2017 Health care plan comparison guide

MyBlue℠

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The Blue Cross difference

There should be more to your health care coverage than deductibles, copays and out-of-pocket costs. The experience, reputation and resources behind that coverage should make you feel confident every time you use your plan's ID card.

As the largest and one of the most reputable and reliable health care companies in the state of Michigan, Blue Cross Blue Shield of Michigan and our HMO partner, Blue Care Network, are confident that we can help you get the most from your health care plan. Throughout our more than 75-year history, we've worked to maintain this promise by building a hard-earned reputation, in-depth experience, and quality selection of health care plans. That's why we're the right choice for your health plan needs.

What other health care company in Michigan can give you first-class coverage that's universally recognized around the country? Only Blue Cross Blue Shield of Michigan. This reputation is one of the many reasons that people in this state choose us more than any other health care company.

We're here to help

Because you'll always have questions about your plan, we want to answer them as quickly and simply as possible. We offer a variety of resources you can use to get answers, find information and talk to experts:

- Our website, **bcbsm.com**, a comprehensive online resource.
- Blue Cross health plan advisors can help you narrow down your plan choices. Don't forget, we're here to help. **Just call 1-877-4MY-BLUE (469-2583)**.
- More than **2,000 agents** throughout Michigan are trained and certified to help you enroll in an Affordable Care Act-compliant health plan.
- Meet face-to-face with a Blue Cross or Blue Care Network agent at any one of our **12 convenient welcome centers** around the state.
- Your Blue Cross or Blue Care Network ID card, where you can **find our toll-free Customer Service number** right on the back.

The numbers add up:

- Blue Cross is Michigan's largest health care company, serving 4.5 million people here and almost 1.6 million more in other states. We also have the largest network of doctors and hospitals in Michigan with 152 hospitals and more than 33,000 doctors.
- Blue Cross continues to grow for the fourth straight year, with more than 115,000 new members.
- Blue Care Network has more than 807,000 members, and a provider network that includes more than 5,000 primary care physicians, nearly 17,000 specialists and most of the state's leading hospitals.
- In 2015, Blue Cross and Blue Care Network had a combined total membership of 5.2 million.
- Blue Dental℠ members have access to nearly 410,000 dental locations around the country.

What's new for 2017

New for 2017 are the **Blue Cross® Extra** plans, which offer services before deductible, and standardized copayments and coinsurances for a key set of benefits to make your health care plan shopping and enrollment experience easier.

The **Gold and Silver Extra** plans offer all office visits, including specialist, mental health and substance abuse, urgent care visits and all prescription drugs with a copay before deductible. The **Bronze Extra** plan offers three primary care office visits, unlimited mental health and substance abuse visits, and generic prescription drugs before deductible.

The **Blue Cross® Metro Detroit EPO Silver Well-Being** plan will appeal to individuals interested in alternative medicine. The plan features are $20 copays for all office visits before deductible including primary care, specialist, mental health and substance abuse. Chiropractic visits including medical massage have a $20 copay before deductible with a 30 visit limit and acupuncture visits are $20 copay before deductible. Online visits have no copay and generic drugs are covered before deductible with up to a $15 copay.

Also new for 2017 — **Blue Cross® Vision for Adults**. This is our first individual stand-alone vision plan for adults, ages 19 and over, including the Medicare-eligible population, available for sale directly from us.

All plans offer coverage for online and retail health center visits. Plus, they offer nationwide discounts available through Member Discounts Blue365®.

2017 plan offerings in Michigan by county

In 2016, Blue Cross was the only health care company to offer affordable plan choices that met ACA standards in all 83 Michigan counties.

PPO Options

Blue Cross® Premier
Gold
Silver/Silver Extra/Silver Saver
Bronze/Bronze Extra/Bronze Saver
Value

Blue Cross® Multi-State Plan
Gold Extra with Dental and Vision
Silver Extra with Dental and Vision

HMO Options

Blue Cross® Preferred
Gold
Silver/Silver Extra/Silver Saver
Bronze

PPO Options

Blue Cross® Premier
Gold
Silver/Silver Extra/Silver Saver
Bronze/Bronze Extra/Bronze Saver
Value

Blue Cross® Multi-State Plan
Gold Extra with Dental and Vision
Silver Extra with Dental and Vision

HMO Options

Blue Cross® Preferred
Silver/Silver Extra
Bronze

Blue Cross® Select
Gold
Silver/Silver Extra/Silver Saver
Bronze/Bronze Extra/Bronze Saver
Value

PPO Options

Blue Cross® Premier
Gold
Silver/Silver Extra/Silver Saver
Bronze/Bronze Extra/Bronze Saver
Value

Blue Cross® Multi-State Plan
Gold Extra with Dental and Vision
Silver Extra with Dental and Vision

HMO Options

Blue Cross® Preferred
Silver/Silver Extra
Bronze

Blue Cross® Partnered
Gold
Silver/Silver Extra/Silver Saver
Bronze/Bronze Saver

PPO Options

Blue Cross® Premier
Gold
Silver/Silver Extra/Silver Saver
Bronze/Bronze Extra/Bronze Saver
Value

Blue Cross® Multi-State Plan
Gold Extra with Dental and Vision
Silver Extra with Dental and Vision

EPO Options

Blue Cross® Metro Detroit EPO
Silver Well-Being
Bronze

HMO Options

Blue Cross® Preferred
Silver/Silver Extra
Bronze

Blue Cross® Select
Gold
Silver/Silver Extra/Silver Saver
Bronze Extra/Bronze Saver
Value

PPO Options

Blue Cross® Premier
Gold
Silver/Silver Extra/Silver Saver
Bronze/Bronze Extra/Bronze Saver
Value

Blue Cross® Multi-State Plan
Gold Extra with Dental and Vision
Silver Extra with Dental and Vision

EPO Options

Blue Cross® Metro Detroit EPO
Silver Well-Being
Bronze

HMO Options

Blue Cross® Preferred
Silver/Silver Extra
Bronze

Blue Cross® Select
Gold
Silver/Silver Extra/Silver Saver
Bronze/Bronze Extra/Bronze Saver
Value

Blue Cross® Metro Detroit HMO
Silver/Silver Extra/Silver Saver
Bronze/Bronze Extra/Bronze Saver

Product offering map

This map shows which products are available in your county.

*PPO plans only.

**Metro Detroit EPO network – St. Clair County will only have partial coverage for 2017.

Network comparison chart

Network type	PPO	EPO
	A PPO, or preferred provider organization, has a broad network of doctors and hospitals. You can choose any doctor you want, both in and out of network, and you don't need referrals from a primary care physician to see a specialist. With a PPO, you'll pay less out-of- pocket when you use an in-network provider.	An EPO, or exclusive provider organization, has a local network of doctors and hospitals. You can choose any doctor or hospital that participates with the EPO network and you don't need referrals from a primary care physician to see a specialist. Other than emergency services or accidental injuries, health care services provided outside the network are not covered.
Network	**Premier and Multi-State PPO**	**Metro Detroit EPO**
Network description	You will have a broad choice of doctors and hospitals within Blue Cross' 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.	You have access to doctors and hospitals in the Metro Detroit EPO network which includes 27 hospitals and more than 6,900 doctors located in **Livingston, Macomb, Oakland, St. Clair, Washtenaw** and **Wayne counties**. Other than emergency services and accidental injuries, you do not have coverage if you visit a doctor that is outside of the Metro Detroit EPO network. **Note:** For 2017, **Saint Clair** county is only partially covered. This plan isn't offered in these cities/townships: **Berlin, Mussey, Lynn, Brockway** and **Greenwood.**
Plan offered by	Blue Cross Blue Shield of Michigan	Blue Cross Blue Shield of Michigan
Out-of-network coverage Care you receive from an out-of-network hospital or doctor while traveling within Michigan	Yes	Emergencies and accidental injuries only
Coverage outside of Michigan Including travel abroad	BlueCard – When you leave Michigan, your benefits travel with you. Your Blue Cross ID card gives you access to more than 90 percent of the doctors and 96 percent of the hospitals in the United States. The BlueCard Worldwide program gives you access to a network of over 900 hospitals in more than 130 countries when you're living or traveling abroad.	Emergencies and accidental injuries only
Participating primary care physicians Numbers are estimates and subject to change.	32,032	6,900
Participating hospitals and systems Numbers are estimates and subject to change.	All 152 Michigan hospitals.	27 participating hospitals, including: • St. John Providence Health • Trinity Health • Garden City Hospital • Botsford Hospital • Detroit Medical Center (DMC) • Oakwood Healthcare Center • Behavioral Centers of America • StoneCrest Center • Straith Hospital for Special Surgery

HMO			
With an HMO, or health maintenance organization, you choose a primary care physician who coordinates your care and provides referrals to specialists. You'll need to pick a Blue Care Network primary care physician in the HMO network and only use hospitals that participate in your plan's network. Other than emergency services and accidental injuries, health care services provided outside the network aren't covered.			
Preferred HMO	**Select HMO**	**Metro Detroit HMO**	**Partnered HMO**
You will have a broad choice of doctors and hospitals from BCN's entire network, the largest HMO network in Michigan. Your primary care physician will coordinate your care and refer you to specialists when necessary. Other than emergency services and accidental injuries, care outside the network is not covered.	You may choose from a select network of quality, primary care physicians and have complete access to specialists and hospitals within BCN's network, the largest HMO network in Michigan. Your primary care physician will coordinate your care and refer you to specialists when necessary. Other than emergency services and accidental injuries, care outside the network is not covered.	You will receive care within a select network of quality doctors and hospitals located in **Wayne, Oakland** and **Macomb counties.** Your primary care physician will coordinate your care. Care within BCN's entire HMO network, but outside the Metro Detroit HMO network, will require primary care physician and plan authorization. Other than emergency services and accidental injuries, care outside BCN's network is not covered.	You will receive care from doctors and hospitals affiliated with Mercy Health located in **Kent, Muskegon** and **Oceana** counties. Your primary care physician will coordinate your care. Care within BCN's entire HMO network, but outside the Partnered HMO network will require primary care physician and plan authorization. Other than emergency services and accidental injuries, care outside BCN's network is not covered.
Blue Care Network	Blue Care Network	Blue Care Network	Blue Care Network
Emergencies and accidental injuries only	Emergencies and accidental injuries only	Emergencies and accidental injuries only	Emergencies and accidental injuries only
Emergencies and accidental injuries only	Emergencies and accidental injuries only	Emergencies and accidental injuries only	Emergencies and accidental injuries only
5,732	3,783	865	254
141	141	22 participating hospitals, including: • St. Joseph Mercy Hospital • St. Mary Mercy Hospital • St. John Hospital • Botsford Hospital • Children's Hospital of Michigan • DMC • Providence Hospital • Oakwood Hospital	8 participating hospitals, including: • Mercy Health-St. Mary's Campus • Mercy Health-Southwest Campus • Mercy Health-General Campus • Mercy Health-Hackley Campus • Mercy Health-Mercy Campus • Mercy Health-Johnson • Family Cancer Center • Mercy Health-Lakes Village • Mercy Health-Lakeshore

Gold plan comparison

Plan Type	PPO Extra
Plan name	**Blue Cross® PPO Gold Extra with Dental and Vision, a Multi-State Plan**
	In–network
Annual deductible Medical and drug expenses are combined to meet the integrated deductible	$1,250 per individual plan $2,500 per family plan
Coinsurance	20% after deductible for most services
Out–of–pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out–of–pocket maximum	$4,750 per individual plan $9,500 per family plan
HSA qualified	No
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible
Physician office visits	$20 copay per primary care office visit with no deductible and $50 copay per specialist office visit with no deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance
Retail health center visit Ex: Going to the clinic at a major pharmacy or retail store for basic health care services on a walk-in basis	$20 copay with no deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance
Online visits Including 24/7 online health care through American Well®	$10 copay with no deductible
Laboratory tests and pathology	Covered 80% after deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for imaging services	Covered 80% after deductible
Inpatient hospital care - semi-private room	Covered 80% after deductible
Surgical care	Covered 80% after deductible
Emergency room	$250 copay after in–network deductible Copay waived if admitted
Transportation by ambulance	Covered 80% after deductible
Urgent care visits at urgent care center or outpatient location	$65 copay with no deductible
Maternity benefit	Covered 80% after deductible
Pediatric vision	Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply
Adult vision	**Multi–State plan only:** See plan details page for coverage information at **bcbsm.com**
Pediatric dental	**Multi–State plan only:** See plan details page for coverage information at **bcbsm.com**
Adult dental	**Multi–State plan only:** See plan details page for coverage information at **bcbsm.com**
Prescription drugs 1–30 days **Retail network pharmacy and mail–order provider**	**Tier 1** – Generic: $10 copay with no deductible **Tier 2** – Preferred brand: $30 copay with no deductible **Tier 3** – Nonpreferred brand: $75 copay with no deductible **Tier 4** – Preferred/Nonpreferred specialty: 30% coinsurance with no deductible

PPO	HMO
Blue Cross® Premier PPO Gold	**Blue Cross® Preferred HMO Gold** **Blue Cross® Select HMO Gold** **Blue Cross® Partnered HMO Gold**
In–network	**In–network**
$250 per individual plan $500 per family plan	$250 per individual plan $500 per family plan
20% after deductible for most services	20% after deductible for most services
$5,100 per individual plan $10,200 per family plan	$5,100 per individual plan $10,200 per family plan
No	No
Covered 100% with no deductible	Covered 100% with no deductible
$30 copay per primary care office visit after deductible and $50 copay per specialist office visit after deductible Diagnostic and laboratory services are subject to plan's deductible and coinsurance	$30 copay per primary care office visit with no deductible $50 copay per specialist office visit after deductible Radiology services are subject to the plan's deductible and coinsurance
$30 copay after deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance	$40 copay with no deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance
$10 copay with no deductible	$30 copay with no deductible
Covered 80% after deductible	Covered 100% with no deductible
Covered 80% after deductible	Covered 80% after deductible
Covered 80% after deductible	Covered 80% after deductible
Covered 80% after deductible	Covered 80% after deductible
Covered 80% after in–network deductible, then $250 copay Copay waived if admitted	$250 copay after deductible, then covered 80% Copay waived if admitted
Covered 80% after in-network deductible	Covered 80% after deductible
Covered 80% after deductible, then $75 copay	$40 copay with no deductible Radiology services are subject to the plan's deductible and coinsurance
Covered 80% after deductible	Covered 80% after deductible
Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply	Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply
Stand-alone plan available for purchase	Stand-alone plan available for purchase
Stand-alone plan available for purchase	Stand-alone plan available for purchase
Stand-alone plan available for purchase	Stand-alone plan available for purchase
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 **Tier 5** – Nonpreferred specialty: 25% coinsurance after in-network integrated deductible	**Tier 1a** – Generic: $4 copay after integrated deductible **Tier 1b** – 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 **Tier 5** – Nonpreferred specialty: 25% coinsurance after integrated deductible

Silver plan comparison

Plan type	PPO Extra	PPO	PPO HSA
Plan name	**Blue Cross® Premier Silver Extra** **Blue Cross® Silver Extra with Dental and Vision, a Multi-State Plan**	**Blue Cross® Premier PPO Silver**	**Blue Cross® Premier PPO Silver Saver HSA**
	In–network	**In–network**	**In–network**
Annual deductible Medical and drug expenses are combined to meet the integrated deductible	$3,500 per individual plan $7,000 per family plan	$1,800 per individual plan $3,600 per family plan	$4,000 per individual plan $8,000 per family plan
Coinsurance	20% after deductible for most services	20% after deductible for most services	20% after deductible for most services
Out-of-pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum	$7,150 per individual plan $14,300 per family plan	$7,150 per individual plan $14,300 per family plan	$4,500 per individual plan $9,000 per family plan
HSA qualified	No	No	Yes
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible	Covered 100% with no deductible	Covered 100% with no deductible, copay
Physician office visits	$30 copay per primary care office visit with no deductible and a $65 copay per specialist office visit with no deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance	$30 copay per primary care office visit after deductible and $50 copay per specialist office visit after deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance	$30 copay per primary care office visit after deductible and $50 copay per specialist office visit after deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance
Retail health center visit Ex: Going to the clinic at a major pharmacy or retail store for basic health care services on a walk-in basis	$30 copay with no deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance	$30 copay after deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance	$30 copay after deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance
Online visits Including 24/7 online health care through American Well®	$10 copay with no deductible	$10 copay with no deductible	$10 copay after deductible
Laboratory tests and pathology	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Diagnostic tests and X-rays including EKG, Chest X-ray	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Inpatient hospital care – semi-private room	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Surgical care	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Emergency room	$400 copay after deductible Copay waived if admitted	Covered 80% after in-network deductible, then $250 copay Copay waived if admitted	$250 copay after in-network deductible, then covered 80% Copay waived if admitted
Transportation by ambulance	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible

EPO Well-Being	HMO Extra	HMO	HMO
Blue Cross® Metro Detroit EPO Silver Well-Being	**Blue Cross® Preferred HMO Silver Extra** **Blue Cross® Select HMO Silver Extra** **Blue Cross® Metro Detroit HMO Silver Extra** **Blue Cross® Partnered HMO Silver Extra**	**Blue Cross® Preferred HMO Silver** **Blue Cross® Select HMO Silver** **Blue Cross® Metro Detroit HMO Silver** **Blue Cross® Partnered HMO Silver**	**Blue Cross® Preferred HMO Silver Saver** **Blue Cross® Partnered HMO Silver Saver** **Blue Cross® Metro Detroit HMO Silver Saver** **Blue Cross® Select HMO Silver Saver**
In–network	**In–network**	**In–network**	**In–network**
$3,500 per individual plan $7,000 per family plan	$3,500 per individual plan $7,000 per family plan	$1,650 per individual plan $3,300 per family plan	$4,500 per individual plan $9,000 per family plan
20% after deductible for most services	20% after deductible for most services	30% after deductible for most services	30% after deductible for most services
$6,000 per individual plan $12,000 per family plan	$7,150 per individual plan $14,300 per family plan	$6,350 per individual plan $12,700 per family plan	$5,500 per individual plan $11,000 per family plan
No	No	No	No
Covered 100% with no deductible EPO network hospitals and professional providers only	Covered 100% with no deductible	Covered 100% with no deductible	Covered 100% with no deductible, copay, or coinsurance
$20 copay per primary care office visit or specialist office visit with no deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance EPO network professional providers only **Chiropractic visits:** $20 copay with no deductible Limited to a maximum of 30 visits, including physical and occupational therapy, osteopathic manipulative therapy with medical massage, per member per calendar year **Acupuncture:** $20 copay with no deductible Limited to a maximum of 30 visits per member per calendar year	$30 copay per primary care office visit with no deductible and a $65 copay per specialist office visit with no deductible Radiology services are subject to the plan's deductible and coinsurance Diagnostic and laboratory services are subject to the plan's deductible and coinsurance	$30 copay per primary care office visit with no deductible $50 copay per specialist office visit after deductible Radiology services are subject to the plan's deductible and coinsurance Diagnostic services are subject to the plan's deductible and coinsurance	$30 copay per primary care office visit with no deductible $50 copay per specialist office visit after deductible Radiology services are subject to the plan's deductible and coinsurance Diagnostic services are subject to the plan's deductible and coinsurance
$20 copay with no deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance	$75 copay with no deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance	$40 copay with no deductible Diagnostic services are subject to the plan's deductible and coinsurance	$40 copay with no deductible Diagnostic services are subject to the plan's deductible and coinsurance
No charge with unlimited visits	$30 copay with no deductible	$30 copay with no deductible	$30 copay with no deductible
Covered 80% after deductible EPO network hospitals and professional providers only	Covered 80% after deductible	Covered 100% with no deductible	Covered 100% with no deductible
Covered 80% after deductible EPO network hospitals and professional providers only	Covered 80% after deductible	Covered 70% after deductible	Covered 70% after deductible
Covered 80% after deductible EPO network hospitals only	Covered 80% after deductible	Covered 70% after deductible	Covered 70% after deductible
Covered 80% after deductible EPO network hospitals only	Covered 80% after deductible	Covered 70% after deductible	Covered 70% after deductible
$250 copay after deductible, then covered 80% Copay waived if admitted Only medical emergencies or accidental injuries are covered out-of-network	$400 copay after deductible Copay waived if admitted	$250 copay after deductible, then covered 70% Copay waived if admitted	$250 copay after deductible, then covered 70% Copay waived if admitted
Covered 80% after deductible	Covered 80% after deductible	Covered 70% after deductible	Covered 70% after deductible

Silver plan comparison (continued)

Plan name	Blue Cross® Premier PPO Silver Extra Blue Cross® PPO Silver Extra with Dental and Vision, a Multi-State Plan	Blue Cross® Premier PPO Silver	Blue Cross® Premier PPO Silver Saver HSA
	In–network	**In–network**	**In–network**
Urgent care visits at urgent care center or outpatient location	$75 copay with no deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance	Covered 80% after deductible, then $75 copay	$75 copay after deductible, then covered 80%
Maternity benefit	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Pediatric vision	Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply	Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply	Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply
Pediatric dental	**Multi-State plan only:** See plan details page for coverage information at bcbsm.com The Blue Cross Premier PPO Silver Extra has stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase
Adult dental	**Multi-State plan only:** See plan details page for coverage information at bcbsm.com The Blue Cross Premier PPO Silver Extra has stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase
Adult vision	**Multi-State plan only:** See plan details page for coverage information at bcbsm.com The Blue Cross Premier PPO Silver Extra has stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase
Prescription drugs 1–30 days Retail network pharmacy and mail-order provider	**Tier 1** – Generic: $15 copay, with no deductible **Tier 2** – Preferred brand: $50 copay with no deductible **Tier 3** – Nonpreferred brand: $100 copay with no deductible **Tier 4** – Preferred /Nonpreferred specialty: 40% coinsurance with no deductible	**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 **Tier 5** - Nonpreferred Specialty: 25% coinsurance after in-network integrated deductible	**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 **Tier 5** - Nonpreferred Specialty: 25% coinsurance after in-network integrated deductible

Blue Cross® Metro Detroit EPO Silver Well-Being	Blue Cross® Preferred HMO Silver Extra Blue Cross® Select HMO Silver Extra Blue Cross® Metro Detroit HMO Silver Extra Blue Cross® Partnered HMO Silver Extra	Blue Cross® Preferred HMO Silver Blue Cross® Select HMO Silver Blue Cross® Metro Detroit HMO Silver Blue Cross® Partnered HMO Silver	Blue Cross® Preferred HMO Silver Saver Blue Cross® Partnered HMO Silver Saver Blue Cross® Metro Detroit HMO Silver Saver Blue Cross® Select HMO Silver Saver
In–network	**In–network**	**In–network**	**In–network**
$20 copay with no deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance Only medical emergencies or accidental injuries are covered out of network	$75 copay with no deductible Radiology services are subject to the plan's deductible and coinsurance Diagnostic services are subject to the plan's deductible and coinsurance	$40 copay with no deductible Radiology services subject to the plan's deductible and coinsurance Diagnostic services are subject to the plan's deductible and coinsurance	$40 copay with no deductible Radiology services are subject to the plan's deductible and coinsurance Diagnostic services are subject to the plan's deductible and coinsurance
Covered 80% after deductible EPO Network hospitals and professional providers only	Covered 80% after deductible	Covered 70% after deductible	Covered 70% after deductible
Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply	Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply	Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply	Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply
Stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase
Stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase
Stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase
Tier 1 – Generic: $15 copay, no 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 **Tier 5** – Nonpreferred specialty: 25% coinsurance after in–network integrated deductible	**Tier 1** – Generic: $15 copay with no deductible **Tier 2** – Preferred brand: $50 copay with no deductible **Tier 3** – Nonpreferred brand: $100 with no deductible **Tier 4** – Preferred/Nonpreferred specialty: 40% coinsurance with no deductible	**Tier 1a** – Generic: $4 copay after integrated deductible **Tier 1b** – 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 **Tier 5** – Nonpreferred specialty: 25% coinsurance after integrated deductible	**Tier 1a** - Generic: $4 copay after integrated deductible **Tier 1b** - 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 **Tier 5** - Nonpreferred Specialty: 25% coinsurance after integrated deductible

Bronze plan comparison

Plan type	PPO Extra	PPO	PPO
Plan name	**Blue Cross® Premier PPO Bronze Extra**	**Blue Cross® Premier PPO Bronze HSA**	**Blue Cross® Premier PPO Bronze Saver**
	In-network	**In-network**	**In-network**
Annual deductible Medical and drug expenses are combined to meet the integrated deductible	$6,650 per individual plan $13,300 per family plan	$6,550 per individual plan $13,100 per family plan	$7,150 per individual plan $14,300 per family plan
Coinsurance	50% after deductible for most services	None	None
Out-of-pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum	$7,150 per individual plan $14,300 per family plan	$6,550 per individual plan $13,100 per family plan	$7,150 per individual plan $14,300 per family plan
HSA qualified	No	Yes	No
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible	Covered 100% with no deductible	Covered 100% with no deductible
Physician office visits	$45 copay with no deductible applies to the first 3 visits, including primary care and postnatal visits, per member per calendar year. The 3-visit limit does not apply to mental health and substance abuse. Additional primary care office visits will be subject to the deductible and coinsurance. Specialist office visits are subject to the deductible and coinsurance. Diagnostic and laboratory services are subject to the plan's deductible	Primary care and specialist office visits are subject to the deductible Diagnostic and laboratory services are subject to the deductible After the deductible is met, office visits are covered at 100%	Primary care and specialist office visits are subject to the deductible Diagnostic and laboratory services are subject to the plan's deductible After the deductible is met, office visits are covered at 100%
Retail health center visit Ex: Going to the clinic at a major pharmacy or retail store for basic health care services on a walk-in basis	$45 copay with no deductible applies to the first 3 visits, including retail health center, primary care and postnatal visits, per member per calendar year Additional retail health center visits and diagnostic and laboratory services are subject to the plan's deductible and coinsurance	Deductible only Diagnostic and laboratory services are subject to the plan's deductible	Deductible only Diagnostic and laboratory services are subject to the plan's deductible
Online visits Including 24/7 online health care through American Well®	$10 copay with no deductible	Covered 100% after deductible	Covered 100% after deductible
Laboratory tests and pathology	Covered 50% after deductible	Covered 100% after deductible	Covered 100% after deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for imaging services	Covered 50% after deductible	Covered 100% after deductible	Covered 100% after deductible
Inpatient hospital care - semi-private room	Covered 50% after deductible	Covered 100% after deductible	Covered 100% after deductible
Surgical care	Covered 50% after deductible	Covered 100% after deductible	Covered 100% after deductible

EPO	HMO	HMO	HMO
Blue Cross® Metro Detroit EPO Bronze HSA	**Blue Cross® Select HMO Bronze Extra** **Blue Cross® Metro Detroit HMO Bronze Extra** **Blue Cross® Partnered HMO Bronze Extra**	**Blue Cross® Preferred HMO Bronze HSA** **Blue Cross® Select HMO Bronze HSA** **Blue Cross® Metro Detroit HMO Bronze HSA** **Blue Cross® Partnered HMO Bronze HSA**	**Blue Cross® Select HMO Bronze Saver HSA** **Blue Cross® Metro Detroit HMO Bronze Saver HSA** **Blue Cross® Partnered HMO Bronze Saver HSA**
In-network	**In-network**	**In-network**	**In-network**
$6,550 per individual plan $13,100 per family plan	$6,650 per individual plan $13,300 per family plan	$5,950 per individual plan $11,900 per family plan	$6,550 per individual plan $13,100 per family plan
None	50% after deductible for most services	40% after deductible for most services	None
$6,550 per individual plan $13,100 per family plan	$7,150 per individual plan $14,300 per family plan	$6,350 per individual plan $12,700 per family plan	$6,550 per individual plan $13,100 per family plan
Yes	No	Yes	Yes
Covered 100% with no deductible EPO network hospitals and professional providers only	Covered 100% with no deductible	Covered 100% with no deductible	Covered 100% with no deductible
Covered 100% after deductible EPO network professional providers only	$45 copay with no deductible applies to the first 3 visits, combined with online, and postnatal visits, per calendar year. The 3-visit limit does not apply to mental health and substance abuse visits. Additional primary care office visits will be subject to the deductible and 50% coinsurance. Specialist office visits are subject to the deductible and 50% coinsurance. Diagnostic and laboratory services are subject to the deductible and coinsurance	$30 copay per primary care visit and $50 copay per specialist office visit after deductible Diagnostic and laboratory services are subject to plan's deductible and coinsurance	Primary care and specialist office visits are subject to the deductible Diagnostic and laboratory services are subject to the plan's deductible After the deductible is met, office visits are covered at 100%
Deductible only Diagnostic and laboratory services are subject to the plan's deductible	Covered 50% after deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance	$40 copay after deductible Diagnostic services are subject to the plan's deductible and coinsurance	Covered 100% after deductible Diagnostic services are subject to the plan's deductible and coinsurance
Covered 100% after deductible	$45 copay with no deductible for the first 3 visits Combined with primary care, and postnatal visits, per calendar year Additional primary care office visits, diagnostic and laboratory services are subject to the plan's deductible and coinsurance	$30 copay after deductible	Covered 100% after deductible
Covered 100% after deductible EPO network hospitals and professional providers only	Covered 50% after deductible	Covered 60% after deductible	Covered 100% after deductible
Covered 100% after deductible EPO network hospitals and professional providers only	Covered 50% after deductible	Covered 60% after deductible	Covered 100% after deductible
Covered 100% after deductible EPO network hospitals only	Covered 50% after deductible	Covered 60% after deductible	Covered 100% after deductible
Covered 100% after deductible EPO network professional providers only	Covered 50% after deductible	Covered 60% after deductible	Covered 100% after deductible

Bronze plan comparison (continued)

Plan name	Blue Cross® Premier PPO Bronze Extra	Blue Cross® Premier PPO Bronze HSA	Blue Cross® Premier PPO Bronze Saver
	In-network	In-network	In-network
Emergency room	Covered 50% after in-network deductible	Covered 100% after in-network deductible	Covered 100% after in-network deductible
Transportation by ambulance	Covered 50% after in-network deductible	Covered 100% after in-network deductible	Covered 100% after in-network deductible
Urgent care visits at Urgent care center or outpatient location	Covered 50% after in-network deductible	Covered 100% after deductible	Covered 100% after deductible
Maternity benefit	Covered 50% after in-network deductible	Covered 100% after deductible	Covered 100% after deductible
Pediatric vision	Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply	Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply	Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply
Adult vision	Stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase
Pediatric dental	Stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase
Adult dental	Stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase
Prescription drugs 1-30 days Retail network pharmacy and mail-order provider	**Tier 1** – Generic: $35 copay with no deductible **Tier 2** – Preferred brand: 35% after in-network integrated deductible **Tier 3** – Nonpreferred brand: 40% after in-network integrated deductible **Tier 4** – Preferred/Nonpreferred specialty: 45% after in-network integrated deductible	**Tier 1** – Generic: Covered 100% after in-network integrated deductible **Tier 2** – Preferred brand: Covered 100% after in-network integrated deductible **Tier 3** – Nonpreferred brand: Covered 100% after in-network integrated deductible **Tier 4** – Preferred specialty: Covered 100% after in-network integrated deductible **Tier 5** – Nonpreferred specialty: Covered 100% after in-network integrated deductible	**Tier 1** – Generic: Covered 100% after in-network integrated deductible **Tier 2** – Preferred brand: Covered 100% after in-network integrated deductible **Tier 3** – Nonpreferred brand: Covered 100% after in-network integrated deductible **Tier 4** – Preferred specialty: Covered 100% after in-network integrated deductible **Tier 5** – Nonpreferred specialty: Covered 100% after in-network integrated deductible

Blue Cross® Metro Detroit EPO Bronze HSA	Blue Cross® Select HMO Bronze Extra Blue Cross® Metro Detroit HMO Bronze Extra Blue Cross® Partnered HMO Bronze Extra	Blue Cross® Preferred HMO Bronze HSA Blue Cross® Select HMO Bronze HSA Blue Cross® Metro Detroit HMO Bronze HSA Blue Cross® Partnered HMO Bronze HSA	Blue Cross® Select HMO Bronze Saver HSA Blue Cross® Metro Detroit HMO Bronze Saver HSA Blue Cross® Partnered HMO Bronze Saver HSA
In-network	**In-network**	**In-network**	**In-network**
Covered 100% after deductible Only medical emergencies or accidental injuries are covered out of network	Covered 50% after deductible	$250 copay after deductible, then covered 60% Copay waived if admitted	Covered 100% after deductible
Covered 100% after in-network deductible	Covered 100% after in-network deductible	Covered 60% after deductible	Covered 100% after deductible
Covered 100% after deductible Only medical emergencies or accidental injuries are covered out of network	Covered 50% after deductible	$40 copay after deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance	Covered 100% after deductible Diagnostic and laboratory services are subject to the plan's deductible
Covered 100% after deductible EPO network hospitals and professional providers	Covered 50% after deductible	Covered 60% after deductible	Covered 100% after deductible
Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply	Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply	Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply	Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply
Stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase
Stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase
Stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase
Tier 1 – Generic: Covered 100% after in-network integrated deductible **Tier 2** – Preferred brand: Covered 100% after in-network integrated deductible **Tier 3** – Nonpreferred brand: Covered 100% after in-network integrated deductible **Tier 4** – Preferred specialty: Covered 100% after in-network integrated deductible **Tier 5** – Nonpreferred specialty: Covered 100% after in-network integrated deductible	**Tier 1**-Generic: $35 copay with no deductible **Tier 2**-Preferred brand: 35% after integrated deductible **Tier 3**-Nonpreferred brand: 40% after integrated deductible **Tier 4**-Preferred/Nonpreferred specialty: 45% after integrated deductible	**Tier 1a** – Generic: $4 copay after integrated deductible **Tier 1b** – 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 **Tier 5** – Nonpreferred specialty: 25% coinsurance after integrated deductible	**Tier 1a** – Generic: Covered 100% after integrated deductible **Tier 1b** – Generic: Covered 100% after integrated deductible **Tier 2** – Preferred brand: Covered 100% after integrated deductible **Tier 3** – Nonpreferred brand: Covered 100% after integrated deductible **Tier 4** – Preferred specialty: Covered 100% after integrated deductible **Tier 5** – Nonpreferred specialty: Covered 100% after integrated deductible

Value plan comparison

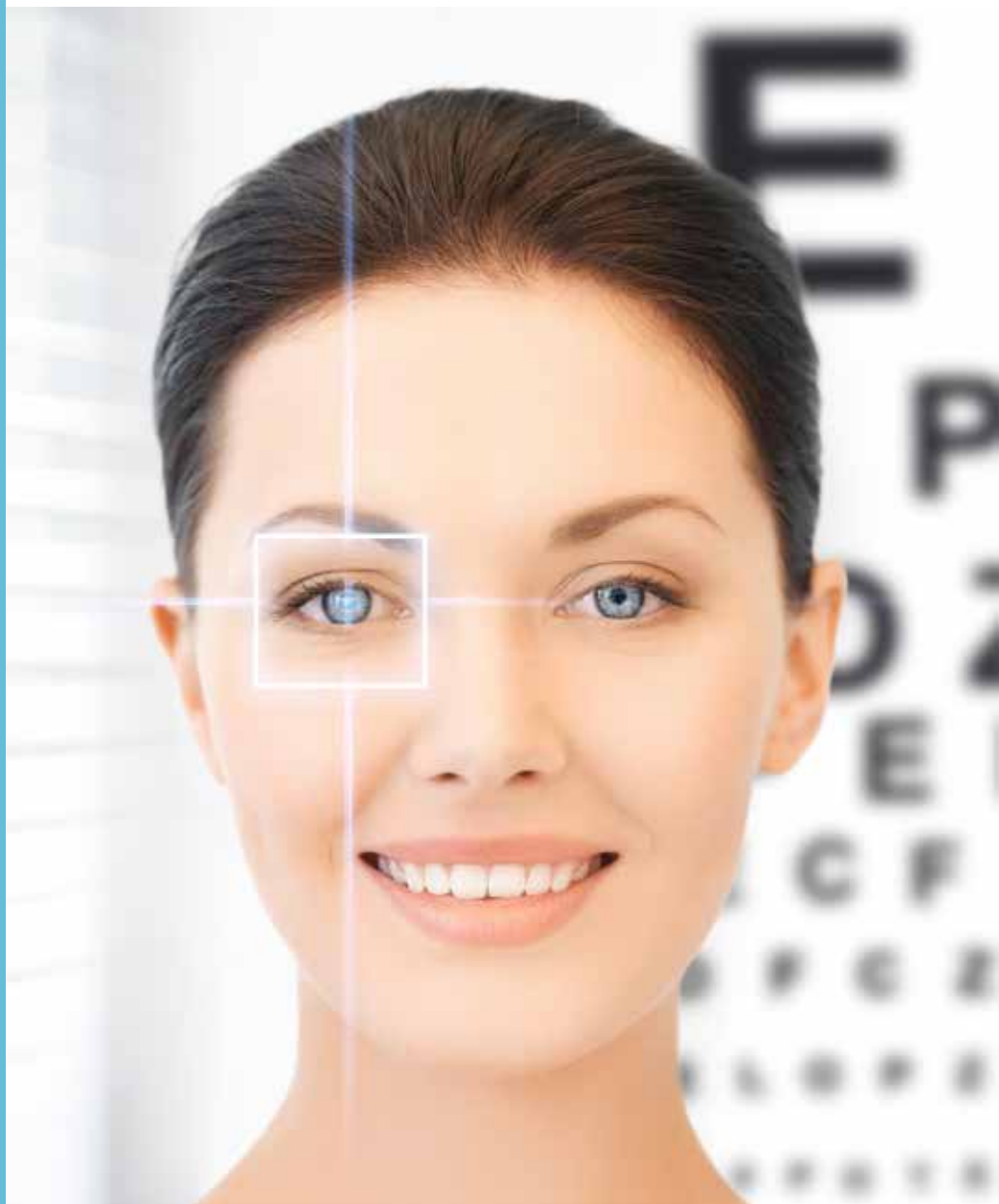
Plan type	PPO
Plan name	**Blue Cross® Premier PPO Value**
	In-network
Annual deductible Medical and drug expenses are combined to meet the integrated deductible	$7,150 per individual plan $14,300 per family plan
Coinsurance	None
Out-of-pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum	$7,150 per individual plan $14,300 per family plan
HSA qualified	No
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible
Physician office visits	$30 copay per primary care visit applies to the first 3 primary care visits per member per calendar year Additional primary care visits will be subject to the in-network integrated deductible Specialist office visits are subject to in-network integrated deductible Diagnostic and laboratory services are subject to the plan's deductible After deductible is met office visits are covered at 100%
Retail health center visit Ex: Going to the clinic at a major pharmacy or retail store for basic health care services on a walk-in basis	$30 copay with no deductible for the first 3 visits, including primary care and retail health center visits, per member per calendar year Additional retail health center visits and diagnostic and laboratory services are subject to plan's deductible
Online visits Including 24/7 online health care through American Well®	Covered 100% after deductible
Laboratory tests and pathology	Covered 100% after deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for imaging services	Covered 100% after deductible
Urgent care visits at urgent care center or outpatient location	Covered 100% after deductible
Inpatient and surgical care	Covered 100% after deductible
Transportation by ambulance and Emergency room	Covered 100% after deductible
Maternity benefit	Covered 100% after deductible
Pediatric vision	Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply
Adult vision	Stand-alone plan available for purchase
Pediatric dental	Stand-alone plan available for purchase
Adult dental	Stand-alone plan available for purchase
Prescription drugs 1-30 days Retail network pharmacy and mail-order provider	**Tier 1** – Generic: Covered 100% after in-network integrated deductible **Tier 2** – Preferred brand: Covered 100% after in-network integrated deductible **Tier 3** – Nonpreferred brand: Covered 100% after in-network integrated deductible **Tier 4** – Preferred specialty: Covered 100% after in-network integrated deductible **Tier 5** – Nonpreferred specialty: Covered 100% after in-network integrated deductible

HMO
Blue Cross® Select HMO Value
In-network
$7,150 per individual plan $14,300 per family plan
None
$7,150 per individual plan $14,300 per family plan
No
Covered 100% with no deductible
$30 copay with no deductible per primary care visit with no deductible Specialist office visits are subject to deductible Radiology services are subject to the plan's deductible After deductible is met office visits are covered at 100%
$40 copay with no deductible Diagnostic services are subject to plan's deducible and coinsurance
$30 copay with no deductible
Covered 100% after deductible
Covered 100% after deductible
$40 copay with no deductible Radiology services are subject to the plan's deductible
Covered 100% after deductible
Covered 100% after deductible
Covered 100% after deductible
Covered 100%, one vision exam per pediatric member per calendar year Covered 100%, standard lenses and frames or contact lenses Frequency limits apply
Stand-alone plan available for purchase
Stand-alone plan available for purchase
Stand-alone plan available for purchase
Tier 1a – Generic: Covered 100% after integrated deductible **Tier 1b** – Generic: Covered 100% after integrated deductible **Tier 2** – Preferred brand: Covered 100% after integrated deductible **Tier 3** – Nonpreferred brand: Covered 100% after integrated deductible **Tier 4** – Preferred specialty: Covered 100% after integrated deductible **Tier 5** – Nonpreferred specialty: Covered 100% after integrated deductible

BlueDental℠ and Blue Cross Vision plans

Quality dental and vision care from Blue Cross

Blue Dental offers you and your family nine individual dental plans. And some plans have dental and vision coverage combined, which you can buy directly from us rather than the Health Insurance Marketplace. These dental and vision plans are comprehensive and include everything from routine cleanings and oral exams to fillings and crowns for dental, and eye exams and glasses for vision. Best of all, these plans are backed by the value, experience and confidence that you can rely on from Blue Cross Blue Shield of Michigan.



Choosing your dentist or eye doctor

Choosing the right dentist or eye doctor for your dental needs or vision is important. That's why our dental and dental with vision plans give you a variety of options that make finding the right dentist or eye doctor easy.

Blue Dental℠ EPO Standard	Blue Dental℠ PPO Standard Blue Dental℠ PPO Plus Blue Dental℠ PPO Pediatric Blue Dental℠ PPO Extra	Blue Dental℠ PPO Standard with Vision Blue Dental℠ PPO Plus with Vision Blue Dental℠ EPO Standard with Vision Blue Dental℠ PPO Extra with Vision
For this plan, you need to receive dental care from a dentist in a PPO network.* Blue Cross negotiates with network dentists so that our members can get quality dental services at discount rates. And this even includes discounts on noncovered services. If you go to an out-of-network dentist, you are not covered by this plan.	These plans give you the freedom to choose any dentist. So whether you pick a network dentist or not — we've got you covered. You have the following options when selecting a dentist: **PPO network dentists** These dentists will always accept your coverage. We negotiate with network dentists to offer services at discount rates for our members, including discounts on non-covered services. **Blue Par Select℠ dentists** Any licensed dentist who is not part of our PPO network can participate with us on a per-claim basis through Blue Par Select. These dentists offer Blue Cross members a discount on their usual charge and accept our approved amount as full payment for covered services, minus your deductible and coinsurance. If you go to a non-network dentist, make sure you ask if he or she participates with Blue Par Select. **Nonparticipating dentists** If you choose a dentist who does not participate with us, you are responsible for any difference between our approved amount** and the dentist's charge, plus any deductible or coinsurance required by your plan. We do not pay nonparticipating dentists directly. You pay your dentist in full for services. We then pay you for covered services based on our approved amount. You may also be responsible for filing you own claim.	Adult vision coverage can be added to the Blue Dental PPO Standard, Blue Dental PPO Plus Standard, Blue Dental EPO Standard or Blue Dental PPO Extra plans. **VSP Choice providers** In-network eye doctors are located in retail, neighborhood, medical and professional settings, with 92 percent of them offering early morning, evening and weekend appointments. Blue Cross members who go to a VSP provider will have no paperwork to complete. All you need to do is show your Blue Cross or Blue Care Network ID card. Finding a doctor who participates in the VSP Choice network is easy. Visit **bcbsm.com**, click *"Find a doctor"* and then click on *VSP*. Or, you can call VSP Member Services at 1-800-877-7195 or visit **vsp.com**. **Note:** VSP doctors verify member eligibility and submit all claims directly to VSP. **Nonparticipating providers** If you choose a provider that does not participate with VSP, you are responsible for any difference between our approved amounts and the doctor's charge plus any copays required by your plan. You are responsible for paying at the time of service and submitting a claim for reimbursement directly to VSP. The reimbursement will be sent directly to you.

*Blue Cross Blue Shield of Michigan uses the Dental Network of America Preferred Network for its dental plan.
**The Blue Cross maximum payment for a covered service.

Looking for a dentist?

To find a PPO network or Blue Par Select dentist in your area, go to **mibluedentist.com**, or call us at **1-888-826-8152**.

DNoA is an independent company that provides dental benefit services for Blue Cross Blue Shield of Michigan and Blue Care Network.

Individual dental plan comparison

All of our Blue Dental plans offer the same quality benefits, but with different premiums and cost-sharing amounts, allowing you to choose the plan that best fits your needs and budget.

Plan name	Blue Dental℠ EPO Standard		Blue Dental℠ PPO Standard	
	In–network	Out–of–network and Blue Par Select	In–network	Out–of–network and Blue Par Select
Coinsurance				
Class I – Preventive services	20%	Not covered	20%	50%
Class II – Minor restorative services	50%	Not Covered	50%	50%
Class III – Major restorative services	50%	Not covered	50%	50%
Class IV – Orthodontic services	Not covered	Not covered	Not covered	Not covered
Plan deductible	**Blue Dental℠ EPO Standard Deductible**		**Blue Dental℠ PPO Standard Deductible**	
	In–network	Out–of–network	In–network	Out–of–network
1 person/2 person/3 person	$25/$50/$75	Not applicable	$25/$50/$75	$50/$100/$150

Blue Dental members have access to nearly 410,000 dental locations around the country.

Blue Dental℠ PPO Extra		Blue Dental℠ PPO Plus Standard		Blue Dental℠ PPO Pediatric	
In–network	**Out–of–network and Blue Par Select**	**In–network**	**Out–of–network and Blue Par Select**	**In–network**	**Out–of–network and Blue Par Select**
Coinsurance					
Covered in full	20%	20%	20%	20%	50%
30%	40%	40%	40%	50%	50%
50%	50%	50%	50%	50%	50%
Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Blue Dental℠ PPO Extra Deductible		**Blue Dental℠ PPO Plus Standard Deductible**		**Blue Dental℠ PPO Pediatric Deductible**	
In–network	**Out–of–network**	**In–network**	**Out–of–network**	**In–network**	**Out–of–network**
$0/$0/$0	$50/$100/$150	$75/$150/$225	$75/$150/$225	$25/$50/$75	$50/$100/$150

Product	Blue Dental℠ EPO Standard	Blue Dental℠ PPO Standard
Class I – Preventive and diagnostic services		
Dental check-up for children	Prophylaxis (Cleaning) - 3x per calendar year Exams - 2x per calendar year Bitewing X-rays - One set (up to 4) per calendar year Fluoride - 2x per calendar year Pediatric members are defined as members age 18 or younger when their coverage begins	Prophylaxis (Cleaning) - 3x per calendar year Exams - 2x per calendar year Bitewing X-rays - One set (up to 4) per calendar year Fluoride - 2x per calendar year Pediatric members are defined as members age 18 or younger when their coverage begins
Routine dental services (adult)	Prophylaxis (Cleaning) - 2x per calendar year (3rd is covered for members with adverse medical condition) Exams - 2x per calendar year Bitewing X-rays - One set (up to 4) per calendar year Fluoride - Not covered Members age 19 or older when their coverage begins are considered non-pediatric	Prophylaxis (Cleaning) - 2x per calendar year (3rd is covered for members with adverse medical condition) Exams - 2x per calendar year Bitewing X-rays - One set (up to 4) per calendar year Fluoride - Not covered Members age 19 or older when their coverage begins are considered non-pediatric
Class II – Minor restorative services*		
Basic dental care-child	Sealants - 1x per permanent molars, every 3 years Fillings - 1x per 24 months for primary teeth, 1x per 48 months for permanent teeth Periodontal maintenance - 3x per calendar year in combination with routine prophylaxis (cleaning) Simple extractions - 1x per lifetime per tooth Root canals - 1x per lifetime per tooth Pediatric members are defined as members age 18 or younger when their coverage begins	Sealants - 1x per permanent molars, every 3 years Fillings - 1x per 24 months for primary teeth, 1x per 48 months for permanent teeth Periodontal maintenance - 3x per calendar year in combination with routine prophylaxis (cleaning) Simple extractions - 1x per lifetime per tooth Root canals - 1x per lifetime per tooth Pediatric members are defined as members age 18 or younger when their coverage begins
Basic dental care-adult	Periodontal maintenance - 2x per calendar year in combination with routine cleaning (3rd is covered for members with adverse medical condition) Sealants - not covered Fillings - 1x per 24 months for primary teeth, 1x per 48 months for permanent teeth Simple extractions - 1x per lifetime per tooth Root canals - 1x per lifetime per tooth Members age 19 or older when their coverage begins are considered non-pediatric 6-month waiting period on Class II services for non-pediatric members except for sealants and emergency palliative treatments	Periodontal maintenance - 2x per calendar year in combination with routine cleaning (3rd is covered for members with adverse medical condition) Sealants - not covered Fillings - 1x per 24 months for primary teeth, 1x per 48 months for permanent teeth Simple extractions - 1x per lifetime per tooth Root canals - 1x per lifetime per tooth Members age 19 or older when their coverage begins are considered non-pediatric 6-month waiting period on Class II services for non-pediatric members except for sealants and emergency palliative treatments

*These services are subject to a waiting period.

Blue Dental℠ PPO Extra	Blue Dental℠ PPO Plus Standard	Blue Dental℠ PPO Pediatric
Class I – Preventive and diagnostic services		
Prophylaxis (Cleaning) - 3x per calendar year Exams - 2x per calendar year Bitewing X-rays - One set (up to 4) per calendar year Fluoride - 2x per calendar year Pediatric members are defined as members age 18 or younger when their coverage begins	Prophylaxis (Cleaning) - 3x per calendar year Exams - 2x per calendar year Bitewing X-rays - One set (up to 4) per calendar year Fluoride - 2x per calendar year Pediatric members are defined as members age 18 or younger when their coverage begins	Prophylaxis (Cleaning) - 3x per calendar year Exams - 2x per calendar year Bitewing X-rays - One set (up to 4) per calendar year Fluoride - 2x per calendar year Pediatric members are defined as members age 18 or younger when their coverage begins
Prophylaxis (Cleaning) - 2x per calendar year (3rd is covered for members with adverse medical condition) Exams - 2x per calendar year Bitewing X-rays - One set (up to 4) per calendar year Fluoride - Not covered Members age 19 or older when their coverage begins are considered non-pediatric	Prophylaxis (Cleaning) - 2x per calendar year (3rd is covered for members with adverse medical condition) Exams - 2x per calendar year Bitewing X-rays - One set (up to 4) per calendar year Fluoride - Not covered Members age 19 or older when their coverage begins are considered non-pediatric	Not covered
Class II – Minor restorative services*		
Sealants - 1x per permanent molars, every 3 years Fillings - 1x per 24 months for primary teeth, 1x per 48 months for permanent teeth Periodontal maintenance - 3x per calendar year in combination with routine prophylaxis (cleaning) Simple extractions - 1x per lifetime per tooth Root canals - 1x per lifetime per tooth Pediatric members are defined as members age 18 or younger when their coverage begins	Sealants - 1x per permanent molars, every 3 years Fillings - 1x per 24 months for primary teeth, 1x per 48 months for permanent teeth Periodontal maintenance - 3x per calendar year in combination with routine prophylaxis (cleaning) Simple extractions - 1x per lifetime per tooth Root canals - 1x per lifetime per tooth Pediatric members are defined as members age 18 or younger when their coverage begins	Sealants - 1x per permanent molars, every 3 years Fillings - 1x per 24 months for primary teeth, 1x per 48 months for permanent teeth Periodontal maintenance - 3x per calendar year in combination with routine prophylaxis (cleaning) Simple extractions - 1x per lifetime per tooth Root canals - 1x per lifetime per tooth Pediatric members are defined as members age 18 or younger when their coverage begins
Periodontal maintenance - 2x per calendar year in combination with routine cleaning (3rd is covered for members with adverse medical condition) Sealants - not covered Fillings - 1x per 24 months for primary teeth, 1x per 48 months for permanent teeth Simple extractions - 1x per lifetime per tooth Root canals - 1x per lifetime per tooth Members age 19 or older when their coverage begins are considered non-pediatric 6-month waiting period on Class II services for non-pediatric members except for sealants and emergency palliative treatments	Periodontal maintenance - 2x per calendar year in combination with routine cleaning (3rd is covered for members with adverse medical condition) Sealants - not covered Fillings - 1x per 24 months for primary teeth, 1x per 48 months for permanent teeth Simple extractions - 1x per lifetime per tooth Root canals - 1x per lifetime per tooth Members age 19 or older when their coverage begins are considered non-pediatric 6-month waiting period on Class II services for non-pediatric members except for sealants and emergency palliative treatments	Not covered

Product	Blue Dental℠ EPO Standard	Blue Dental℠ PPO Standard
Class III – Major restorative services*		
Major dental care-child	Scaling and root planing - 1x per quadrant, per 24 months Onlays, crowns, veneers - 1x every 84 months Bridges and dentures - 1x every 84 months Implants - not covered Pediatric members are defined as members age 18 or younger when their coverage begins	Scaling and root planing - 1x per quadrant, per 24 months Onlays, crowns, veneers - 1x every 84 months Bridges and dentures - 1x every 84 months Implants - not covered Pediatric members are defined as members age 18 or younger when their coverage begins
Major dental care-adult	Scaling and root planing - 1x per quadrant, per 36 months Onlays, crowns, veneers - 1x every 84 months Bridges and dentures - 1x every 84 months Implants - not covered Members age 19 or older when their coverage begins are considered non-pediatric 12-month waiting period on Class III services for non-pediatric members	Scaling and root planing - 1x per quadrant, per 36 months Onlays, crowns, veneers - 1x every 84 months Bridges and dentures - 1x every 84 months Implants - not covered Members age 19 or older when their coverage begins are considered non-pediatric 12-month waiting period on Class III services for non-pediatric members

2017 Dental with Vision plan details	Description
Blue Dental℠ PPO Standard with Vision	Offers same dental benefits of the Blue Dental℠ PPO Standard dental plan as well as the adult vision benefits
Blue Dental℠ PPO Plus Standard with Vision	Offers same dental benefits of the Blue Dental℠ PPO Plus Standard dental plan as well as the adult vision benefits
Blue Dental℠ EPO Standard with Vision	Offers same dental benefits of the Blue Dental℠ EPO Standard dental plan as well as the adult vision benefits
Blue Dental℠ PPO Extra with Vision	Offers same dental benefits of the Blue Dental℠ PPO Extra dental plan as well as the adult vision benefits
Eligibility	Non-pediatric members (members age 19 or older on the plan effective date are considered non-pediatric)
Benefits	Exam every 12 months, lenses every 12 months and frames every 24 months
Allowance	$130
Copays	$10 exam and $25 materials
Network	VSP Choice

*These services are subject to a waiting period.

Blue Dental℠ PPO Extra	Blue Dental℠ PPO Plus Standard	Blue Dental℠ PPO Pediatric
Class III – Major restorative services*		
Scaling and root planing - 1x per quadrant, per 24 months Onlays, crowns, veneers - 1x every 84 months Bridges and dentures - 1x every 84 months Implants - not covered Pediatric members are defined as members age 18 or younger when their coverage begins	Scaling and root planing - 1x per quadrant, per 24 months Onlays, crowns, veneers - 1x every 84 months Bridges and dentures - 1x every 84 months Implants - not covered Pediatric members are defined as members age 18 or younger when their coverage begins	Scaling and root planing - 1x per quadrant, per 24 months Onlays, crowns, veneers - 1x every 84 months Bridges and dentures - 1x every 84 months Implants - not covered Pediatric members are defined as members age 18 or younger when their coverage begins
Scaling and root planing - 1x per quadrant, per 36 months Onlays, crowns, veneers - 1x every 84 months Bridges and dentures - 1x every 84 months Implants - not covered Members age 19 or older when their coverage begins are considered non-pediatric 12-month waiting period on Class III services for non-pediatric members	Scaling and root planing - 1x per quadrant, per 36 months Onlays, crowns, veneers - 1x every 84 months Bridges and dentures - 1x every 84 months Implants - not covered Members age 19 or older when their coverage begins are considered non-pediatric 12-month waiting period on Class III services non-pediatric members	Not Covered

New Blue Cross Vision - Adults only plan	
Eligibility	Members age 19 or older as of plan effective date are eligible
Benefits	Eye exam every 12 months, lenses every 12 months and frames every 12 months
Allowance	$150
Copays	$15 exam and $25 materials
Network	VSP Choice
Enrollment	Available year round

VSP is an independent company that provides vision benefit services for Blue Cross Blue Shield of Michigan and Blue Care Network customers. VSP is a registered trademark of Vision Service Plan

Helpful links

Enroll in a Blue Cross or Blue Care Network plan
bcbsm.com/myblue • 1-877-4MY-BLUE (469-2583)

Eligible for savings?
bcbsm.com/subsidy

Find a doctor or hospital
bcbsm.com/find-a-doctor

Summary of benefits and coverage
Visit bcbsm.com/sbc

Billing, claims and benefits
Customer service number on the back of ID card

Pay my bill
bcbsm.com/paybill
bcbsm.com/payments

How to select a primary care physician (for HMO plans):
bcbsm.com/selectpcp

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ئەگەر تۆ، یان کەسێک کە ئێستا فریای دەکەویت، پێویستی بە یارمەتی هەیە، مافی ئەوەت هەیە بە بێ هیچ تێچووێک یارمەتی و زانیاری پێویست بە زمانەکەت وەربگریت. بۆ قسەکردن لەگەڵ وەرگێڕ، پەیوەندی بە ژمارەی خزمەتگوزاری بەکارهێنەران بکە کە لەسەر کارتەکەتە، یان 877-469-2583 TTY:711، ئەگەر ئەندام نیت.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号 (メンバーでない方は877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

For cost information and to purchase your MyBlue health care plan for 2017, go to **bcbsm.com/myblue**.

Call a health plan advisor at **1-877-4MY-BLUE (469-2583)**, or contact your Blue Cross or Blue Care Network agent.

Blue Cross Blue Shield Blue Care Network of Michigan

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This brochure only displays in-network coverage and an overview of covered services. For detailed benefit information and out-of network coverage, please see your Summary of Benefits and Coverage at **bcbsm.com/sbc.**

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