

# Choose Blue. Peace of mind included.

	Individual Care Blue PPO	Value Blue PPO and Traditional	Young Adult Blue PPO and Traditional
Deductible	None	\$1,000 per individual and \$2,000 per family	\$1,000
Copayment	30% for general services	30%	30%
Out-of-pocket copay maximum (excludes prescription drug copays)	\$2,500 per family	\$2,500 per family	\$2,500
<b>Inpatient care in participating hospitals</b>			
120 general care days in a semi-private room with general nursing and physician care, per benefit period	Covered — 70%	Covered — 70% after deductible	Covered — 70% after deductible
<b>Emergency room care</b>			
Life-threatening medical emergencies	Covered — 70%	Covered — 70% after deductible	Covered — 70% after deductible
<b>Mental health care and substance abuse treatment in BCBSM-participating hospitals and residential substance abuse facilities</b>			
Inpatient facility charges	Covered — 70% up to 30 days; 60-day renewal	Covered — 70% after deductible up to 30 days; 60-day renewal	Covered — 70% after deductible up to 30 days; 60-day renewal
Outpatient substance abuse	Covered — 70% up to state-mandated dollar amount	Covered — 70% after deductible up to state-mandated dollar amount	Covered — 70% after deductible up to state-mandated dollar amount
<b>Medical and surgical care</b>			
Surgery	Covered — 70%	Covered — 70% after deductible	Covered — 70% after deductible
Maternity — delivery and newborn exam only	Covered — 70%	Covered — 70% after deductible	Not covered
Physical therapy	Covered — 70%; 60 consecutive, renewable days per condition	Covered — 70% after deductible; 60 consecutive, renewable days	Covered — 70% after deductible; 60 consecutive, renewable days
Lab and pathology, EKGs, X-rays	Covered — 70%	Covered — 70% after deductible	Covered — 70% after deductible

PPO benefits noted are for care provided by contracted providers. 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.

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<b>Medical and surgical care (continued)</b>			
Mammography screening	Covered — 70%	Covered — 70% after deductible	Covered — 70% after deductible
Prosthetic appliances	Covered — 70%	Covered — 70% after deductible	Covered — 70% after deductible
Office visits	2 visits per year	Not covered	Not covered
Preventive care services	In-network services are covered up to a combined maximum of \$500 per member, per calendar year  Services include: 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	Not covered	Not covered
<b>Hospice care</b>			
Two 90-day periods and one 30-day period	Covered — 100% up to lifetime dollar maximum	Covered — 100% up to lifetime dollar maximum	Covered — 100% up to lifetime dollar maximum
<b>Human organ transplants</b>			
Liver, heart, pancreas, lung and heart-lung	Covered — 100% up to \$1 million lifetime maximum for each	Covered — 100% up to \$1 million lifetime maximum for each	Covered — 100% up to \$1 million lifetime maximum for each
Bone marrow, kidney, cornea and skin	Covered — 70%	Covered — 70% after deductible	Covered — 70% after deductible
<b>Prescription drugs</b>			
Prescription drugs	Covered — 50% with \$10 minimum/\$100 maximum; covered up to \$2,500 per member per calendar year*	Not covered; discounts available through Affinity Rx program	Not covered; discounts available through Affinity Rx program

\*Medicare considers the drug coverage on this product to be noncreditable.