any questions about specialty drugs, please call Option Care at 866–515–1355.	Not covered
<b>Contraceptives: self–administered prescription drugs only</b>	Covered – prescription drug copay applies	Covered – prescription drug copay applies
<b>Drugs prescribed for cosmetic purposes</b>	Not covered	Not covered
<b>Elective drugs</b>	Covered – prescription drug copay applies	Covered – prescription drug copay applies
<b>Prescription drugs ordered on the Internet</b>	Not covered	Not covered
<b>Vaccines given solely to resist infectious diseases</b>	Not covered	Not covered
<b>Notes</b>		
<b>Dispense as written (DAW)</b>	If you request a brand–name drug when a generic equivalent is available, and your physician has not indicated “Dispense as Written” or “DAW” on the prescription, you must pay the difference in cost between the brand–name drug dispensed and the maximum allowable cost for the generic, plus your copay, if applicable.	
<b>Prior authorization</b>	Not applicable	
<b>Step therapy</b>	Not applicable	

**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.