



# Blue Cross® Premier Silver — 94

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

You will have a broad choice of doctors and hospitals within BCBSM's unsurpassed statewide PPO network including nationwide coverage. You may receive services from hospitals or doctors outside the network, but you will pay less if you use providers within the network.

Benefits	In-Network	Out-of-Network
<b>Annual deductible</b>	<b>Individual plan (one member)</b>	
	\$175 per individual plan per calendar year	\$350 per individual plan per calendar year
	<b>Family plan (two or more members)</b>	
	\$350 per family plan per calendar year Medical and drug expenses are combined to meet the integrated deductible.	\$700 per family plan per calendar year Medical and drug expenses are combined to meet the integrated deductible.
	<i>NOTE: If your plan is a family plan, the entire family deductible must be met before BCBSM pays for covered services. The family deductible may be met by one or more family members.</i>	
<b>Coinsurance</b>	10% after deductible for most services. 50% after deductible for bariatric, temporomandibular joint, infertility, prosthetics and orthotics, and durable medical equipment services.	30% after deductible for most services. 70% after deductible for bariatric, temporomandibular joint, infertility, prosthetics and orthotics, and durable medical equipment services.
<b>Annual coinsurance maximum</b>	<b>Individual plan (one member)</b>	
	\$325 per individual plan per calendar year	\$650 per individual plan per calendar year
	<b>Family plan (two or more members)</b>	
	\$650 per family plan per calendar year	\$1,300 per family plan per calendar year
	<i>NOTE: If your plan is a family plan, all copays and coinsurance paid by the members on your family plan will apply to the family coinsurance and copay maximum. The entire family coinsurance and copay maximum must be met before BCBSM pays for covered services at 100% of the approved amount. The family coinsurance and copay maximum may be met by one or more family members.</i>	
<b>Out-of-Pocket maximum</b> The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum	<b>Individual plan (one member)</b>	
	\$500 per individual plan per calendar year	\$1,000 per individual plan per calendar year
	<b>Family plan (two or more members)</b>	
	\$1,000 per family plan per calendar year	\$2,000 per family plan per calendar year
	<i>NOTE: If your plan is a family plan, the entire family out-of-pocket maximum must be met before BCBSM pays for covered services at 100% of the approved amount. The family out-of-pocket maximum may be met by one or more family members.</i>	

Find other important information about Blues benefits and membership at [bcbsm.com/importantinfo](http://bcbsm.com/importantinfo).

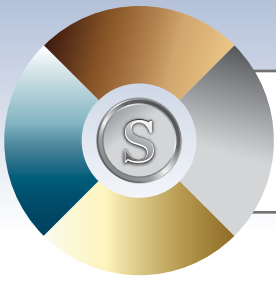
Call a Health Plan Advisor at 1-877-469-2583 if you have any questions.





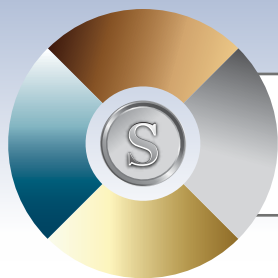
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Benefits	In-Network	Out-of-Network
<b>Preventive Care</b>		
<b>Preventive medical, prescription drugs and immunizations include:</b> health maintenance exam, select laboratory services, gynecologic exam, pap smear screening, mammogram screening, select female contraceptives, female voluntary sterilization and other adult and childhood 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	Not covered
<b>Screening colonoscopy</b>	Covered 100% with no deductible, copay or coinsurance. Routine colonoscopy must be billed as preventive to be covered at 100%.	Not covered
<b>Pediatric Services</b>		
<b>Well baby/child</b>	Covered 100% with no deductible, copay or coinsurance	Not covered
<b>Pediatric dental</b>	Stand alone plan available for purchase	
<b>Pediatric vision</b>	Covered 100%. One annual vision exam; standard lenses and frames or contact lenses (frequency limits apply)	Covered 100%. One annual vision exam; standard lenses and frames or contact lenses. Frequency limits apply. Member responsible for the difference between the BCBSM approved amount and the provider's charge.
<b>Ambulatory Services</b>		
<b>Physician office visits, presurgical consultations, office consultations</b>	\$10 copay per primary care visit and \$30 copay per specialist office visit after deductible. Diagnostic and laboratory services are subject to plan's deductible and coinsurance.	Not covered
<b>Urgent care — physician's office</b>	Covered 90% after deductible plus \$30 copay	Not covered
<b>Laboratory and Diagnostic Services</b>		
<b>Laboratory tests and pathology</b>	Covered 90% after deductible	Covered 70% after deductible
<b>Diagnostic tests and X-rays (including EKG, Chest X-ray)</b>	Covered 90% after deductible	Covered 70% after deductible
<b>Imaging aervices: CT scans, MRIs, PET, etc.</b> Prior authorization required	Covered 90% after deductible plus \$200 copay	Covered 70% after deductible plus \$200 copay
<b>Allergy testing and therapy</b>	Covered 90% after deductible	Not covered



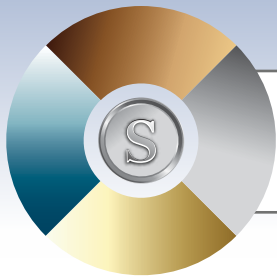
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Benefits	In-Network	Out-of-Network
<b>Maternity &amp; Newborn Care</b>		
<b>Maternity benefit</b>	Covered 90% after deductible	Covered 70% after deductible
<b>Prenatal visits</b>	Covered 100% with no deductible, copay or coinsurance	Covered 70% after deductible
<b>Postnatal visits</b>	Covered 90% after deductible	Covered 70% after deductible
<b>Emergency Services</b>		
<b>Emergency room</b>	Covered 90% after deductible plus \$100 copay (copay waived if admitted)	
<b>Ambulance services</b>	Covered 90% after deductible	
<b>Urgent care visits</b> Urgent care center or outpatient location	Covered 90% after deductible plus \$30 copay	Covered 70% after deductible plus \$30 copay
<b>Hospitalization and Other Services</b>		
<b>Inpatient hospital care, long-term acute care hospital — semi-private room</b> BCBSM participating facilities only	Covered 90% after deductible	Covered 70% after deductible
<b>Physician surgical services</b>	Covered 90% after deductible	Covered 70% after deductible
<b>Home health care</b> BCBSM participating agencies only	Covered 90% after deductible	Not covered
<b>Hospice care</b> BCBSM participating hospice programs only	Covered 100% after deductible	Not covered
<b>Skilled Nursing Facility — Limited to a maximum of 45 days per member per calendar year</b> BCBSM participating facilities only	Covered 90% after deductible	Covered 70% after deductible
<b>Chemotherapy</b>	Covered 90% after deductible	Covered 70% after deductible
<b>Organ transplant — Bone marrow, kidney, cornea, and skin</b>	Covered 90% after deductible	Covered 70% after deductible
<b>Specified organ transplant</b> BCBSM designated facilities only	Covered 90% after deductible	Not covered
<b>Sleep studies including testing and surgeries</b> Prior authorization required	Covered 90% after deductible	Covered 70% after deductible
<b>Bariatric surgery — once per lifetime</b>	Covered 50% after deductible	Covered 30% after deductible
<b>Male voluntary sterilization</b>	Covered 90% after deductible	Covered 70% after deductible
<b>Artificial insemination</b>	Not covered	Not covered



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Benefits	In-Network	Out-of-Network
<b>Rehabilitative and Habilitative Services and Devices</b>		
<b>Outpatient physical &amp; occupational therapy</b>	Covered 90% after deductible — Limited to a combined maximum of 30 visits per member per calendar year	Covered 70% after deductible — Limited to a combined maximum of 30 visits per member per calendar year
<b>Chiropractic spinal manipulation and osteopathic manipulative therapy</b>		
<b>Speech therapy</b>	Covered 90% after deductible — Limited to a maximum of 30 visits per member per calendar year	Covered 70% after deductible — Limited to a maximum of 30 visits per member per calendar year
<b>Cardiac and pulmonary rehabilitation</b>	Covered 90% after deductible — Limited to a combined maximum of 30 visits per member per calendar year	Covered 70% after deductible — Limited to a combined maximum of 30 visits per member per calendar year
<b>Specified autism spectrum disorder — applied behavioral analysis</b>	Covered 90% after deductible — Diagnosis and treatment in accordance with state mandate	Covered 70% after deductible — Diagnosis and treatment in accordance with state mandate
<b>Prosthetic and orthotic appliances</b> BCBSM approved providers only	Covered 50% after deductible	Covered 30% after deductible
<b>Durable medical equipment</b>	Covered 50% after deductible	Covered 30% after deductible
<b>Mental Health/Substance Abuse</b>		
<b>Inpatient mental health</b> BCBSM participating facilities only	Covered 90% after deductible	Covered 70% after deductible
<b>Outpatient mental health</b>	Covered 90% after deductible	Covered 70% after deductible
<b>Inpatient substance abuse</b> BCBSM participating facilities only	Covered 90% after deductible	Not covered
<b>Outpatient substance abuse</b> BCBSM participating programs only	Covered 90% after deductible.	Covered 70% after deductible.
<b>Prescription Drugs</b>		
<b>Prescription drugs 1-30 days</b> (Retail network pharmacy and mail-order provider)	<p><b>Tier 1 — Generic:</b> \$15 copay after in-network integrated deductible</p> <p><b>Tier 2 — Preferred brand:</b> 25% coinsurance after in-network integrated deductible, \$40 minimum and \$100 maximum copay</p> <p><b>Tier 3 — Nonpreferred brand:</b> 50% coinsurance after in-network integrated deductible, \$80 minimum and \$100 maximum copay</p> <p><b>Tier 4 — Preferred specialty:</b> 20% coinsurance after in-network integrated deductible, no minimum and \$200 maximum copay</p> <p><b>Tier 5 — Nonpreferred specialty:</b> 25% coinsurance after in-network integrated deductible, no minimum and \$300 maximum copay</p>	Members must pay the pharmacist the full cost of the drug. After the in-network integrated deductible, BCBSM will reimburse 80% of the BCBSM-approved amount for covered drugs, less the copay and the difference between the out-of-network pharmacy's charge and the BCBSM-approved amount for the drug.



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Benefits	In-Network	Out-of-Network
<b>Prescription Drugs</b> <i>continued</i>		
<b>Prescription drugs 31-60 days</b> <b>Note:</b> Specialty drugs (Tier 4 and 5) are limited to a 30-day supply. <b>(MAIL ORDER ONLY)</b>	<b>Tier 1 — Generic:</b> \$30 copay after in-network integrated deductible <b>Tier 2 — Preferred brand:</b> 25% coinsurance after in-network integrated deductible, \$80 minimum and \$200 maximum copay <b>Tier 3 — Nonpreferred brand:</b> 50% coinsurance after in-network integrated deductible, \$160 minimum and \$200 maximum copay <b>Tier 4 — Preferred specialty:</b> Not covered <b>Tier 5 — Nonpreferred specialty:</b> Not covered	Not covered
<b>Prescription drugs 61-83 days</b> <b>Note:</b> Specialty drugs (Tier 4 and 5) are limited to a 30-day supply. <b>(MAIL ORDER ONLY)</b>	<b>Tier 1 — Generic:</b> \$45 copay after in-network integrated deductible <b>Tier 2 — Preferred brand:</b> 25% coinsurance after in-network integrated deductible, \$120 minimum and \$300 maximum copay <b>Tier 3 — Nonpreferred brand:</b> 50% coinsurance after in-network integrated deductible, \$240 minimum and \$300 maximum copay <b>Tier 4 — Preferred specialty:</b> Not covered <b>Tier 5 — Nonpreferred specialty:</b> Not covered	Not covered



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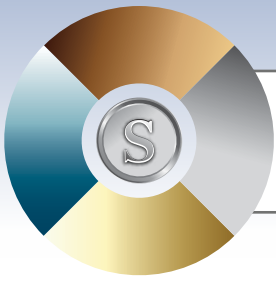
Benefits	In-Network	Out-of-Network
<b>Prescription Drugs</b> <i>continued</i>		
<b>Prescription drugs 84-90 days</b> <b>Note:</b> Specialty drugs (Tier 4 and 5) are limited to a 30-day supply. <b>(90-day retail network pharmacy or mail-order provider)</b>	<b>Tier 1 — Generic:</b> \$45 copay after in-network integrated deductible <b>Tier 2 — Preferred brand:</b> 25% coinsurance after in-network integrated deductible, \$120 minimum and \$300 maximum copay <b>Tier 3 — Nonpreferred brand:</b> 50% coinsurance after in-network integrated deductible, \$240 minimum and \$300 maximum copay <b>Tier 4 — Preferred specialty:</b> Not covered <b>Tier 5 — Nonpreferred specialty:</b> Not covered	Not covered

### NOTES

- To be eligible for coverage, the following services require approval before they are provided: inpatient acute care, rehabilitation services, some radiology services (CT, CTA, MRI, MRA, MRS, QCT bone densitometry, nuclear cardiology, PET, PET and PET/CT fusion, diagnostic CT colonography, CT abdomen and pelvis), mental health and substance abuse, skilled nursing facilities, self- and physician-administered specialty drugs, applied behavioral analysis and human organ transplant services.
- Estimated pricing information for various procedures by in-network providers can be obtained by calling the Customer Service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

**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; services for gender reassignment or for the treatment of gender identity disorder including hormonal therapy; dental care, dental implants or treatment to the teeth except as specifically stated in your benefit plan; hearing aids; infertility-related drugs; private duty nursing; 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; 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 vasectomy reversals; 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 except as specifically stated in your benefit plan; dental services, except for dental injury; appliances, supplies or services as a result of 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; 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. In the event of a conflict between this document and the applicable certificate and riders, the certificate and riders will rule. Payment amounts are based on the BCBSM-approved amount, less any applicable deductible, copay and/or coinsurance 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.**



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