Benefit Highlights	Flexible Blue 1500SM	
	In–Network	Out–of–Network
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. Your 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. Your entire integrated deductible must be met before covered services are paid.
Copays	None	20% of the BCBSM–approved amount
Annual copay dollar maximum	None	$2,000 per individual contract. $4,000 per family contract (two or more members). One or more family members may satisfy the family annual copay dollar maximum.
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.	$1,500 per individual contract. $3,000 per family contract (two or more members).	$5,000 per individual contract. $10,000 per family contract (two or more members).
Lifetime maximum per member	$5 million	
Fourth–quarter deductible carryover	Not applicable	Not applicable
Preventive Services		
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	Covered – 100% with no deductible, up to a combined maximum of $500 per member, per calendar year.	Not covered
Mammography	Covered – 100% with no deductible	Covered – 100% with no deductible
Physician Office Services		
Office visits	Covered – 100% after deductible; 2 per member, per calendar year	Not covered
Outpatient presurgical second opinion consultations	Covered – 100% after deductible	Not covered
Office consultations	Not covered	Not covered
Emergency Services		
Medical emergencies and accidental injuries	Covered – 100% after in–network deductible	Covered – 100% after in–network deductible
Ambulance service: medically necessary, ground transport and air ambulance	Covered – 100% after in–network deductible	Covered – 100% after in–network deductible

Benefit Highlights	Flexible Blue 1500	
	In–Network	Out–of–Network
Diagnostic and Radiation Services		
Ultrasound	Covered – 100% after deductible	Covered – 80% after deductible
Laboratory tests and pathology	Covered – 100% after deductible	Covered – 80% after deductible
EKGs	Covered – 100% after deductible	Covered – 80% after deductible
Diagnostic radiology and X–rays	Covered – 100% after deductible	Covered – 80% after deductible
Colonoscopies (diagnostic)	Covered – 100% after deductible	Covered – 80% after deductible
CT scans and MRIs (BCBSM–participating facilities only)	Covered – 100% after deductible	Covered – 80% after deductible
Radiation therapy	Covered – 100% after deductible	Covered – 80% after deductible
Maternity Services		
Delivery and newborn exam	Not covered (optional coverage available)	Not covered (optional coverage available)
Prenatal and postnatal exams (office visits)	Not covered (optional coverage available)	Not covered (optional coverage available)
Laboratory tests and pathology	Covered – 100% after deductible	Covered – 80% after deductible
Inpatient Hospital Care		
Semi–private room: 120 days with 60–day renewal period, (BCBSM–participating facilities only)	Covered – 100% after deductible	Covered – 80% after deductible
Inpatient consultations	Covered – 100% after deductible	Covered – 80% after deductible
Complications of pregnancy	Covered – 100% after deductible	Covered – 80% after deductible
Surgical Care – Hospital or Outpatient		
Inpatient surgical care	Covered – 100% after deductible	Covered – 80% after deductible
Outpatient surgical care	Covered – 100% after deductible	Covered – 80% after deductible
Physician surgical services	Covered – 100% after deductible	Covered – 80% after deductible
Alternatives to Hospitalization		
Home health care (participating providers only)	Covered – 100% after in-network deductible	
Hospice care: covered at a participating program up to the annual dollar maximum	Covered – 100% after in-network deductible	
Outpatient Services		
Outpatient physical, occupational and speech therapy: 60 consecutive days per condition	Not covered	Not covered
Chemotherapy (IV and oral)	Covered – 100% after deductible	Covered – 80% after deductible
Home infusion therapy (participating providers only)	Covered – 100% after in-network deductible	
Voluntary sterilization	Covered – 100% after deductible	Covered – 80% after deductible
Prosthetics (participating providers only)	Covered – 100% after in-network deductible	
Other medical benefits		
Insulin, disposable needles and syringes dispensed with insulin and diabetic testing supplies	Covered – 100% after deductible	Covered – 80% after deductible
Outpatient diabetes management program	Covered – 100% after deductible	Covered – 80% after deductible
Contraceptives: physician-administered, prescription drugs only, devices and contraceptive injectables (Implants are not covered)	Covered – 100% after deductible	Covered – 80% after deductible

Benefit Highlights	Flexible Blue 1500	
	In–Network	Out–of–Network
Organ Transplantation		
Bone marrow transplant	Covered – 100% after deductible	Covered – 80% after deductible
Kidney, cornea and skin transplants	Covered – 100% after deductible	Covered – 80% 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	
Mental Health and Substance Abuse Treatment		
Inpatient mental health (BCBSM-approved facilities only)	Covered – 100% after deductible	Covered – 80% after deductible
Outpatient mental health	Not covered	Not covered
Substance abuse – inpatient (residential) and outpatient: up to state–mandated benefit (BCBSM-approved facilities only)	Covered – 100% after deductible	Covered – 80% after deductible

Prescription Drugs		
	Network Pharmacy	**Non–Network Pharmacy**
Annual maximum	Covered – $2,500 per member, per calendar year after in-network integrated deductible, retail and mail order combined. 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 – 100% of the approved amount after in-network integrated deductible.	You must pay the pharmacist the full cost of the drug. BCBSM will reimburse you 80% of the BCBSM-approved amount for covered drugs obtained in the United States, less your copay, after the in-network integrated deductible. You are responsible for the difference between the non-network pharmacy's charge and the BCBSM-approved amount for the drug.
90–day retail (84 – 90 day supply)	Not covered	Not covered
Mail order (35 – 90 day supply)	Covered – 100% of the approved amount after in-network integrated deductible	Not covered

Benefit Highlights	Flexible Blue 1500	
	Network Pharmacy	Non–Network Pharmacy
Other Prescription Drug Benefits		
Specialty drugs	Covered – after in-network integrated deductible. 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 **bcbsm.com**. If you have any questions about specialty drugs, please call Option Care at 866-515-1355.	Not covered
Contraceptives: self-administered, prescription drugs only	Covered – after in-network integrated deductible. Prescription drug copay applies.	Covered – after in-network integrated deductible. Prescription drug copay applies.
Drugs prescribed for cosmetic purposes	Not covered	Not covered
Elective drugs	Not covered	Not covered
Prescription drugs ordered on the Internet	Not covered	Not covered
Vaccines given solely to resist infectious diseases	Not covered	Not covered
Notes		
Dispense as written (DAW)	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 BCBSM–approved amount for the brand–name drug dispensed and the maximum allowable cost for the generic, plus your copay, if applicable	
Prior authorization	Not applicable	
Step therapy	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.

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