



Blue Cross® Select Silver — 94

Blue Cross® Preferred Silver — 94

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.

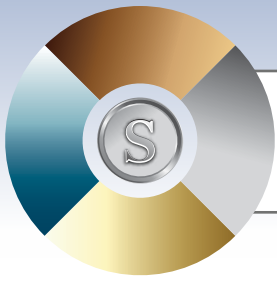
Blue Cross® Preferred — You will have a broad choice of doctors and hospitals from BCN's entire HMO network. Your primary care doctor will coordinate your care and refer you to specialists when necessary. Care outside the network is not covered.

Benefits	In-Network
Annual deductible	Individual plan (one member)
	\$175 per individual plan per calendar year
	Family plan (two or more members)
	\$350 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 BCN pays for covered services. The family deductible may be met by one or more family members.</i>
Coinsurance	10% after deductible for most services. 50% after deductible for bariatric, temporomandibular joint, infertility, prosthetics and orthotics, and durable medical equipment services.
Annual coinsurance maximum	Individual plan (one member)
	\$325 per individual plan per calendar year
	Family plan (two or more members)
	\$650 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 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.</i>
Out-of-pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum	Individual plan (one member)
	\$500 per individual plan per calendar year
	Family plan (two or more members)
	\$1,000 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 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.</i>

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.

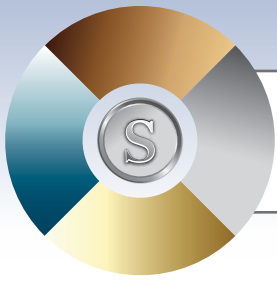




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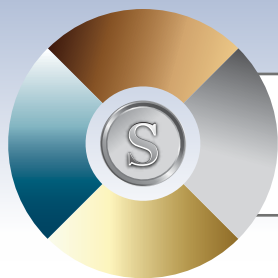
Benefits	In-Network
Preventive Care	
Preventive medical, prescription drugs and immunizations include: health maintenance exam, select laboratory services, gynecologic exam, pap smear screening, mammogram screening, select female contraceptives, female voluntary sterilization and other adult and childhood 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	\$10 copay per primary care visit with no deductible. \$30 copay per specialist visit after deductible. Radiology services are subject to the plan's deductible and coinsurance.
Urgent care — physician's office	\$10 copay per primary care visit with no deductible. \$30 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
Prenatal visits	Covered 100% with no deductible, copay or coinsurance
Postnatal visits	\$10 copay per visit after deductible. Radiology services are subject to the plan's deductible and coinsurance.



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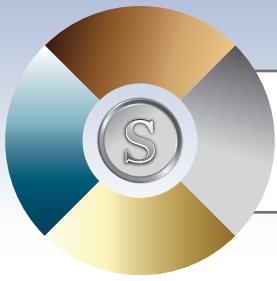
Benefits	In-Network
Emergency Services	
Emergency room	Covered 90% after deductible plus \$100 copay (copay waived if admitted)
Ambulance services	Covered 90% after deductible
Urgent care visits Urgent care center or outpatient location	Covered with a \$40 copay with no deductible. Radiology services are subject to the plan's deductible and coinsurance.
Hospitalization and Other Services	
Inpatient hospital care, long-term acute care hospital (LTACH) — semi-private room	Covered 90% after deductible
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
Chemotherapy	Covered 90% after deductible
Organ transplant — Bone marrow, kidney, cornea, and skin	Covered 90% after deductible
Specified organ transplant BCN designated facilities only	Covered 90% after deductible
Sleep studies including testing and surgeries 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 BCN approved suppliers only	Covered 50% after deductible
Durable medical equipment BCN approved suppliers only	Covered 50% after deductible



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Benefits	In-Network
Mental Health/Substance Abuse	
Inpatient mental health	Covered 90% after deductible
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
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 (Retail network pharmacy and mail-order provider)	Tier 1a — Preferred generic: \$4 copay after integrated deductible Tier 1b — Nonpreferred generic: \$20 copay after integrated deductible Tier 2 — Preferred brand: 25% coinsurance after integrated deductible, \$40 minimum and \$100 maximum copay Tier 3 — Nonpreferred brand: 50% coinsurance after integrated deductible, \$80 minimum and \$100 maximum copay Tier 4 — Preferred specialty: 20% coinsurance after integrated deductible, no minimum and \$200 maximum copay Tier 5 — Nonpreferred specialty: 25% coinsurance after integrated deductible, no minimum and \$300 maximum copay
Prescription drugs 31-60 days Note: Specialty drugs (Tier 4 and 5) are limited to a 30-day supply. (MAIL ORDER ONLY)	Tier 1a — Preferred generic: \$12 copay after integrated deductible Tier 1b — Nonpreferred generic: \$60 copay after integrated deductible Tier 2 — Preferred brand: 25% coinsurance after integrated deductible, \$120 minimum and \$300 maximum copay Tier 3 — Nonpreferred brand: 50% coinsurance after integrated deductible, \$240 minimum and \$300 maximum copay Tier 4 — Preferred specialty: Not covered Tier 5 — Nonpreferred specialty: Not covered
Prescription drugs 61-83 days Note: Specialty drugs (Tier 4 and 5) are limited to a 30-day supply. (MAIL ORDER ONLY)	Tier 1a — Preferred generic: \$12 copay after integrated deductible Tier 1b — Nonpreferred generic: \$60 copay after integrated deductible Tier 2 — Preferred brand: 25% coinsurance after integrated deductible, \$120 minimum and \$300 maximum copay Tier 3 — Nonpreferred brand: 50% coinsurance after integrated deductible, \$240 minimum and \$300 maximum copay Tier 4 — Preferred specialty: Not covered Tier 5 — Nonpreferred specialty: Not covered



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Benefits	In-Network
Prescription Drugs <i>continued</i>	
Prescription drugs 84-90 days Note: Specialty drugs (Tier 4 and 5) are limited to a 30-day supply. (90-day retail network pharmacy or mail-order provider)	Tier 1a — Preferred generic: \$12 copay after integrated deductible Tier 1b — Nonpreferred generic: \$60 copay after integrated deductible Tier 2 — Preferred brand: 25% coinsurance after integrated deductible, \$120 minimum and \$300 maximum copay Tier 3 — Nonpreferred brand: 50% coinsurance after integrated deductible, \$240 minimum and \$300 maximum copay Tier 4 — Preferred specialty: Not covered Tier 5 — Nonpreferred specialty: Not covered
NOTES	
<ul style="list-style-type: none"> 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.

