

MyBlueSM

My Life, My Health Plan



Individual health care plans tailored to fit your life.



MyBlueSM
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 BlueSM Individual Dental
- Low monthly premiums



Individual Care BlueSM

MyBlue

Individual Care Blue Benefit Highlights

Deductible	
Individual	None
Family	
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 noncreditable.

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



MyBlue

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 BlueSM

MyBlue

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



MyBlue

Flexible BlueSM

Flexible Blue

Flexible Blue Benefit Highlights

Deductible	Plan 1500	Plan 2500
Deductible	\$1,500 per individual and \$3,000 per family (in-network) \$3,000 per individual and \$6,000 per family (out-of-network)	\$2,500 per individual and \$5,000 per family (in-network) \$5,000 per individual and \$10,000 per family (out-of-network)
Copays	0% (in-network) 20% (out-of-network)	20% (in-network) 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) \$2,000 (out-of-network)	\$2,500 (in-network) \$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 Covered — 80% out-of-network after out-of-network deductible	Covered — 80% in-network after in-network deductible 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 Covered — 100% out-of-network after in-network deductible	Covered — 80% in-network after in-network deductible 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 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 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 amount (\$3,671 in 2007) after in-network deductible 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 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 NOTE: Outpatient office consultations are not covered	Covered — 100% in-network after in-network deductible Not covered (out-of-network)	Covered — 80% in-network after in-network deductible 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 Covered — 80% out-of-network after out-of-network deductible	Covered — 80% in-network after in-network deductible Covered — 60% out-of-network after out-of-network deductible
Prescription drugs		
Prescription drugs	Covered — 100% after deductible, network pharmacy Covered — 80% after deductible, non-network pharmacy \$2,500 calendar year maximum per member after deductible	Covered — 50% after deductible with \$10 minimum/\$100 maximum copay. Covered 50% after deductible less an additional 20% copay, non-network pharmacy \$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) Covered – 80% (out of network)	Covered – 80% (in-network) Covered – 60% (out-of-network)
Pre-and post-natal maternity care	Covered – 100% (in-network) Covered – 80% (out of network)	Covered – 80% (in-network) 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) 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)		
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.



MyBlueSM

My Life, My Health Plan

Enrollment Forms





Individual and Direct Billed Enrollment Application

Choose your health plan:

- Value BlueSM PPO
- Value BlueSM Traditional
- Young Adult BlueSM Traditional
- Young Adult BlueSM PPO

- Individual Care BlueSM PPO
- Flexible BlueSM 1500
- Flexible BlueSM 2500
- Optional Dental
- Optional Maternity

PLEASE PRINT CLEARLY

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

Your Last Name	First Name	Initial	Requested Coverage Start Date (N/A if you answered "Yes" to question 2.) MMDDYYYY
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> - Must be Future Date

Street Address	City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Social Security Number	Telephone Number with Area Code	Date of Birth MM/DD/YYYY
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Single <input type="checkbox"/> Married

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 (Spouse)	First name	Initial	Birth Date MM/DD/YYYY	Gender	Social Security Number	Preex Date MMDDYY
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>

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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>

- I live in Michigan six or more months each year: Yes No
- 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
<input type="text"/>	<input type="text"/>	<input type="text"/>

- 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.

Area below for BCBSM Use Only			Signature of Applicant		Date
Agent Code	MA/GA Code	Assoc./Chamber Code	Agent's Signature	Date	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

Group Number	Service Code	Eff.Date: MMDDYYYY	U/W:	Preex Date	DEID
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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 preceding 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

