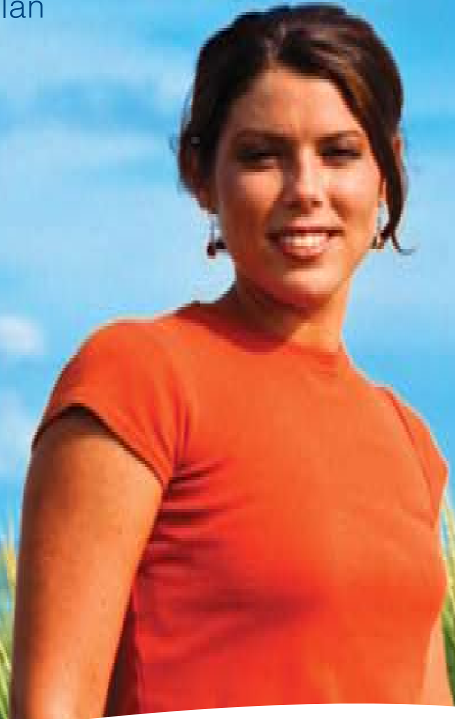
# MyBlue℠

My Life, My Health Plan



Individual health care plans tailored to fit your life.

MyBlue℠

My Life, My Health Plan

## Welcome to MyBlue

Blue Cross Blue Shield of Michigan offers a suite of individual plan options to cover you and your family at all stages of life. Whether you're single, a recent college graduate, self-employed, starting a family or considering early retirement, we have a plan to meet your needs and fit your budget.

Each plan offers the quality benefits, flexibility and valuable services you've come to expect from Michigan's most trusted name in health care including:

### Extensive provider network

In Michigan, 25,000 doctors and all hospitals participate with BCBSM. If you're traveling or have a child attending college in another state, we've got you covered. As one of 39 Blue plans, BCBSM provides you with access to more than 660,000 participating doctors and hospitals across the country.

### Innovative decision-support resources

We offer Web-based resources to educate you about your health care options and to help you make informed health care treatment decisions.

### Exceptional wellness and health care management

Our BlueHealthConnection® program includes nurse health coaches, targeted outreach, case and disease management, Web-based wellness information, an online personal health risk appraisal and a smoking-cessation program.

### Unmatched experience

With nearly 70 years of experience in the health care industry, you can count on BCBSM for security, exemplary service and innovative products.

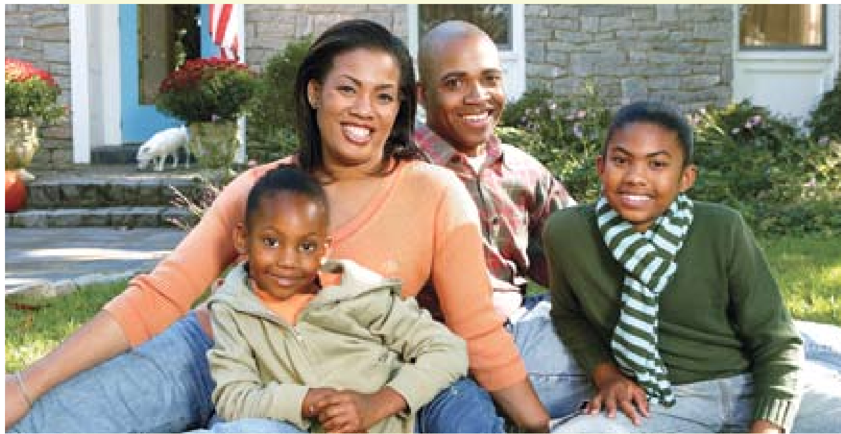
### Significant member discounts

Simply show your Blues ID card to receive discounts on Weight Watchers® registration, safety-related equipment, select alternative medical services and natural health care related products.

# Individual Care Blue

A comprehensive medical plan tailored to fit all stages of your life. This plan is available to you and your family members under age 65.

- Prescription drug coverage
- Preventive care and office visits
- Affordable copays and no deductible
- Flexible Blue[SM] Individual Dental
- Low monthly premiums



Individual Care Blue[SM]

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# **Individual Care Blue** Benefit Highlights

| | |
|---|---|
| **Deductible** | |
| Individual<br>Family | None |
| **Copays** | |
| General services | You pay 30% unless otherwise noted |
| **Out-of-pocket copay maximum (excludes prescription drug copays)** | |
| The out-of-pocket copay maximum limits the amount you will be responsible for paying each year. Once your family expenses reach the maximum, most services will be paid at 100 percent. | $2,500 per family |
| **Inpatient care in participating hospitals** | |
| 120 general-care days in a semi-private room with general nursing and physician care per benefit period | Covered — 70% |
| **Emergency room care** | |
| Medical emergencies or accidental injuries | Covered — 70% |
| **Mental health care and substance abuse treatment in BCBSM-participating hospitals and residential substance abuse facilities** | |
| Inpatient facility charges | Covered — 70% up to 30 days |
| Outpatient substance abuse | Covered — 70% up to state-mandated dollar amount ($3,671 in 2007) |
| **Medical and surgical care** | |
| Office visits | Covered — 70%; 2 visits per year (covered in-network only) |
| Outpatient presurgical second opinion consultations | Covered - 100% (covered in-network only) |
| 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 | Covered — 100%; In-network services are covered up to a combined maximum of $500 per member, per calendar year |
| Mammography routine screening | Covered — 100% |
| Maternity — delivery and newborn exam only | Covered — 70% |
| Lab and pathology, EKGs, X-rays | Covered — 70% |
| **Prescription drugs*** | |
| Prescription drugs | Covered — 50% with $10 minimum/$100 maximum copay; covered up to $2,500 per member per calendar year |

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

# Flexible Blue Individual Dental
## Benefit Highlights

| Class I — Preventive services | |
|---|---|
| Oral exams, bitewing X-rays and teeth cleanings | Covered — 75%; twice per year |
| **Class II — Restorative services** | |
| Fillings, inlays, onlays, crowns and root canal therapy | Covered — 50% of the approval amount; subject to frequency limitations |
| **Benefit maximum** | |
| The benefit maximum limits the amount payable for services each year. Once a member reaches the benefit maximum, services will not be paid for that member for the balance of the year. We will continue to pay claims for other eligible members until each member has reached the maximum. | $600 per member per calendar year |

NOTE: Dental benefits are optional. You may choose to purchase dental benefits with your Individual Care Blue plan.

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# Individual Care Blue Monthly Rates

**Individuals and families that don't currently have BCBSM coverage**

| Age | 24 and younger | 25–29 | 30–34 | 35–39 | 40–44 | 45–49 | 50–54 | 55 and older |
|---|---|---|---|---|---|---|---|---|
| One-Person | $141.15 | $176.46 | $190.73 | $210.84 | $239.66 | $282.71 | $345.93 | $504.20 |
| Two-Person | $282.30 | $352.92 | $381.45 | $421.68 | $479.31 | $565.41 | $691.89 | $1,008.42 |
| Family | $296.44 | $370.58 | $400.55 | $442.76 | $503.28 | $593.67 | $726.48 | $1,058.85 |
| Dependent Continuation | $108.61 | $108.61 | $108.61 | $108.61 | $108.61 | $108.61 | $108.61 | $108.61 |

**Individuals and families transferring or converting from a BCBSM employer-sponsored group health plan***
**(NOTE: Your group health plan must meet qualifying criteria.)**

| Age | 24 and younger | 25–29 | 30–34 | 35–39 | 40–44 | 45–49 | 50–54 | 55 and older |
|---|---|---|---|---|---|---|---|---|
| One-Person | $138.54 | $173.82 | $188.61 | $209.44 | $238.72 | $282.33 | $345.91 | $503.81 |
| Two-Person | $277.08 | $347.64 | $377.22 | $418.88 | $477.44 | $564.66 | $691.82 | $1,007.62 |
| Family | $290.95 | $365.03 | $396.10 | $439.83 | $501.32 | $592.90 | $726.42 | $1,058.02 |
| Dependent Continuation | $107.74 | $107.74 | $107.74 | $107.74 | $107.74 | $107.74 | $107.74 | $107.74 |

* Rates for members who are transferring or who have already transferred from a qualifying BCBSM employer-sponsored health plan will apply for one year and will change in the second year.

NOTE: The rates listed in this section are in effect at the time of printing.

# Flexible Blue Individual Dental Monthly Rates

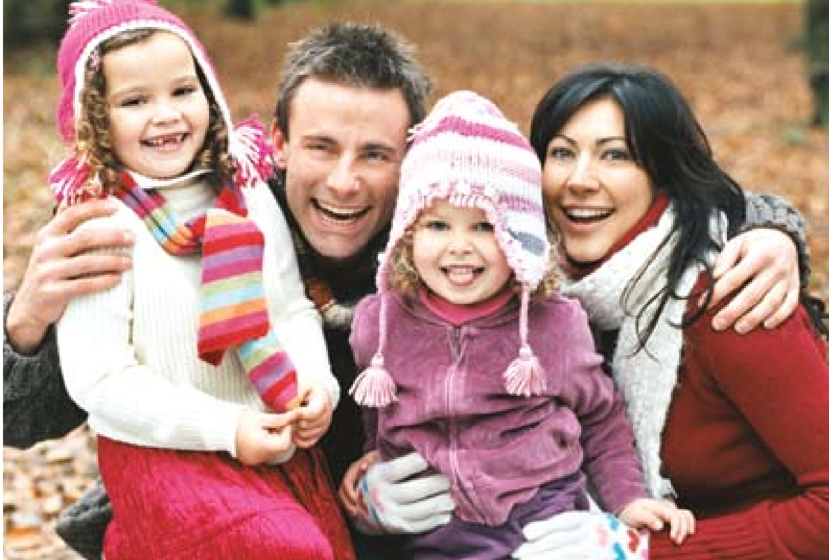
| Age | One-Person | Two-Person | Family | Dependent Continuation |
|---|---|---|---|---|
| Under 25 | $15.10 | $30.20 | $31.71 | $11.00 |
| 25 - 29 | $19.01 | $38.02 | $39.92 | $11.00 |
| 30 - 34 | $20.40 | $40.80 | $42.84 | $11.00 |
| 35 - 39 | $23.82 | $47.64 | $50.02 | $11.00 |
| 40 - 44 | $26.85 | $53.70 | $56.39 | $11.00 |
| 45 - 49 | $31.43 | $62.86 | $66.00 | $11.00 |
| 50 - 54 | $39.85 | $79.70 | $83.69 | $11.00 |
| 55+ | $39.85 | $79.70 | $83.69 | $11.00 |

NOTE: The rates listed in this section are in effect at the time of printing.

# Value Blue

Whether you're self-employed or starting a family, this plan offers basic health care coverage that gives good value to ensure you and your family are covered when you need it.

- Low monthly premiums with higher out-of-pocket costs
- Affordable copays
- Prescription drug discounts through the Affinity Rx discount drug program



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Value Blue℠

# **Value Blue** Benefit Highlights

| **Deductible** | |
|---|---|
| Individual | $1,000 per individual |
| Family | $2,000 per family |
| **Copays** | |
| General services | You pay 30% unless otherwise noted |
| **Out-of-pocket copay maximum** | |
| The out-of-pocket copay maximum limits the amount you will be responsible for paying each year. Once your family expenses reach the maximum, most services will be paid at 100 percent. | $2,500 per family |
| **Inpatient care in participating hospitals** | |
| 120 general-care days in a semi-private room with general nursing and physician care per benefit period | Covered — 70% after deductible |
| **Emergency room care** | |
| Medical emergencies or accidental injuries | Covered — 70% after deductible |
| **Mental health care and substance abuse treatment in BCBSM-participating hospitals and residential substance abuse facilities** | |
| Inpatient facility charges | Covered — 70% after deductible up to 30 days |
| Outpatient substance abuse | Covered — 70% after deductible up to state-mandated dollar amount ($3,671 in 2007) |
| **Medical and surgical care** | |
| Mammography routine screening | Covered — 70% after deductible |
| Maternity — delivery and newborn exam only | Covered — 70% after deductible |
| Lab and pathology, EKGs, X-rays | Covered — 70% after deductible |
| **Prescription drugs** | |
| Prescription drugs | Discounts available through Affinity Rx program |

# Value Blue Monthly Rates

**Individuals and families that don't currently have BCBSM coverage**

| | PPO | Traditional |
|---|---|---|
| **One-Person** | $171.70 | $195.14 |
| **Two-Person** | $343.39 | $390.30 |
| **Family** | $360.55 | $409.81 |
| **Dependent Continuation** | $60.09 | $68.30 |

**Individuals and families transferring or converting from a BCBSM employer-sponsored group health plan* (NOTE: Your group health plan must meet qualifying criteria.)**

| | PPO | Traditional |
|---|---|---|
| **One-Person** | $126.33 | $144.20 |
| **Two-Person** | $252.66 | $288.40 |
| **Family** | $265.29 | $302.83 |
| **Dependent Continuation** | $44.22 | $50.47 |

* Rates for members who are transferring or who have already transferred from a qualifying BCBSM employer-sponsored health plan will apply for one year and will change in the second year.

NOTE: The rates listed in this section are in effect at the time of printing.

# Young Adult Blue

If you're starting a new career and are no longer eligible to be covered by your parents' insurance, this plan is for you.

- Offered to individuals 19 to 30 years old
- Premiums less than $48 a month
- Prescription drug discounts through the Affinity Rx discount drug program

Young Adult Blue℠

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# **Young Adult Blue** Benefit Highlights

| **Deductible** | |
|---|---|
| Deductible | $1,000 |
| **Copays** | |
| General services | You pay 30% |
| **Out-of-pocket copay maximum** | |
| The out-of-pocket copay maximum limits the amount you will be responsible for paying each year. Once your expenses reach the maximum, most services will be paid at 100 percent. | $2,500 |
| **Inpatient care in participating hospitals** | |
| 120 general-care days in a semi-private room with general nursing and physician care per benefit period | Covered — 70% after deductible |
| **Emergency room care** | |
| Medical emergencies or accidental injuries | Covered — 70% after deductible |
| **Mental health care and substance abuse treatment in BCBSM-participating hospitals and residential substance abuse facilities** | |
| Inpatient facility charges | Covered — 70% after deductible up to 30 days |
| Outpatient substance abuse | Covered — 70% after deductible up to state-mandated dollar amount ($3,671 in 2007) |
| **Medical and surgical care** | |
| Mammography routine screening | Covered — 70% after deductible |
| Lab and pathology, EKGs, X-rays | Covered — 70% after deductible |
| **Prescription drugs** | |
| Prescription drugs | Discounts available through Affinity Rx program |

# Young Adult Blue Monthly Rates

**Individuals who don’t currently have BCBSM coverage**

| PPO | Traditional |
|---|---|
| $47.14 | $54.00 |

**Individuals transferring or converting from a BCBSM employer-sponsored group health plan* (NOTE: Your group health plan must meet qualifying criteria.)**

| PPO | Traditional |
|---|---|
| $47.14 | $54.00 |

* Rates for members who are transferring or who have already transferred from a qualifying BCBSM employer-sponsored health plan will apply for one year and will change in the second year.

NOTE: The rates listed in this section are in effect at the time of printing.

# Flexible Blue

A comprehensive medical plan combined with a health savings account that gives you the freedom to choose how and when you use your savings. Two plan options are available.

- Tax-free investment earnings
- Year-to-year rollover
- Preventive care and office visits
- Prescription drug benefits
- Flexible Blue Individual Dental and maternity benefits optional

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Flexible Blue[SM]

# **Flexible Blue** Benefit Highlights

| **Deductible** | **Plan 1500** | **Plan 2500** |
|---|---|---|
| Deductible | $1,500 per individual and $3,000 per family (in-network)<br>$3,000 per individual and $6,000 per family (out-of-network) | $2,500 per individual and $5,000 per family (in-network)<br>$5,000 per individual and $10,000 per family (out-of-network) |
| Copays | 0% (in-network)<br>20% (out-of-network) | 20% (in-network)<br>40% (out-of-network) |
| **Out-of-pocket copay maximum (per individual)** | | |
| The out-of-pocket copay maximum limits the amount you will be responsible for paying each year. Once your individual and family expenses reach the maximum, most services will be paid at 100 percent. | Not applicable (in-network)<br>$2,000 (out-of-network) | $2,500 (in-network)<br>$5,000 (out-of-network) |
| **Inpatient care in participating hospitals** | | |
| 120-general care days in a semi-private room with general nursing and physician care per benefit period | Covered — 100% in-network after in-network deductible<br>Covered — 80% out-of-network after out-of-network deductible | Covered — 80% in-network after in-network deductible<br>Covered — 60% out-of-network after out-of-network deductible |
| **Emergency room care** | | |
| Medical emergencies or accidental injuries | Covered — 100% in-network after in-network deductible<br>Covered — 100% out-of-network after in-network deductible | Covered — 80% in-network after in-network deductible<br>Covered — 80% out-of-network after in-network deductible |
| **Mental health care and substance abuse treatment in BCBSM-participating hospitals and residential substance abuse facilities** | | |
| Inpatient mental health care | Covered – 100 percent in-network after in-network deductible; up to 30 days<br>Covered – 80 percent out-of-network after out-of-network deductible; up to 30 days | Covered – 80 percent in-network after in-network deductible; up to 30 days<br>Covered – 60 percent out-of-network after out-of-network deductible; up to 30 days |
| Residential and outpatient substance abuse | Covered – 100 percent in-network up to state-mandated dollar ($3,671 in 2007) after in-network deductible<br>Covered – 80 percent out-of-network up to state-mandated dollar amount ($3,671 in 2007) after out-of-network deductible | Covered – 80 percent in-network up to state-mandated dollar amount ($3,671 in 2007) after in-network deductible<br>Covered – 60 percent out-of-network up to state-mandated dollar amount ($3,671 in 2007) after out-of-network deductible |
| Outpatient mental health care | Not covered | Not covered |
| **Medical and surgical care** | | |
| Office visits — two visits per year are covered in-network<br>NOTE: Outpatient office consultations are not covered | Covered — 100% in-network after in-network deductible<br>Not covered (out-of-network) | Covered — 80% in-network after in-network deductible<br>Not covered (out-of-network) |
| 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 | Covered — 100% up to a combined maximum of $500 per member per calendar year before deductible (covered in-network only) | Covered — 100% up to a combined maximum of $500 per member per calendar year before deductible (covered in-network only) |
| Mammography routine screening | Covered — 100% in- and out-of-network before deductible | Covered — 100% in- and out-of-network before deductible |

# **Flexible Blue** Benefit Highlights continued

| Medical and surgical care | | |
|---|---|---|
| Lab and pathology, EKGs, X-rays | Covered — 100% in-network after in-network deductible<br><br>Covered — 80% out-of-network after out-of-network deductible | Covered — 80% in-network after in-network deductible<br><br>Covered — 60% out-of-network after out-of-network deductible |
| **Prescription drugs** | | |
| Prescription drugs | Covered — 100% after deductible, network pharmacy<br>Covered — 80% after deductible, non-network pharmacy<br><br>$2,500 calendar year maximum per member after deductible | Covered — 50% after deductible with $10 minimum/$100 maximum copay.<br><br>Covered 50% after deductible less an additional 20% copay, non-network pharmacy<br><br>$2,500 calendar year maximum per member after deductible |

# **Flexible Blue Optional** Benefit Highlights

## Maternity*

| | Plan 1500 | Plan 2500 |
|---|---|---|
| Delivery and routine newborn nursery care | Covered – 100% (in-network)<br><br>Covered – 80% (out of network) | Covered – 80% (in-network)<br><br>Covered – 60% (out-of-network) |
| Pre-and post-natal maternity care | Covered – 100% (in-network)<br><br>Covered – 80% (out of network) | Covered – 80% (in-network)<br><br>Covered – 60% (out-of-network) |

* Maternity benefits are subject to a 180-day waiting period

## Flexible Blue Individual Dental

| Class I — Preventive services | |
|---|---|
| Oral exams, bitewing X-rays and teeth cleanings | Covered — 75%;twice per calendar year |
| **Class II — Restorative services** | |
| Fillings, inlays, onlays, crowns and root canal therapy | Covered — 50% of the approval amount; subject to frequency limitations |
| **Benefit maximum** | |
| The benefit maximum limits the amount payable for services each year. Once a member reaches the benefit maximum, services will not be paid for that member for the balance of the year. We will continue to pay claims for other eligible members until each member has reached the maximum. | $600 per member per calendar year |

NOTE: Dental and maternity benefits are optional. You may choose to purchase these benefits with your Flexible Blue plan.

# Flexible Blue Plan 1500 Monthly Rates

## Plan 1500 offers a lower copay and deductible

**Individuals and families that don’t currently have BCBSM coverage**

| Age | One-Person | Two-Person | Family | Dependent Continuation |
|---|---|---|---|---|
| Under 25 | $102.92 | $205.83 | $216.13 | $89.12 |
| 25 - 29 | $132.43 | $264.85 | $278.10 | $89.12 |
| 30 - 34 | $147.55 | $295.10 | $309.86 | $89.12 |
| 35 - 39 | $175.56 | $351.13 | $368.69 | $89.12 |
| 40 - 44 | $202.62 | $405.23 | $425.50 | $89.12 |
| 45 - 49 | $242.05 | $484.11 | $508.32 | $89.12 |
| 50 - 54 | $305.44 | $610.89 | $641.44 | $89.12 |
| 55+ | $449.28 | $898.56 | $943.50 | $89.12 |

**Individuals and families transferring or converting from a BCBSM employer-sponsored group health plan* (NOTE: Your group health plan must meet qualifying criteria.)**

| Age | One-Person | Two-Person | Family | Dependent Continuation |
|---|---|---|---|---|
| Under 25 | $102.37 | $204.74 | $214.99 | $89.69 |
| 25 - 29 | $132.32 | $264.63 | $277.87 | $89.69 |
| 30 - 34 | $148.18 | $296.36 | $311.18 | $89.69 |
| 35 - 39 | $176.89 | $353.79 | $371.49 | $89.69 |
| 40 - 44 | $204.79 | $409.58 | $430.06 | $89.69 |
| 45 - 49 | $245.38 | $490.76 | $515.31 | $89.69 |
| 50 - 54 | $309.70 | $619.39 | $650.37 | $89.69 |
| 55+ | $454.91 | $909.82 | $955.32 | $89.69 |

* Rates for members who are transferring or who have already transferred from a qualifying BCBSM employer-sponsored health plan will apply for one year and will change in the second year.

NOTE: The rates listed in this section are in effect at the time of printing.

# Flexible Blue Plan 2500 Monthly Rates

## Plan 2500 offers lower monthly premiums

**Individuals and families that don’t currently have BCBSM coverage**

| Age | One-Person | Two-Person | Family | Dependent Continuation |
|---|---|---|---|---|
| Under 25 | $59.83 | $119.66 | $125.65 | $48.01 |
| 25 - 29 | $74.85 | $149.69 | $157.18 | $48.01 |
| 30 - 34 | $81.38 | $162.75 | $170.89 | $48.01 |
| 35 - 39 | $95.09 | $190.17 | $199.68 | $48.01 |
| 40 - 44 | $107.83 | $215.65 | $226.44 | $48.01 |
| 45 - 49 | $126.70 | $253.41 | $266.09 | $48.01 |
| 50 - 54 | $159.05 | $318.09 | $334.00 | $48.01 |
| 55+ | $233.94 | $467.89 | $491.29 | $48.01 |

**Individuals and families transferring or converting from a BCBSM employer-sponsored group health plan* (NOTE: Your group health plan must meet qualifying criteria.)**

| Age | One-Person | Two-Person | Family | Dependent Continuation |
|---|---|---|---|---|
| Under 25 | $58.53 | $117.07 | $122.92 | $47.22 |
| 25 - 29 | $73.37 | $146.74 | $154.09 | $47.22 |
| 30 - 34 | $79.99 | $159.98 | $167.98 | $47.22 |
| 35 - 39 | $93.64 | $187.28 | $196.65 | $47.22 |
| 40 - 44 | $106.35 | $212.70 | $223.34 | $47.22 |
| 45 - 49 | $125.18 | $250.35 | $262.88 | $47.22 |
| 50 - 54 | $157.11 | $314.21 | $329.92 | $47.22 |
| 55+ | $230.85 | $461.69 | $484.78 | $47.22 |

* Rates for members who are transferring or who have already transferred from a qualifying BCBSM employer-sponsored health plan will apply for one year and will change in the second year.

NOTE: The rates listed in this section are in effect at the time of printing.

# Flexible Blue Optional Benefits Monthly Rates

## Maternity

**Maternity services are optional for both Flexible Blue plans.**

| | One-Person | Two-Person | Family | Dependent Continuation |
|---|---|---|---|---|
| **Plan 1500** | $133.72 | $133.72 | $133.72 | $0.00 |
| **Plan 2500** | $94.08 | $94.08 | $94.08 | $0.00 |

## Flexible Blue Individual Dental

**Dental services are optional for both Flexible Blue plans.**

| Age | One-Person | Two-Person | Family | Dependent Continuation |
|---|---|---|---|---|
| Under 25 | $15.10 | $30.20 | $31.71 | $11.00 |
| 25 - 29 | $19.01 | $38.02 | $39.92 | $11.00 |
| 30 - 34 | $20.40 | $40.80 | $42.84 | $11.00 |
| 35 - 39 | $23.82 | $47.64 | $50.02 | $11.00 |
| 40 - 44 | $26.85 | $53.70 | $56.39 | $11.00 |
| 45 - 49 | $31.43 | $62.86 | $66.00 | $11.00 |
| 50 - 54 | $39.85 | $79.70 | $83.69 | $11.00 |
| 55+ | $39.85 | $79.70 | $83.69 | $11.00 |

NOTE: The rates listed in this section are in effect at the time of printing.

# HSA Basics

Health savings accounts allow you to save money for your health care needs while maximizing tax savings.

## How does it work?

**Choose**
Blue Cross Blue Shield of Michigan offers two health care plan options that meet U.S. Treasury Department requirements for HSA eligibility. Select the plan that best fits your needs.

**Save**
You make tax-free contributions to your HSA. You can use funds in your account to pay for current medical expenses or save for future health care needs. The current maximum contribution allowed is $2,850 for individuals and $5,650 for family coverage. These dollar limits are adjusted annually by the federal government.

**Invest**
Money not used by the end of the calendar year rolls over to the next year and can earn interest. Once your balance reaches a specific dollar amount, you may invest the money in a variety of investment options.

## The HSA Advantage

- HSA plans offer lower health care premiums.
- An HSA provides triple tax savings: tax deductions when you contribute to your account, tax-free earnings through investment and tax-free withdrawals for qualified medical expenses.
- You can use HSA funds to cover qualified medical expenses including:
    - Health insurance or medical expenses if you're unemployed
    - Qualified long-term care insurance
    - Medicare premiums and out-of-pocket expenses
    - Medical expenses after retirement
    - Medicare Advantage premiums

# Health Savings Account Plan Example*

**Individual**

Mary enrolled in an HSA-compliant health plan with individual coverage for herself. She may contribute up to $2,850 into her HSA on a pretax basis. She chooses to contribute $2,500.

**Mary's Health Plan**
**In-network deductible:** $2,500
**Maximum out-of-pocket:** $5,000 (including deductible)

| | In-network | Out-of-network |
|---|---|---|
| Health plan pays | 80% | 60% |
| Individual pays | 20% | 40% |
| Preventive care: 100% coverage (deductible does not apply)<br>Pharmacy coverage: Subject to deductible | | |

**Scenario**
During the year, Mary has in-network health care expenses of $1,000 that are not considered preventive care. Because her deductible is $2,500, Mary is responsible for all of these costs. She chooses to pay only $600 of these expenses from the balance in her HSA, because she wants to start saving for her future health care needs.

| Estimated reduction in federal income tax | Amount in HSA | Amount paid from HSA | Amount paid by health plan | Remaining out of pocket expense | Amount remaining in HSA to carry-over |
|---|---|---|---|---|---|
| $583 | $2,500 | $600 | $0 | $400 | $1,900 (plus earnings) |

* This example is for illustrative purposes only. Individual situations will vary depending on the specifics of the HSA-compliant health plan and individual contributions. This example assumes a 28 percent tax bracket.

# Health Savings Account Plan Example*

**Family**

John enrolled in an HSA-compliant plan with family coverage for himself, his wife and two children. He may contribute up to $5,650 but he chooses to contribute $5,000.

**John's Health Plan**
**In-network deductible:** $5,000
**Maximum out-of-pocket:** $10,000 (including deductible)

| | **In-network** | **Out-of-network** |
|---|---|---|
| Health plan pays | 80% | 60% |
| Individual pays | 20% | 40% |
| Preventive care: 100% coverage (deductible does not apply)<br>Pharmacy coverage: Subject to deductible | | |

**Scenario**
During the year, John and his family have in-network health care expenses of $6,000 that are not considered preventive care. John chooses to pay these expenses from the balance in his HSA. Because his deductible is $5,000, the health plan covers 80 percent of the remaining $1,000, or $800. This leaves $200 (20 percent) as John's out-of-pocket expense.

| Estimated reduction in federal income tax | Amount in HSA | Amount paid from HSA | Amount paid by health plan | Remaining out of pocket expense | Amount remaining in HSA to carry-over |
|---|---|---|---|---|---|
| $1,033 | $5,000 | $5,000 | $800 | $200 | $0 |

* This example is for illustrative purposes only. Individual situations will vary depending on the specifics of the HSA-complaint health plan and individual contributions. This example assumes a 28 percent tax bracket.

MyBlue SM
My Life, My Health Plan

# Enrollment Forms

# Individual and Direct Billed Enrollment Application

PLEASE PRINT CLEARLY

**Choose your health plan:**

☐ Value Blue℠ PPO ☐ Young Adult Blue℠ Traditional
☐ Value Blue℠ Traditional ☐ Young Adult Blue℠ PPO

☐ Individual Care Blue℠ PPO
☐ Optional Dental

☐ Flexible Blue℠ 1500
☐ Flexible Blue℠ 2500
☐ Optional Dental
☐ Optional Maternity

**To be eligible for this coverage, you must reside in Michigan at least six months a year and cannot be enrolled in Medicare.**

Requested Coverage Start Date
**(N/A if you answered "Yes" to question 2.)**
MMDDYYYY — Must be Future Date

Your Last Name | First Name | Initial

Street Address | City | State | Zip Code

Social Security Number | ☐ Male ☐ Female | Telephone Number with Area Code | ☐ Single ☐ Married | Date of Birth MM/DD/YYYY

If you wish to apply for coverage for a spouse and/or unmarried children who are under age 19 or who will turn 19 this year, please list them below. Provide last name if different from yours. (Please use an additional sheet of paper for more than three children.)
Spouses and dependent children are not eligible for Young Adult Blue. If you need family coverage, Individual Care Blue or Value Blue may be better options.

| Last name | First name | Initial | Birth Date MM/DD/YYYY | Gender | Social Security Number | Preex Date MMDDYY |
|---|---|---|---|---|---|---|
| Last name (Spouse) | | | | ☐ M ☐ F | | |
| Last name (Child/Dependent) | | | | ☐ M ☐ F | | |
| Last name (Child/Dependent) | | | | ☐ M ☐ F | | |
| Last name (Child/Dependent) | | | | ☐ M ☐ F | | |

If you wish to apply for coverage for an unmarried child who is age 20-25 this year, please complete below. Provide last name if different from yours. (Please use an additional sheet of paper for more than one child.)

| Last name (Child/Dependent) | First name | Initial | Birth Date MM/DD/YYYY | Gender | Social Security Number | Preex Date MMDDYY |
|---|---|---|---|---|---|---|
| | | | | ☐ M ☐ F | | |

1. I live in Michigan six or more months each year: ☐ Yes ☐ No
2. Are you currently active under a Blue Cross Blue Shield of Michigan (BCBSM) employer-sponsored group health plan or have you left a BCBSM employer-sponsored group health plan within the last 60 days? ☐ Yes ☐ No
   If yes, please provide your:
   Contract Number | Group Number | Policy End Date MM/DD/YYYY
3. Are any individuals listed above:
   - Enrolled in Medicare? ☐ Yes ☐ No
   - Eligible for or enrolled in a group-sponsored health plan? ☐ Yes ☐ No If yes, when will your current policy terminate?
   - Enrolled in an individual (non group) health Plan? ☐ Yes ☐ No If yes, when will your current policy terminate?
4. Does your employer pay for or reimburse you for all or part of your health care coverage or provide you with a health care plan? ☐ Yes ☐ No

I am applying for BCBSM coverage subject to the terms and conditions in the material that accompanied this application and I agree that I and my covered dependents will be bound by all provisions in the BCBSM certificates and riders. Approval of this application and coverage effective date will be determined by BCBSM and shall be subject to requirements by BCBSM for additional information and payment of bills. I certify that the requirements of eligibility are met and that the information I have given on this application is true and correct to the best of my knowledge. I authorize BCBSM to obtain from providers of service any and all records relating to me and my covered dependents and acknowledge that BCBSM has the right to use and disclose these records and other confidential member information for valid business purpose.

Signature of Applicant | Date

Area below for BCBSM Use Only

| Agent Code | MA/GA Code | Assoc./Chamber Code | Agent's Signature | Date |
|---|---|---|---|---|
| | | | | |

| Group Number | Service Code | Eff.Date: MMDDYYYY | U/W: | Preex Date | DEID |
|---|---|---|---|---|---|
| | | | | | |


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## BCBSM Pre-existing Condition Waiting Period

If you have a pre-existing condition, there may be an initial 180-day waiting period from the start date of your coverage for which related claims may not be reimbursable. You may be eligible to waive the pre-existing condition waiting period associated with BCBSM non-group coverage (including any limitation on pregnancy benefits) if you meet all of the following criteria:

- Immediately proceeding to your application for this coverage, you were continuously covered under one or more health plans for a total of at least 18 months, with no more than a 62-day break. Coverage may include group health plans, individual health insurance, Medicare, Medicaid, public health plans, military or federal benefit programs, Indian Health Services, freestanding prescription drug coverage or other health plans. Freestanding dental and vision coverage, workers compensation or automobile insurance cannot be counted as prior health care coverage.
- Your most recent health coverage must have been through a group health plan. (Please note that even though health coverage might be provided through an association or other organizations, it is considered to be "individual" health insurance if it is not provided through an employer-sponsored group health plan. Also, a business owner and spouse are usually not considered employees of a business if no other employee participates in the health plan. If this is the case, the health plan cannot be defined as a "group" health plan but is instead an individual plan. If, however, the spouse of the business owner is a bona fide employee of the business, the plan may be a group health plan. Proof may be required of employee status.)
- You have elected and exhausted any COBRA coverage for which you were eligible.
- You are no longer eligible for group coverage and you are not eligible for Medicare.
- Your prior coverage was not terminated due to premium nonpayment or fraud.

When your application is processed, you will receive a welcome letter that further explains waiving the pre-existing condition waiting period.

## Check List for Submitting Your Application

- Review your application for completeness and accuracy.
- Sign and date your application.
- Submit your application (page 1 of 3) and Automatic Payment Plan enrollment form (page 3 of 3) as follows:
  - If you are enrolling through an independent agent, submit your application directly to your agent so that he or she can process the application for you
  - If you are enrolling directly with BCBSM, please mail your completed application to:

**Blue Cross Blue Shield of Michigan - MC B576**
**600 E. Lafayette Blvd.**
**Detroit, MI 48226-2298**

After your application is reviewed and approved, you will receive a bill. A start date for your coverage will be assigned as close as possible to the date you requested on the application (page 1 of 3) or as close as possible to the "Policy End Date" indicated in question 2 (on page 1 of 3). Your coverage will become effective upon receipt of payment.

**Questions:** 888-642-2276

Blue Cross Blue Shield of Michigan

# Automatic Payment Plan for Individual and Direct Billed Customers

BCBSM Automatic Payment Plan offers the convenience of paying your health care bill on time, every time. No need to write checks, mail payments or worry about late payments resulting in rejected services. To participate, simply fill out and mail in this enrollment form. Please include a blank, voided check or a deposit slip from your designated account for verification. Please allow three to four weeks for processing your application. Continue to mail your payment as usual until you see “Automatic Payment” on your bill.

Enrollment is easy. Just complete this enrollment form and mail it along with your application.

Please complete the requested information below: (Please print or type)

Last Name ______ First Name ______ Middle Initial ______

Address ______

City ______ State ______ Zip Code ______

( ) ______
Daytime Phone Number

**Please include a blank, voided check or deposit slip from your designated account**

Name of Financial Institution ______

Please check one: ☐ Checking Account ☐ Savings Account

Bank Account Number ______ ABA/Routing Number (9 digits) ______

**This form cannot be processed without your signature**

I authorize Blue Cross Blue Shield of Michigan to deduct my payments from the checking or savings account listed above. I understand that I control my payments and if at any time I decide to discontinue the payment, I will notify BCBSM. I also understand that all information provided will remain confidential.

Signature ______ Date ______

**BCBSM Use Only**

| DEID | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

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