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

Flexible Blue℠ Medical Coverage, Flexible Blue Rx℠ Prescription Drugs With Preventative Care Benefits-at-a-Glance Plan 2

This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificate and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by the plan. 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.

Preventive Care Services

*Payment for preventive care services is limited to a **combined** maximum of $500 per member per calendar year.

	In-Network	Out-of-Network
Health Maintenance Exam – includes chest X-ray, EKG, cholesterol screening and other select lab procedures	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Gynecological Exam	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Pap Smear Screening – laboratory and pathology services	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Well-Baby and Child Care	Covered – 100% (no deductible or copay)* • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Not covered
Immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics	Covered – 100% (no deductible or copay)*	Not covered
Fecal Occult Blood Screening	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Flexible Sigmoidoscopy Exam	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered
Prostate Specific Antigen (PSA) Screening	Covered – 100% (no deductible or copay)*, one per member per calendar year	Not covered

Mammography

Mammography Screening	Covered – 100% (no deductible or copay)	Covered – subject to your Flexible Blue medical out-of-network deductible and percent copay
	One per member per calendar year, no age restriction	

Physician Office Services

Office Visits	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Outpatient and Home Medical Care Visits	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Office Consultations	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Urgent Care Visits	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible

Emergency Medical Care

Hospital Emergency Room	Covered – 100% after in-network deductible	Covered – 100% after in-network deductible
Ambulance Services – medically necessary	Covered – 100% after in-network deductible	Covered – 100% after in-network deductible

	In-Network	Out-of-Network
Diagnostic Services		
Laboratory and Pathology Services	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Diagnostic Tests and X-rays	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Therapeutic Radiology	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Colonoscopy	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
	One per member per calendar year	
Maternity Services Provided by a Physician		
Prenatal and Postnatal Care	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
	Includes care provided by a certified nurse midwife	
Delivery and Nursery Care	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
	Includes delivery provided by a certified nurse midwife	
Hospital Care		
Semiprivate Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Note: Nonemergency services must be rendered in a **participating** hospital	Unlimited days	
Inpatient Consultations	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Chemotherapy	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Alternatives to Hospital Care		
Skilled Nursing Care	Covered – 100% after in-network deductible, in **participating** skilled nursing facilities **only** Limited to 90 days per member per calendar year	
Hospice Care	Covered – 100% after in-network deductible, through a **participating** hospice program **only** Limited to dollar maximum that is reviewed and adjusted periodically	
Home Health Care – medically necessary	Covered – 100% after in-network deductible, by a **participating** home health care agency **only**	
Home Infusion Therapy – medically necessary	Covered – 100% after in-network deductible, by **participating** providers **only**	
Surgical Services		
Surgery – includes presurgical consultations, related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Voluntary Sterilization	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Human Organ Transplants		
Specified Organ Transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered – 100% after in-network deductible, in designated facilities **only,** limited to $1 million **lifetime** maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone Marrow – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504); specific criteria applies	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Kidney, Cornea and Skin	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Mental Health Care and Substance Abuse Treatment		
Inpatient Mental Health Care and Inpatient Substance Abuse Treatment	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
	Limited to a **combined** maximum of 60 days per calendar year with 120 days lifetime per member	
Outpatient Mental Health Care	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible, in participating facilities **only**
	Limited to a **combined** maximum of 120 visits per member per calendar year	
Outpatient Substance Abuse Treatment – in approved facilities **only**	Covered – 100% after in-network deductible	Covered – 100% after in-network deductible, in approved facilities **only**
	Limited to annual state-dollar amount (that combines outpatient and residential substance abuse)	
Other Covered Services		
Outpatient Diabetes Management Program (ODMP)	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Allergy Testing and Therapy	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible
Osteopathic Manipulative Therapy	Covered - 100% after in-network deductible	Covered – 80% after out-of network deductible
Chiropractic Spinal Manipulation	Covered- 100% after in-network deductible	Covered – 80% after out-of network deductible
	Limited to a **combined** maximum of 24 visits per member per calendar year	

Other Covered Services (cont.)	In-Network	Out-of-Network
Outpatient Physical, Speech and Occupational Therapy Services – provided for rehabilitation	Covered – 100% after in-network deductible	Covered – 80% after out-of-network deductible **Note:** Outpatient physical therapy is **not** covered at nonparticipating facilities.
	Limited to a **combined** maximum of 60 visits per member per calendar year	
Durable Medical Equipment	Covered – 100% after in-network deductible	Covered – 100% after in-network deductible
Prosthetic and Orthotic Appliances	Covered – 100% after in-network deductible	Covered – 100% after in-network deductible
Private Duty Nursing Services	Covered – 100% after in-network deductible	Covered – 100% after in-network deductible

Prescription Drug Coverage

Your Flexible Blue prescription drug benefits, including mail order drugs, are subject to the same deductible, copay, out-of-pocket copay maximum and lifetime dollar maximum required under your Flexible Blue medical coverage.

Flexible Blue Rx[SM] Prescription Drug Plan: • Federal-legend drugs • State-controlled drugs • Disposable needles and syringes – dispensed with insulin • Mail Order (Home Delivery) Prescription Drugs – up to a 90-day supply of prescribed medication by mail from Medco (no coverage out-of-network)	**Network Pharmacy**: 100% of approved amount after Flexible Blue medical coverage deductible **Non-Network Pharmacy**: 80% of approved amount after Flexible Blue medical coverage deductible (The 20% out-of-network copay will **not** be applied toward your annual Flexible Blue deductible, out-of-pocket copay maximum or lifetime dollar maximum.)

Note: A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a MedImpact pharmacy outside Michigan.
A **non-network** pharmacy is a pharmacy NOT in the Preferred Rx or MedImpact networks.

Deductible, Copays and Dollar Maximums

Note: If a PPO provider refers you to a non-network provider, all covered services obtained from that non-network provider will be subject to applicable out-of-network cost-sharing. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

	In-Network	Out-of-Network
Deductible **Note:** Your deductible **combines** the deductible amounts paid under your Flexible Blue medical coverage **and** your Flexible Blue prescription drug coverage.	$1,250 for a one-person contract or $2,500 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)	$2,500 for a one-person contract or $5,000 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)
	Deductibles are based on amounts defined annually by the federal government for Flexible Blue-related health plans. Please call your customer service center for an annual update.	
Copays • Fixed Dollar Copays	None	None
• Percent Copays	None	20% of approved amount **Note**: Services without a PPO network and emergency services are covered at the in-network level.
Copay Dollar Maximums • Fixed Dollar Copays	Not applicable	Not applicable
• Percent Copays	Not applicable	$1,000 for a one-person contract or $2,000 for a family contract (2 or more members) each calendar year (excludes 20% out-of-network prescription drug copays) **Note:** Your copay dollar maximum **combines** the copay amounts paid under your Flexible Blue medical coverage **and** your Flexible Blue prescription drug coverage.
Dollar Maximums	**Combined** $5 million lifetime per member for Flexible Blue medical coverage and Flexible Blue prescription drug coverage and a **separate** $1 million lifetime per member per covered specified organ transplant type	

Riders Included

Rider FB – OCSM-24	Adds coverage for osteopathic and chiropractic spinal manipulation, up to 24 visits per member per calendar year.
Rider FB – RM100 and **Rider FB – PC 500M**	Removes copay and deductible for mammography services provided by PPO providers. Adds coverage for preventive care benefits provided by PPO providers, up to a combined maximum of $500 per member per calendar year. Mammography services are not included in the $500 annual maximum. **Note**: These riders are available only as a "package" of preventive care services.
Rider CI, **Rider PCD2** and **Rider PD-CM**	Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and IUDs, and federal legend oral or injectable contraceptive medications. **Note**: These riders are only available as a "prescription drug package" with the Flexible Blue Prescription Drug Plan. Riders CI and PCD2 are part of your medical-surgical coverage and Rider PD-CM is part of your prescription drug coverage.
Rider XVA	Excludes benefits for voluntary abortions.