Young Adult Blue MAX℠

An individual health plan from Blue Cross Blue Shield of Michigan.

	In-Network	Out-of-Network
	NOTE: All benefits, except preventive services and outpatient diabetes management training program, are subject to a 180-day waiting period for pre-existing conditions.	
Benefit Highlights		
Annual deductible	$1,000 per individual contract per calendar year.	$2,000 per individual contract per calendar year.
% Coinsurance	30 percent of the BCBSM-approved amount	50 percent of the BCBSM-approved amount
Annual Coinsurance Maximum	$2,500 per individual contract. Flat-dollar copays do not contribute to the annual coinsurance maximum	$3,500. Flat dollar copays do not contribute to the annual coinsurance maximum. Out-of-network coinsurance does not contribute to in-network coinsurance maximum
Annual out-of-pocket maximum. The annual out-of-pocket maximum limits the amount a member is 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.	$3,500 per individual contract	$5,500 per individual contract
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, and other adult preventive services 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 Protection 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	Covered – 100% with no deductible. One dental exam, cleaning and set (up to four bitewings) per calendar year. 90-day benefit waiting period applies.	
Preventive vision (VSP network provider only)	Covered – 100% with no deductible. One vision exam per calendar year. Discounts available on other vision services.	

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Physician Office Services		
Office visits	Professional services: $30 copay per visit with no deductible; 2 visits per calendar year. $30 copay does not contribute to annual coinsurance maximum. Diagnostic and laboratory services performed in the physician office are subject to deductible and coinsurance, except for preventive care laboratory services.	Not covered
Outpatient pre-surgical second opinion consultations	Covered – 100% before deductible	Not covered
Office consultations	Not covered	
Emergency and Urgent Care Services		
Medical emergencies	Facility: Covered 70% after in-network deductible plus $150 copay (waived if admitted); Professional: Covered 70% after in-network deductible	
Accidental injuries	Facility: Covered 70% before in-network deductible plus $150 copay (waived if admitted); Professional: Covered 70% before in-network deductible	
Accidental injury deductible waiver	The deductible is waived for an accidental injury and all covered services related to that injury. Coinsurance and flat-dollar copays apply.	
Ambulance Service: medically necessary, emergency ground transport and air ambulance	Covered – 70% after in-network deductible	
Urgent Care	Facility: Covered 70% after deductible plus $50 copay Professional: Covered 70% after deductible	Facility: Covered 50% after deductible plus $50 copay Professional: Covered 50% after deductible”
Diagnostic and Radiation Services		
Laboratory tests, Pathology, EKGs, Diagnostic radiology and X-rays	Covered – 70% after deductible	Covered – 50% after deductible
Mammography (diagnostic)	Covered – 70% after deductible	Covered – 50% after deductible
Colonoscopy (diagnostic)	Covered – 70% after deductible	Covered – 50% after deductible
CT scans and MRIs (BCBSM participating facilities only)	Covered – 70% after deductible	Covered – 50% after deductible
Radiation therapy	Covered – 70% after deductible	Covered – 50% after deductible
Maternity Services		
Delivery and newborn routine care	Not covered	
Pre- and post-natal exams	Not covered	

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Inpatient Hospital Care		
Semi-private room (BCBSM-approved facilities only)	Covered – 70% after deductible, up to 180 days combined per calendar year	Covered – 50% after deductible, up to 180 days combined per calendar year
Long term acute care hospital (LTACH)		
Skilled nursing facility (SNF)		
Inpatient consultations	Covered – 70% after deductible	Covered – 50% after deductible
Complications of pregnancy	Covered – 70% after deductible	Covered – 50% after deductible
Surgical Care – Hospital or Outpatient		
Inpatient surgical care	Covered – 70% after deductible	Covered – 50% after deductible
Outpatient surgical care	Covered – 70% after deductible	Covered – 50% after deductible
Physician surgical services	Covered – 70% after deductible	Covered – 50% 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 – 70% after in-network deductible up to 30 visits per calendar year	
Hospice care (BCBSM participating programs only)	Covered 100% after in-network deductible	
Outpatient Services and other benefits		
Outpatient physical, occupational and speech therapy	Covered – 70% after deductible, 12 visits per calendar year, all therapies combined	Covered – 50% after deductible, 12 visits per calendar year, all therapies combined
Spinal manipulations	Not covered	
Orthotics	Not covered	
Chemotherapy (IV and oral)	Covered – 70% after deductible	Covered – 50% after deductible
Home infusion therapy (BCBSM participating providers only)	Covered – 70% after in-network deductible	
Voluntary sterilization	Not covered	
Prosthetics: mandated only (BCBSM-participating providers only)	Covered – 70% after in-network deductible	
Durable medical equipment	Not covered	
Allergy testing and therapy	Not covered	
Outpatient diabetes management: Insulin, disposable needles and syringes, monitors, lancets, test strips, pumps and supplies.	Covered – 70% after deductible	Covered – 50% after deductible
Outpatient diabetes management training	Covered – 100% with no deductible	
Contraceptives for the purpose of preventing pregnancy (oral medications, devices or injectables) and implants	Not covered	

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Organ Transplantation		
Bone marrow transplants	Covered – 70% after deductible	Covered – 50% after deductible
Kidney, cornea and skin transplants	Covered – 70% after deductible	Covered – 50% after deductible
Specified organ transplant: (BCBSM-designated facilities only)	Covered – 100% after deductible	
Mental Health and Substance Abuse Treatment		
Inpatient mental health (BCBSM-approved facilities only)	Covered – 70% after deductible, up to 30 days of unused 180 inpatient hospital days, per calendar year	Covered – 50% after deductible, up to 30 days of unused 180 inpatient hospital days, per calendar year
Outpatient mental health	Not covered	
Substance abuse: Inpatient (residential) and outpatient. (BCBSM-approved facilities only)	Covered – 70% after deductible	Covered – 50% after deductible
Prescription Drugs		
You are eligible for the BCBSM affinity Rx program, which allows you to purchase prescription drugs at the BCBSM-negotiated rate rather than at full retail price.		

NOTE: Young Adult Blue Max is available for 19-30 year olds only. A 90-day benefit waiting period applies to preventive medical, mammography screening and preventive dental. The waiting period will be waived with proof of creditable coverage under HIPAA-eligibility.

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, admissions and hospitalizations; dental care, dental implants or treatment to the teeth except as specifically stated in your benefit plan; hearing aids; infertility services or related drugs; 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 or specifically stated in your benefit plan; 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; voluntary abortions or sterilizations including vasectomies and vasectomy reversals; sleep studies and surgeries; medications, drugs or hormones to stimulate growth; genetic testing, except for the purpose of organ transplantation and bone marrow transplantation; RK, PRK, or LASIK; 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.

Blue Cross Blue Shield of Michigan

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