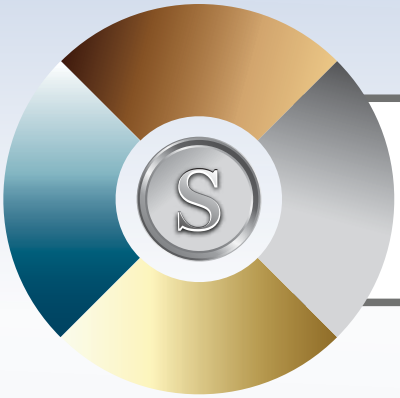

Blue Cross® Silver, a Multi-State Plan — 94

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
Annual deductible	**Individual plan (one member)**	
	$175 per individual plan per calendar year	$350 per individual plan (one member) 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.	$700 per family plan per calendar year 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 BCBSM pays for covered services. The family deductible may be met by one or more family members.	
Coinsurance	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.
Annual coinsurance maximum	**Individual plan (one member)**	
	$325 per individual plan per calendar year	$650 per individual plan per calendar year
	Family plan (two or more members)	
	$650 per family plan per calendar year	$1,300 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 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.	
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	$1,000 per individual plan per calendar year
	Family plan (two or more members)	
	$1,000 per family plan per calendar year	$2,000 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 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.	

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.

MyBlue℠

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Benefits	In-Network	Out-of-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 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
Screening colonoscopy	Covered 100% with no deductible, copay or coinsurance. Routine colonoscopy must be billed as preventive to be covered at 100%.	Not covered
Pediatric Services		
Well baby/child	Covered 100% with no deductible, copay or coinsurance	Not covered
Pediatric Dental	Covered	Covered
Class I — Preventive and diagnostic services	90%	50%
Class II — Minor restorative services	50%	50%
Class III — Major restorative services	50%, no waiting period, $700 out-of-pocket maximum (one member) or $1,400 out-of-pocket maximum (2 or more members) up to the age of 19	50%, no waiting period, $700 out-of-pocket maximum (one member) or $1,400 out-of-pocket maximum (2 or more members) up to the age of 19
Pediatric Vision	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.
Adult Dental and Vision Services		
Adult Dental	Covered	Covered
Class I — Preventive and diagnostic services	90%	50%
Class II — Minor restorative services	50% with a 6 month waiting period	50% with a 6 month waiting period
Class III — Major restorative services	50% with a 12 month waiting period, no deductible, $1,200 annual maximum per adult member	50% with a 12 month waiting period, no deductible, up to $800 of the unused in-network $1,200 annual maximum per adult member

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Benefits	In-Network	Out-of-Network
Adult Dental and Vision Services *continued*		
Adult vision	One annual vision exam: $10 copay. Standard lenses and frames or contact lenses: $25 copay with a $130 annual benefit maximum. Frequency limits apply.	One annual vision exam: $10 copay with a $34 annual benefit maximum. Standard lenses and frames or contact lenses: $25 copay with a $100 annual benefit maximum. Frequency limits apply. Member responsible for the difference between the BCBSM approved amount and the provider's charge, less copay.
Ambulatory Services		
Physician office visits, presurgical consultations, office consultations	$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
Urgent care — physician's office	Covered 90% after deductible plus $30 copay	Not covered
Laboratory and Diagnostic Services		
Laboratory tests and pathology	Covered 90% after deductible	Covered 70% after deductible
Diagnostic tests and X-rays (including EKG, Chest X-ray)	Covered 90% after deductible	Covered 70% after deductible
Imaging services: CT scans, MRIs, PET, etc. Prior authorization required	Covered 90% after deductible plus $200 copay	Covered 70% after deductible plus $200 copay
Allergy Testing and Therapy	Covered 90% after deductible	Not Covered
Maternity & Newborn Care		
Maternity benefit	Covered 90% after deductible	Covered 70% after deductible
Prenatal visits	Covered 100% with no deductible, copay or coinsurance	Covered 70% after deductible
Postnatal visits	Covered 90% after deductible	Covered 70% after deductible
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 90% after deductible plus $30 copay	Covered 70% after deductible plus $30 copay

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Benefits	In-Network	Out-of-Network
Hospitalization and Other Services		
Inpatient hospital care, long-term acute care hospital — semi-private room BCBSM participating facilities only	Covered 90% after deductible	Covered 70% after deductible
Physician surgical services	Covered 90% after deductible	Covered 70% after deductible
Home health care BCBSM participating agencies only	Covered 90% after deductible	Not covered
Hospice care BCBSM participating hospice program only	Covered 100% after deductible	Not covered
Skilled nursing facility — Limited to a maximum of 45 days per member per calendar year BCBSM participating facilities only	Covered 90% after deductible	Covered 70% after deductible
Chemotherapy	Covered 90% after deductible	Covered 70% after deductible
Organ transplant — Bone marrow, kidney, cornea, and skin	Covered 90% after deductible	Covered 70% after deductible
Specified organ transplant BCBSM designated facilities only	Covered 90% after deductible	Not covered
Sleep studies including testing and surgeries prior authorization required	Covered 90% after deductible	Covered 70% after deductible
Bariatric surgery — once per lifetime	Covered 50% after deductible	Covered 30% after deductible
Male voluntary sterilization	Covered 90% after deductible	Covered 70% after deductible
Artificial insemination	Not covered	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	Covered 70% after deductible — Limited to a combined maximum of 30 visits per member per calendar year
Chiropractic spinal manipulation and osteopathic manipulative therapy		
Speech therapy	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
Cardiac and pulmonary rehabilitation	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
Specified autism spectrum disorder — applied behavioral analysis	Covered 90% after deductible — Diagnosis and treatment in accordance with state mandate	Covered 70% after deductible — Diagnosis and treatment in accordance with state mandate
Prosthetic and orthotic appliances BCBSM approved providers only	Covered 50% after deductible	Covered 30% after deductible
Durable medical equipment	Covered 50% after deductible	Covered 30% after deductible

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Benefits	In-Network	Out-of-Network
Mental Health/Substance Abuse		
Inpatient mental health BCBSM participating facilities only	Covered 90% after deductible	Covered 70% after deductible
Outpatient mental health	Covered 90% after deductible	Covered 70% after deductible
Inpatient substance abuse BCBSM participating facilities only	Covered 90% after deductible	Not covered
Outpatient substance abuse BCBSM participating programs only	Covered 90% after deductible.	Covered 70% after deductible.
Prescription Drugs		
Prescription drugs 1-30 days **(Retail network pharmacy and mail-order provider)**	**Tier 1 — Generic:** $15 copay after in-network integrated deductible **Tier 2 — Preferred brand:** 25% coinsurance after in-network integrated deductible, $40 minimum and $100 maximum copay **Tier 3 — Nonpreferred brand:** 50% coinsurance after in-network integrated deductible, $80 minimum and $100 maximum copay **Tier 4 — Preferred specialty:** 20% coinsurance after in-network integrated deductible, no minimum and $200 maximum copay **Tier 5 — Nonpreferred specialty:** 25% coinsurance after in-network integrated deductible, no minimum and $300 maximum copay	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.
Prescription drugs 31-60 days **Note:** Specialty drugs (Tier 4 and 5) are limited to a 30-day supply. **(MAIL ORDER ONLY)**	**Tier 1 — Generic:** $30 copay after in-network integrated deductible **Tier 2 — Preferred brand:** 25% coinsurance after in-network integrated deductible, $80 minimum and $200 maximum copay **Tier 3 — Nonpreferred brand:** 50% coinsurance after in-network integrated deductible, $160 minimum and $200 maximum copay **Tier 4 — Preferred specialty:** Not covered **Tier 5 — Nonpreferred specialty:** Not covered	Not covered

Benefits	In-Network	Out-of-Network
Prescription Drugs *continued*		
Prescription drugs 61-83 days **Note:** Specialty drugs (Tier 4 and 5) are limited to a 30-day supply. **(MAIL ORDER ONLY)**	**Tier 1 — Generic:** $45 copay after in-network integrated deductible **Tier 2 — Preferred brand:** 25% coinsurance after in-network integrated deductible, $120 minimum and $300 maximum copay **Tier 3 — Nonpreferred brand:** 50% coinsurance after in-network integrated deductible, $240 minimum and $300 maximum copay **Tier 4 — Preferred specialty:** Not covered **Tier 5 — Nonpreferred specialty:** Not covered	Not covered
Prescription drugs 84-90 days **Note:** Specialty drugs (Tier 4 and 5) are limited to a 30-day supply. **(90-day retail network pharmacy and mail-order provider)**	**Tier 1 — Generic:** $45 copay after in-network integrated deductible **Tier 2 — Preferred brand:** 25% coinsurance after in-network integrated deductible, $120 minimum and $300 maximum copay **Tier 3 — Nonpreferred brand:** 50% coinsurance after in-network integrated deductible, $240 minimum and $300 maximum copay **Tier 4 — Preferred specialty:** Not covered **Tier 5 — Nonpreferred specialty:** 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.

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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.