Welcome to MyBlue℠

My Life, My Health Plan

bcbsm.com/myblue

You selected **Flexible Blue℠ II 1500** as your new health plan. Good thinking – you just simplified your life.

Simple? Not necessarily the first word that comes to mind when you think health insurance. But that's exactly what you'll get with your new health plan.

Your quality health benefits, helpful online resources and exclusive member discounts will become available to you once we receive your first payment.

Check off everything on your health care to-do list. **We've got you covered.**

Your opinions are important to us. Please help us continuously improve our enrollment process by giving us your feedback.

Tell us about your enrollment experience at bcbsm.com/mybluewelcome.

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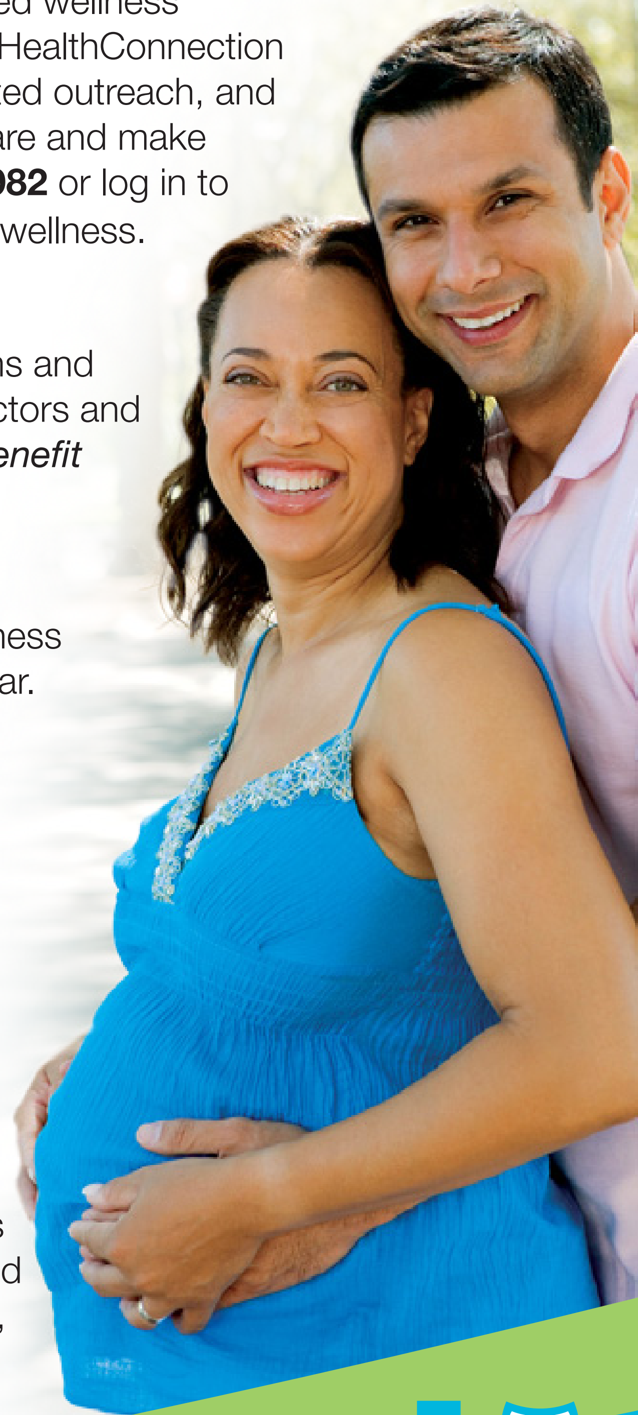
My Extras

Flexible Blue II 1500 offers more than just quality benefits. Your plan is packed with complementary programs and services to help you get or stay healthy. And creating your online account on *Member Secured Services* at **bcbsm.com** puts valuable resources at your fingertips.

Wellness and health care management

Our **BlueHealthConnection®** program offers Web-based wellness information and an online health assessment. Plus, BlueHealthConnection goes beyond the Web by offering health coaches, targeted outreach, and case management to help you coordinate your health care and make more informed health care decisions. Call **1-800-845-5982** or log in to **bcbsm.com** to get started on your customized road to wellness.



Resources

With your online account, you have access to your claims and eligibility information, cost and quality information on doctors and hospitals, health education resources, *Explanation of Benefit Payments* statements, and much more.

Informative publications

Living Healthy magazine is loaded with health tips, wellness ideas and lifestyle advice. It's delivered to you twice a year. We also offer two monthly electronic newsletters called *Living Health-e for Women* and *Living Health-e for Individual and Direct-billed Members*. You can sign up on **bcbsm.com** to receive them by e-mail.

Member savings

As a member of the Michigan Blues, we're helping you save money and live healthier. Score big savings and special offers on a wide variety of healthy products and services from Michigan businesses with our **Healthy Blue Xtras℠** program, and at companies throughout the U.S. with **Blue365®**, our national savings program. From groceries and fitness gear to yoga and gym packages, you can find promotions on everything you need to support a healthy, balanced lifestyle.

Visit **bcbsm.com/xtras** to unlock these big savings on healthy products and services.

My Health Plan

Flexible **Blue** II **1500**

Welcome to the Blues' network.

To make the most of your coverage and avoid paying out-of-network costs, find out if your doctor and pharmacy are in our provider network. You can search **bcbsm.com**, call Customer Service at 1-888-288-2738 or check with your provider. But you also have the freedom to choose an out-of-network provider.

	In-Network	Out-of-Network
	NOTE: For individuals 19 years of age and older, all benefits, except preventive services, are subject to a 180-day waiting period for pre-existing conditions. Flexible Blue II 1500 is not available to group conversion	
Benefit Highlights		
Annual deductible	$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.
Copays	20% of the BCBSM-approved amount	40% of the BCBSM-approved amount
Annual copay dollar maximum	$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.
Annual out-of-pocket maximum: The annual out-of-pocket maximum limits the amount members are responsible for paying each calendar 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).
Lifetime maximum (per member)	No lifetime maximum	
Fourth-quarter deductible carryover	Not applicable	
Preventive Services		
Preventive medical and immunizations: Includes health maintenance exam, select laboratory services, gynecologic exam, 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) 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 Protections and Affordable Care Act.	Covered – 100% with no deductible, copay or coinsurance. 90-day benefit waiting period applies.	Not covered
Mammography screening	Covered – 100% with no deductible, copay or coinsurance. 90-day benefit waiting period applies.	
Preventive dental	Not covered	
Preventive vision (VSP network provider only)	Not covered	

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

	In-Network	Out-of-Network
Outpatient Services		
Outpatient physical, occupational and speech therapy	Not covered	
Chemotherapy (IV)	Covered – 80% after deductible	Covered – 60% after deductible
Chemotherapy (oral)	Covered under prescription drug benefit	
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	
Other medical benefits		
Outpatient diabetes management program	Covered – 80% after deductible; includes monitors, lancets, test strips, pumps and supplies. Insulin and syringes dispensed with insulin covered under prescription drug benefit.	Covered – 60% after deductible; includes monitors, lancets, test strips, pumps and supplies. Insulin and syringes dispensed with insulin covered under prescription drug benefit.
Outpatient diabetes training program	Covered – 80% after deductible	
Contraceptives: devices and contraceptive injectables (implants are not covered)	Covered – 80% after deductible	Covered – 60% after deductible
Organ Transplantation		
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: (BCBSM-designated facilities only)	Covered – 100% after in-network deductible	
Mental Health and Substance Abuse Treatment		
Inpatient mental health (BCBSM-approved facilities only)	Covered – 80% after deductible, up to 30 days of unused 120 inpatient hospital days per calendar year with 60 day renewal.	Covered – 60% after deductible, up to 30 days of unused 120 inpatient hospital days per calendar year with 60 day renewal.
Outpatient mental health	Not covered	
Substance abuse: inpatient (residential) and outpatient (BCBSM-approved facilities only)	Covered – 80% after deductible	Covered – 60% after deductible
Prescription Drugs		
	Network Pharmacy	**Non-network Pharmacy**
	For individuals 19 years of age and older, 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.	
Annual maximum	None	
Retail (1-30 day supply)	Covered – 50% of the approved amount with $10 minimum and $100 maximum copay, after in-network integrated deductible. Insulin and disposable needles and syringes for diabetes management covered.	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. Insulin and disposable needles and syringes for diabetes management covered.
90-day retail (84-90 day supply)	Covered – 50% of the approved amount with a minimum of $20 and a maximum of $200 per prescription, after in–network integrated deductible. Insulin and disposable needles and syringes for diabetes management covered.	Not covered

	In-Network	Out-of-Network
Mail order (31-90 day supply)	Covered – 50% of the approved amount with a minimum of $20 and a maximum of $200 per prescription, after in–network integrated deductible. Insulin and disposable needles and syringes for diabetes management covered.	Not covered

NOTES: Flexible Blue II 1500 is not available for group conversion.

- The 90-day benefit waiting period for preventive services will be waived with proof of creditable coverage.
- 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[SM] 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.

Dental Plan

Flexible **Blue** Dental Plus

Class I – Preventive services	
Oral exams, bitewing X–rays, teeth cleanings and flouride	Covered – 75%, twice per calendar year. (90-day benefit waiting period applies)
Class II — Restorative services	
Replacement fillings and onlays, crowns, extractions and root canal therapy	Covered – 50% of the approved amount; subject to frequency limitations (90 day benefit waiting period applies)
Benefit maximum	
The benefit maximum limits the amount payable for services each calendar year. Once a member reaches the benefit maximum, services will not be paid for that member for the balance of the calendar year. We will continue to pay claims for other eligible members until each member has reached the maximum.	$800 per member, per calendar year

NOTES:
- The 90-day benefit waiting period for Class I and II services is waived with proof of creditable coverage.
- Flexible Blue Dental Plus is optional coverage that may be purchased with Individual Care Blue Plus[SM] or Flexible Blue II[SM] plans. Members may choose a DNoA network dentist. If a member chooses to receive care outside the DNoA network, their out–of–pocket costs may be higher.

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My Maternity Plan

	In-Network	Out-of-Network
	Note: For individuals 19 years of age and older, all benefits are subject to a 180-day waiting period for pre-existing conditions	
Delivery and newborn routine care	Covered – 80% after deductible	Covered – 60% after deductible
Pre and postnatal exams	Covered – 80% after deductible	Covered – 60% after deductible

Note: Maternity coverage is optional and may be purchased with Flexible Blue II[SM] 1500 and 2500 plans. If the optional maternity coverage is not purchased at the same time as Flexible Blue II 1500 or 2500 (i.e., at a later date), the 180–day pre-existing condition waiting period, for individuals 19 years of age and older, maternity benefits begin with the effective date of the optional maternity coverage, not the effective date of Flexible Blue II 1500 or 2500.

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.

My Questions

What are my payment options?

- Our automatic bill payment plan allows you to transfer your premium payment automatically from your checking or savings account and eliminates a paper bill. If you choose to pay monthly, you must enroll in this plan. To enroll, **click here** or visit **bcbsm.com** and follow these steps:

    1. Click on the *Member* tab.
    2. Click on *More*.
    3. Click on *Managing Your Coverage* from the *Member Services* menu on the left.
    4. Click on *How to Make a Payment*.
    5. Click on and complete the *Automatic Payment Enrollment Form*.

- To pay by mail, please send your check or money order to:

    Blue Cross Blue Shield of Michigan
    P.O. Box 553174
    Detroit, MI 48255-3174

By when do I need to make my payment?

Your individual policy is a pre-paid plan, so you pay for your coverage in advance. If we don't receive your payment by the due date of your bill, your coverage will be put on hold. We will advise your doctor, hospital or pharmacy that you are responsible for any claims until we receive your payment. If we don't receive your payment within 30 days of the due date, your coverage will be cancelled and you must wait six months to reapply for any individual Blues product.

How do I make changes to my personal information?

A **Change of Status Form** is available online at **bcbsm.com/myblue**. This form may be used to change your coverage options, billing address and phone number, and to add or remove dependents. Fill out the form, then mail or fax it to us using the address or fax number provided on the form.

What is my deductible?

A deductible is an amount you must pay each year before your plan begins to pay for covered benefits. Your deductible is listed in the benefits summary included with this booklet. If you have a family contract, one or more family members must meet the family deductible before services are covered. Most benefits, including office visits, prescription drugs and the optional maternity benefits, are subject to the deductible requirements.

What is my copayment?

A copay is a flat dollar amount or a percentage of the BCBSM-approved amount that is your responsibility when you receive care. Your copays are listed in the benefits summary included with this booklet.

What is my waiting period?

For individuals 19 years of age and older, there is a 180-day waiting period for pre-existing conditions. Your pre-existing waiting period may be waived if you've met Health Insurance Portability and Accountability Act of 1996 eligibility criteria and have had 18 months of creditable coverage. Please refer to Terms and Conditions on Page 9 of this kit or call the number on the back of your ID card to find out if this applies to you. You will need to send an **Application for Waiver of the Pre-Existing Waiting Period** and a *Certificate of Creditable Coverage* from your former health carrier to:

Mail:
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Mail Code 1124
Detroit, MI 48226

Fax:
Blue Cross Blue Shield of Michigan
313-983-2286

Individual Business Customer Service

Phone Number: 1-888-288-2738

Hours of Operations

7 a.m. to 8 p.m. Monday through Friday;

10 a.m. to 4 p.m. Saturday.

I'm traveling outside of Michigan. Will I have health care coverage?

Blues members take their health care benefits with them — across the country and around the world. Under *Find a Doctor*, just click on *National* next to *More Searches,* or you can **click here**. If you need help finding a doctor or hospital while you're traveling, call 1-800-810-BLUE (2583).

Are prescription drugs covered when I travel?

Your prescription drug coverage can also be used across the country and around the world. Coverage will vary based on network and non-network rules. If you use a pharmacy in our network or a retail pharmacy participating in the Medco network outside of Michigan, your prescription drug claims will be paid according to your plan benefits. If you are traveling outside of Michigan, check with the pharmacy to make sure they are in the Medco network before you fill your prescription.

You can find our approved list of prescription drugs by accessing the drug formulary online at **bcbsm.com**.

How can I get a copy of my certificates and riders?

Your certificate is a legal document approved by Michigan's Office of Financial and Insurance Regulation. A rider is a legal document that amends a certificate by increasing, limiting, deleting or clarifying the scope of coverage. The certificate lists the terms, benefits and limitations of your health care coverage, and includes any riders that amend the certificate. You can view and print copies of your certificates and riders through *Member Secured Services* at **bcbsm.com**.

TERMS AND CONDITIONS OF INDIVIDUAL COVERAGE

Thank you for choosing **Blue Cross Blue Shield of Michigan's Flexible Blue II 1500** plan. You have been approved for coverage based on the following terms and conditions:

- You are a resident of Michigan and live in the state at least six months of the year.
- You are not eligible for group coverage through an employer or your spouse's employer.
- You are not currently covered by another health plan, excluding Medicaid.
- You do not have Medicare and are not eligible for Medicare supplemental coverage.

BCBSM considers you to be eligible for group coverage if your employer or your spouse's employer pays any part of your premium.

Pre-existing conditions
A pre-existing condition is any medical condition for which medical advice, diagnosis, care or treatment was recommended or received in the six months prior to your coverage effective date.

Pre-existing condition waiting period
For individuals 19 years of age and older, BCBSM does not provide coverage for treatment of a pre-existing condition for 180 days following the date we received your application.

You are subject to BCBSM's 180-day pre-existing condition waiting period if:

- You are 19 years of age and older.
- You had no prior coverage or your previous coverage was an individual policy. If your previous individual coverage was with BCBSM, you may receive credit toward the waiting period for the number of days you were covered under the previous certificate, provided there was no lapse in coverage.
- You were covered under COBRA but have not exhausted your COBRA benefit.

You are not subject to BCBSM's 180-day pre-existing condition waiting period if (all of the following conditions must be met):

- You are 18 years of age or younger.
- Prior to your application for this coverage you were continuously covered under one or more health plans for a total of at least 18 months, with no more than a 62-day break. Coverage may include group health plans, individual health insurance, Medicare, Medicaid, public health plans, military or federal programs, Indian Health Services, freestanding prescription drug coverage or other health plans. Freestanding dental and vision coverage cannot be counted as prior health coverage.
- Your most recent health coverage was through a group health plan. (Please note that even though health coverage might be provided through an association or other organization, it is considered to be "individual" health insurance if it is not provided through an employer-sponsored group health plan. Also, a business owner and spouse are usually not considered employees of a business if no other employees take part in the health plan. If this is the case, the health plan cannot be defined as a group health plan but is instead an individual plan. If, however, the spouse of the business owner is a bona fide employee of the business, the plan may be a group health plan. Proof may be required of employee status.)
- You have elected and exhausted any COBRA coverage for which you or they were eligible.
- You're no longer eligible for group coverage, and you're not eligible for Medicare or Medicaid.
- Your prior coverage was not terminated due to premium nonpayment or fraud.

If you have any questions about the terms and conditions of your coverage, please call the Customer Service phone number on the back of your Blues ID card.

Terms and conditions are subject to change by Blue Cross Blue Shield of Michigan.

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