

Flexible BlueSM

Benefits-at-a-Glance

Deductible, copays and dollar maximums		Plan 1500	Plan 2500
Deductible	In-network	\$1,500 per individual and \$3,000 per family	\$2,500 per individual and \$5,000 per family
	Out-of-network	\$3,000 per individual and \$6,000 per family	\$5,000 per individual and \$10,000 per family
Copayment	In-network	Not applicable	20 percent
	Out-of-network	20 percent	40 percent
Copay maximum (individual)	In-network	Not applicable	\$2,500
	Out-of-network	\$2,000	\$5,000
Out-of-pocket maximum (including deductible – individual)	In-network	\$1,500	\$5,000
	Out-of-network	\$5,000	\$10,000

Hospital care in participating hospitals		Plan 1500	Plan 2500
120 general care days in a semi-private room with general nursing and physician care with 60-day renewal period	In-network	Covered – 100 percent after in-network deductible	Covered – 80 percent after in-network deductible
	Out-of-network	Covered – 80 percent after out-of-network deductible	Covered – 60 percent after out-of-network deductible
Inpatient consultations	In-network	Covered – 100 percent after in-network deductible	Covered – 80 percent after in-network deductible
	Out-of-network	Covered – 80 percent after out-of-network deductible	Covered – 60 percent after out-of-network deductible
Chemotherapy	In-network	Covered – 100 percent after in-network deductible	Covered – 80 percent after in-network deductible
	Out-of-network	Covered – 80 percent after out-of-network deductible	Covered – 60 percent after out-of-network deductible

Emergency room care		Plan 1500	Plan 2500
Medical emergency or accidental injury	In-network	Covered – 100 percent after in-network deductible	Covered – 80 percent after in-network deductible
	Out-of-network	Covered – 100 percent after in-network deductible	Covered – 80 percent after in-network deductible
Emergency ambulance services	In-network	Covered – 100 percent after in-network deductible	Covered – 80 percent after in-network deductible
	Out-of-network	Covered – 100 percent after in-network deductible	Covered – 80 percent after in-network deductible

Mental health care and substance abuse treatment in BCBSM-participating hospitals and residential substance abuse facilities		Plan 1500	Plan 2500
Inpatient mental health care	In-network	Covered – 100 percent after in-network deductible; up to 30 days, 60-day renewal	Covered – 80 percent after in-network deductible; up to 30 days, 60-day renewal
	Out-of-network	Covered – 80 percent after out-of-network deductible; up to 30 days, 60-day renewal	Covered – 60 percent after out-of-network deductible; up to 30 days, 60-day renewal
Residential and outpatient substance abuse	In-network	Covered – 100 percent (up to state-mandated dollar amount) after in-network deductible	Covered – 80 percent (up to state-mandated dollar amount) after in-network deductible
	Out-of-network	Covered – 80 percent (up to state-mandated dollar amount) after out-of-network deductible	Covered – 60 percent (up to state-mandated dollar amount) after out-of-network deductible
Outpatient mental health care	In-network	Not covered	Not covered
	Out-of-network	Not covered	Not covered

Medical and surgical care		Plan 1500	Plan 2500
Surgery	In-network	Covered – 100 percent after in-network deductible	Covered – 80 percent after in-network deductible
	Out-of-network	Covered – 80 percent after out-of-network deductible	Covered – 60 percent after out-of-network deductible
Lab and pathology, EKGs, X-rays	In-network	Covered – 100 percent after in-network deductible	Covered – 80 percent after in-network deductible
	Out-of-network	Covered – 80 percent after out-of-network deductible	Covered – 60 percent after out-of-network deductible
Mammography screening – one baseline ages 35 to 40, one annually at age 40 and older	In-network	Covered – 100 percent with no deductible	Covered – 100 percent with no deductible
	Out-of-network	Covered – 100 percent with no deductible	Covered – 100 percent with no deductible
Prosthetic appliances	In-network	Covered – 100 percent after in-network deductible	Covered – 80 percent after in-network deductible
	Out-of-network	Covered – 80 percent after out-of-network deductible	Covered – 60 percent after out-of-network deductible
Office visits – 2 visits per year are covered.	In-network	Covered – 100 percent after in-network deductible	Covered – 80 percent after in-network deductible
	Out-of-network	Not covered	Not covered
Outpatient office consultations	In-network	Not covered	Not covered
	Out-of-network	Not covered	Not covered
Preventive care services – includes: health maintenance exam, sigmoidoscopy, gynecological exams, routine Pap smear, fecal occult blood screening, prostate specific antigen screening, routine laboratory and radiology services, well-baby care and immunizations	In-network	Covered – 100 percent with no deductible, up to a combined maximum of \$500 per member, per calendar year.	Covered – 100 percent with no deductible, up to a combined maximum of \$500 per member, per calendar year.
	Out-of-network	Not covered	Not covered

Alternatives to hospital care		Plan 1500	Plan 2500
Skilled nursing care	In-network	Not covered	Not covered
	Out-of-network	Not covered	Not covered
Hospice care – Covered up to the dollar maximum, which is adjusted periodically	In-network	Covered – 100 percent after in-network deductible, through a participating hospice program only	Covered – 100 percent after in-network deductible, through a participating hospice program only
	Out-of-network		
Home health care	In-network	Covered – 100 percent after in-network deductible	Covered – 80 percent after in-network deductible
	Out-of-network	Covered – 80 percent after out-of-network deductible	Covered – 60 percent after out-of-network deductible

Human Organ Transplants		Plan 1500	Plan 2500
Specified human organ transplants in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504) \$1 million dollar lifetime maximum per member, per transplant type for transplant procedure (s) and related professional, hospital and pharmacy services	In-network	Covered – 100 percent after in-network deductible	Covered – 100 percent after in-network deductible
	Out-of-network		
Bone marrow, kidney, cornea and skin	In-network	Covered – 100 percent after in-network deductible	Covered – 80 percent after in-network deductible
	Out-of-network	Covered – 80 percent after out-of-network deductible	Covered – 60 percent after out-of-network deductible

Other services		Plan 1500	Plan 2500
Outpatient diabetes management program and supplies	In-network	Covered – 100 percent after in-network deductible	Covered – 80 percent after in-network deductible
	Out-of-network	Covered – 80 percent after out-of-network deductible	Covered – 60 percent after out-of-network deductible
Voluntary sterilization	In-network	Covered – 100 percent after in-network deductible	Covered – 80 percent after in-network deductible
	Out-of-network	Covered – 80 percent after out-of-network deductible	Covered – 60 percent after out-of-network deductible
Other services		Plan 1500	Plan 2500
Outpatient physical, speech and occupational therapy		Not covered	Not covered
Chiropractic spinal manipulation		Not covered	Not covered
Allergy testing and therapy		Not covered	Not covered
Durable medical equipment		Not covered	Not covered
Maternity: prenatal, postnatal, delivery and nursery		Not covered (Optional rider available)	Not covered (Optional rider available)

Prescription drug coverage

Benefits include:

- Federal-legend drugs
- State-controlled drugs
- Disposable needles and syringes – dispensed with insulin
- Contraceptive medication and injections
- Mail Order Prescription Drugs – up to a 90-day supply of prescribed medication by mail from Medco (no coverage out-of-network)
- **Note:** Effective October 1, 2006, the mail order pharmacy for specialty drugs changed to Option Care. Specialty prescription drugs are used to treat complex conditions such as Enbrel and Humira for rheumatoid arthritis. These drugs require special handling, administration or monitoring. Option Care handles mail order prescriptions only for specialty drugs. A list of specialty drugs is available on our Web site at bcbsm.com. If you have any questions about specialty drugs, please call Option Care Customer Service at 866-515-1355.

Benefits exclude:

- Elective drugs
Note: Elective drugs are health, habit and reproductive drugs such as those that treat sexual impotency, or infertility, help in weight loss or help to stop smoking.
- Physician-administered injectable drugs (Plan 2 only)

Plan 1500

Network Pharmacy	Covered – 100 percent of the approved amount after Flexible Blue Individual medical coverage deductible Note: If you request the 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
Non-Network Pharmacy	Covered – 80 percent of the approved amount after Flexible Blue Individual medical coverage deductible. (The 20% out-of-network copay will not be applied toward your annual Flexible Blue Individual deductible)
Additional Plan 1500 features	– Benefits are covered up to an annual maximum of \$2,500 per member, per calendar year after in-network deductible. – Uses BCBSM clinical formulary

Plan 2500

<p>Network Pharmacy</p>	<p>Covered – as follows:</p> <p>Retail copay: 50 percent with a minimum of \$10 and a maximum of \$100 per prescription for a 1 to 34 day supply after Flexible Blue Individual medical coverage deductible</p> <p>90-Day Retail copay: 50 percent with a minimum of \$20 and a maximum of \$200 per prescription for an 84 to 90 day supply after Flexible Blue Individual medical coverage deductible.</p> <p>Mail Order copay: 50 percent with a minimum of \$20 and a maximum of \$200 per prescription for a 35 to 90-day supply after Flexible Blue Individual medical coverage deductible.</p> <p>Note: If you or your physician requests the brand-name drug when a generic equivalent is available, you must pay the difference in cost between the brand name drug dispensed and the maximum allowable cost for the generic, plus your applicable copay.</p> <p>Exception: If your physician requests and receives authorization for a formulary brand-name drug from BCBSM and writes “Dispense as Written” or DAW on the prescription, you pay only your applicable copay.</p>
<p>Non-Network Pharmacy</p>	<p>Covered – 80 percent of the approved amount less the Plan 2500 copay after Flexible Blue Individual medical coverage deductible. (The 20% out-of-network copay will not be applied toward your annual Flexible Blue Individual deductible or out-of-pocket copay maximum)</p>
<p>Additional Plan 2500 features</p>	<ul style="list-style-type: none"> – Benefits are covered up to an annual maximum of \$2,500 per member, per calendar year after in-network deductible. – Uses the BCBSM custom formulary. This plan is administered with a closed formulary. Drugs listed as nonformulary (Tier 3) in the formulary are not covered. – 90-day supply available at a participating 90-day retail network pharmacy* – Prior authorization: a process that requires a physician to obtain approval from BCBSM before select prescription drugs are covered. – Step Therapy: an automated part of the Prior Authorization process that applies criteria to select prior authorization medications to determine if a less costly drug may be used for the same drug therapy. <p>* The member must have been on the medication under BCBSM coverage for at least 60 out of the previous 120 days before becoming eligible for the 90-day supply.</p>

Flexible Blue Individual Dental – an optional rider that can be purchased with Flexible Blue Individual

The annual combined benefit maximum under this rider is \$600 per member, per calendar year for Class I and Class II services.

<p>Deductible</p>	<p>None</p>
<p>Copayment</p>	<p>Class I services – 25 percent of the approved amount Class II services – 50 percent of the approved amount</p> <p>No coverage for Class III or Class IV services.</p>
<p>Annual maximum</p>	<p>\$600 per member per calendar year</p>
<p>Copay maximum (individual)</p>	<p>None</p>
<p>Preventive services</p>	<p>Class I – Oral exams, bitewing X-rays and teeth cleaning: covered 75 percent of the approved amount, twice per calendar year</p>
<p>Restorative services</p>	<p>Class II – Fillings, covered 50 percent of the approved amount Replacement filling and onlays, crowns and root canal therapy: covered 50 percent of the approved amount, subject to frequency limitations</p>