# Blue Cross® Select Silver — 87

# Blue Cross® Preferred Silver — 87

An individual HMO health plan from Blue Care Network of Michigan.

**Blue Cross® Select —** You may choose from a select network of quality primary care doctors with complete access to specialists and hospitals within BCN's entire HMO network. Your primary care doctor will coordinate your care and refer you to specialists when necessary. Care outside the network is not covered.

**Blue Cross® Preferred —** You will have a broad choice of doctors and hospitals from BCN's entire HMO network. Your primary care doctor will coordinate your care and refer you to specialists when necessary. Care outside the network is not covered.

| Benefits | In-Network |
|---|---|
| **Annual deductible** | **Individual plan (one member)** |
| | $450 per individual plan per calendar year |
| | **Family plan (two or more members)** |
| | $900 per family plan per calendar year<br>Medical and drug expenses are combined to meet the integrated deductible. |
| | *NOTE: If your plan is a family plan, the entire family deductible must be met before BCN pays for covered services. The family deductible may be met by one or more family members.* |
| **Coinsurance** | 10% after deductible for most services.<br>50% after deductible for bariatric, temporomandibular joint, infertility, prosthetics and orthotics, and durable medical equipment services. |
| **Annual coinsurance maximum** | **Individual plan (one member)** |
| | $1,000 per individual plan per calendar year |
| | **Family plan (two or more members)** |
| | $2,000 per family plan per calendar year |
| | *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 BCN 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.* |
| **Out-of-pocket maximum**<br>The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum | **Individual plan (one member)** |
| | $1,450 per individual plan per calendar year |
| | **Family plan (two or more members)** |
| | $2,900 per family plan per calendar year |
| | *NOTE: If your plan is a family plan, the entire family out-of-pocket maximum must be met before BCN 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.* |

Find other important information about Blues benefits and membership at **bcbsm.com/importantinfo**.

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

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| **Preventive Care** | |
| **Preventive medical, prescription drugs and immunizations include:** 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 BCN that are in compliance with the provisions of the Patient Protection and Affordable Care Act. | Covered 100% with no deductible, copay or coinsurance |
| **Screening colonoscopy** | Covered 100% with no deductible, copay or coinsurance |
| **Pediatric Services** | |
| **Well baby/child** | Covered 100% with no deductible, copay or coinsurance |
| **Pediatric dental** | Stand alone plan available for purchase |
| **Pediatric vision** | Covered 100%. One annual vision exam; standard lenses and frames or contact lenses (frequency limits apply) |
| **Ambulatory Services** | |
| **Physician office visits, presurgical consultations, office consultations** | $30 copay per primary care visit with no deductible. $50 copay per specialist visit after deductible. Radiology services are subject to the plan's deductible and coinsurance. |
| **Urgent care — physician's office** | $30 copay per primary care visit with no deductible. $50 copay per specialist visit after deductible. Radiology services are subject to the plan's deductible and coinsurance. |
| **Laboratory & Diagnostic Services** | |
| **Laboratory tests and pathology** | Covered 100% before deductible |
| **Diagnostic tests and X-rays (including EKG, Chest X-ray)** | Covered 90% after deductible |
| **Imaging services: CT scans, MRIs, PET, etc.** Prior authorization required | Covered 90% after deductible plus $200 copay |
| **Allergy testing and therapy** | Covered 90% after deductible |
| **Maternity & Newborn Care** | |
| **Maternity benefit** | Covered 90% after deductible plus $500 copay |
| **Prenatal visits** | Covered 100% with no deductible, copay or coinsurance |
| **Postnatal visits** | $30 copay per visit after deductible. Radiology services are subject to the plan's deductible and coinsurance. |

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| **Emergency Services** | |
| **Emergency room** | Covered 90% after deductible plus $250 copay (copay waived if admitted) |
| **Ambulance services** | Covered 90% after deductible |
| **Urgent care visits**<br>Urgent care center or outpatient location | Covered with a $40 copay with no deductible. Radiology services are subject to the plan's deductible and coinsurance. |
| **Hospitalization and Other Services** | |
| **Inpatient hospital care, long-term acute care hospital — semi-private room** | Covered 90% after deductible plus $500 copay |
| **Physician surgical services** | Covered 90% after deductible |
| **Home health care** | Covered 90% after deductible |
| **Hospice care** | Covered 100% after deductible |
| **Skilled nursing facility — Limited to a maximum of 45 days per member per calendar year** | Covered 90% after deductible plus $500 copay |
| **Chemotherapy** | Covered 90% after deductible |
| **Organ transplant — Bone marrow, kidney, cornea, and skin** | Covered 90% after deductible |
| **Specified organ transplant**<br>BCN designated facilities only | Covered 90% after deductible |
| **Sleep studies including testing and surgeries**<br>Prior authorization required | Covered 90% after deductible |
| **Bariatric surgery — once per lifetime** | Covered 50% after deductible |
| **Male voluntary sterilization** | Covered 90% after deductible |
| **Artificial insemination** | Not covered |
| **Rehabilitative and Habilitative Services and Devices** | |
| **Outpatient physical & occupational therapy** | Covered 90% after deductible — Limited to a combined maximum of 30 visits per member per calendar year |
| **Chiropractic spinal manipulation and osteopathic manipulative therapy** | Covered 90% after deductible — Limited to a combined maximum of 30 visits per member per calendar year |
| **Speech therapy** | Covered 90% after deductible — Limited to a maximum of 30 visits per member per calendar year |
| **Cardiac and pulmonary rehabilitation** | Covered 90% after deductible — Limited to a combined maximum of 30 visits per member per calendar year |
| **Specified autism spectrum disorder — applied behavioral analysis** | Covered 90% after deductible — Diagnosis and treatment in accordance with state mandate |
| **Prosthetic and orthotic appliances**<br>BCN approved suppliers only | Covered 50% after deductible |
| **Durable medical equipment**<br>BCN approved suppliers only | Covered 50% after deductible |

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| **Mental Health/Substance Abuse** | |
| **Inpatient mental health** | Covered 90% after deductible plus $500 copay |
| **Outpatient mental health** | $30 copay per visit after deductible. Radiology services are subject to the plan's deductible and coinsurance. |
| **Inpatient substance abuse** | Covered 90% after deductible plus $500 copay |
| **Outpatient substance abuse** | $30 copay per visit after deductible. Radiology services are subject to the plan's deductible and coinsurance. |
| **Prescription Drugs** | |
| **Prescription drugs 1-30 days**<br>**(Retail network pharmacy and mail-order provider)** | **Tier 1a — Preferred generic:** $4 copay after integrated deductible<br>**Tier 1b — Nonpreferred generic:** $20 copay after integrated deductible<br>**Tier 2 — Preferred brand:** 25% coinsurance after integrated deductible, $40 minimum and $100 maximum copay<br>**Tier 3 – Nonpreferred brand:** 50% coinsurance after integrated deductible, $80 minimum and $100 maximum copay<br>**Tier 4 – Preferred specialty:** 20% coinsurance after integrated deductible, no minimum and $200 maximum copay<br>**Tier 5 — Nonpreferred specialty:** 25% coinsurance after integrated deductible, no minimum and $300 maximum copay |
| **Prescription drugs 31-60 days**<br>**Note:** Specialty drugs (Tier 4 and 5) are limited to a 30-day supply.<br>**(MAIL ORDER ONLY)** | **Tier 1a — Preferred generic:** $12 copay after integrated deductible<br>**Tier 1b — Nonpreferred generic:** $60 copay after integrated deductible<br>**Tier 2 – Preferred brand:** 25% coinsurance after integrated deductible, $120 minimum and $300 maximum copay<br>**Tier 3 — Nonpreferred brand:** 50% coinsurance after integrated deductible, $240 minimum and $300 maximum copay<br>**Tier 4 — Preferred specialty:** Not covered<br>**Tier 5 — Nonpreferred specialty:** Not covered |
| **Prescription drugs 61-83 days**<br>**Note:** Specialty drugs (Tier 4 and 5) are limited to a 30-day supply.<br>**(MAIL ORDER ONLY)** | **Tier 1a — Preferred generic:** $12 copay after integrated deductible<br>**Tier 1b — Nonpreferred generic:** $60 copay after integrated deductible<br>**Tier 2 — Preferred brand:** 25% coinsurance after integrated deductible, $120 minimum and $300 maximum copay<br>**Tier 3 — Nonpreferred brand:** 50% coinsurance after integrated deductible, $240 minimum and $300 maximum copay<br>**Tier 4 — Preferred specialty:** Not covered<br>**Tier 5 — Nonpreferred specialty:** Not covered |

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|---|---|
| **Prescription Drugs** *continued* | |
| **Prescription drugs 84-90 days**<br>**Note:** Specialty drugs (Tier 4 and 5) are limited to a 30-day supply.<br>**(90-day retail network pharmacy or mail-order provider)** | **Tier 1a — Preferred generic:** $12 copay after integrated deductible<br>**Tier 1b — Nonpreferred generic:** $60 copay after integrated deductible<br>**Tier 2 — Preferred brand:** 25% coinsurance after integrated deductible, $120 minimum and $300 maximum copay<br>**Tier 3 – Nonpreferred brand:** 50% coinsurance after integrated deductible, $240 minimum and $300 maximum copay<br>**Tier 4 — Preferred specialty:** Not covered<br>**Tier 5 — Nonpreferred specialty:** Not covered |
| NOTES<br>• To be eligible for coverage, some services require approval before they are provided. | |

**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 BCN'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 BCN 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 Care Network 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 BCN–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.**