Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

2018 Health care plan comparison guide

Individuals and **families**

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. This reputation is one of the many reasons that people in this state choose us more than any other health care company.

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 have the largest network of doctors and hospitals in Michigan with 152 hospitals and more than 33,000 doctors.
- Blue Care Network is the largest HMO in Michigan with 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.
- Blue Dental℠ members have access to nearly 450,000 dental locations around the country.

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.

These resources include:

- Our comprehensive website, **bcbsm.com**.
- Blue Cross health plan advisors that can help you narrow down your plan choices and help you determine if you're eligible for a subsidy on the Marketplace. 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 choose and enroll in a health care plan.
- Meeting face-to-face with a Blue Cross or Blue Care Network agent at any of our **walk-in centers** around the state. Visit **bcbsm.com/index/health-insurance-help/walk-in-centers.html** to find one near you.
- Your Blue Cross or Blue Care Network member ID card, where you can **find our toll-free Customer Service number** right on the back.

Highlights for 2018

New services and savings in 2018.

- Blue Cross Dental and Dental & Vision plans are available for enrollment year-round.
- The Blue Cross Silver Off Marketplace plans are available on PPO and all HMO networks. These new plans offer deductibles and out-of-pocket maximums lower than the Silver On Marketplace plans.
- The Preferred HMO network is available statewide for all plans on the Preferred network.
- We're enhancing our online health care to include therapy visits.

BCBSM Mobile App

Your health information is secure when you 'pack the app'.

Protecting our members' information is our top priority. You can be sure that using the mobile app is a safe and secure way to access information about your health plan.

We protect all information through secured connections, and we regularly update our information systems to stay current and ensure the security of your data.

What you can do with the app:

- View deductible and other plan balances
- Check claims and explanation of benefits
- See medical, dental and vision coverage
- Research drug prices
- Access HealthEquity® spending account balances
- View and share member ID Card
- Find doctors and hospitals and compare costs for services
- Access to Blue365® member discounts

Download the app now!

Get the BCBSM Mobile app wherever you normally download apps for your device. For more information, visit **bcbsm.com/app**.

2018 Health Plan offerings in Michigan by county

In 2018, Blue Cross is the only health care company to offer plan choices that met ACA standards in all 83 Michigan counties.

PPO Options

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

HMO Options

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

PPO Options

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

HMO Options

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

Blue Cross® Select
Silver/Silver Extra/Silver Saver/Silver Off Marketplace
Bronze/Bronze Saver
Value

PPO Options

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

HMO Options

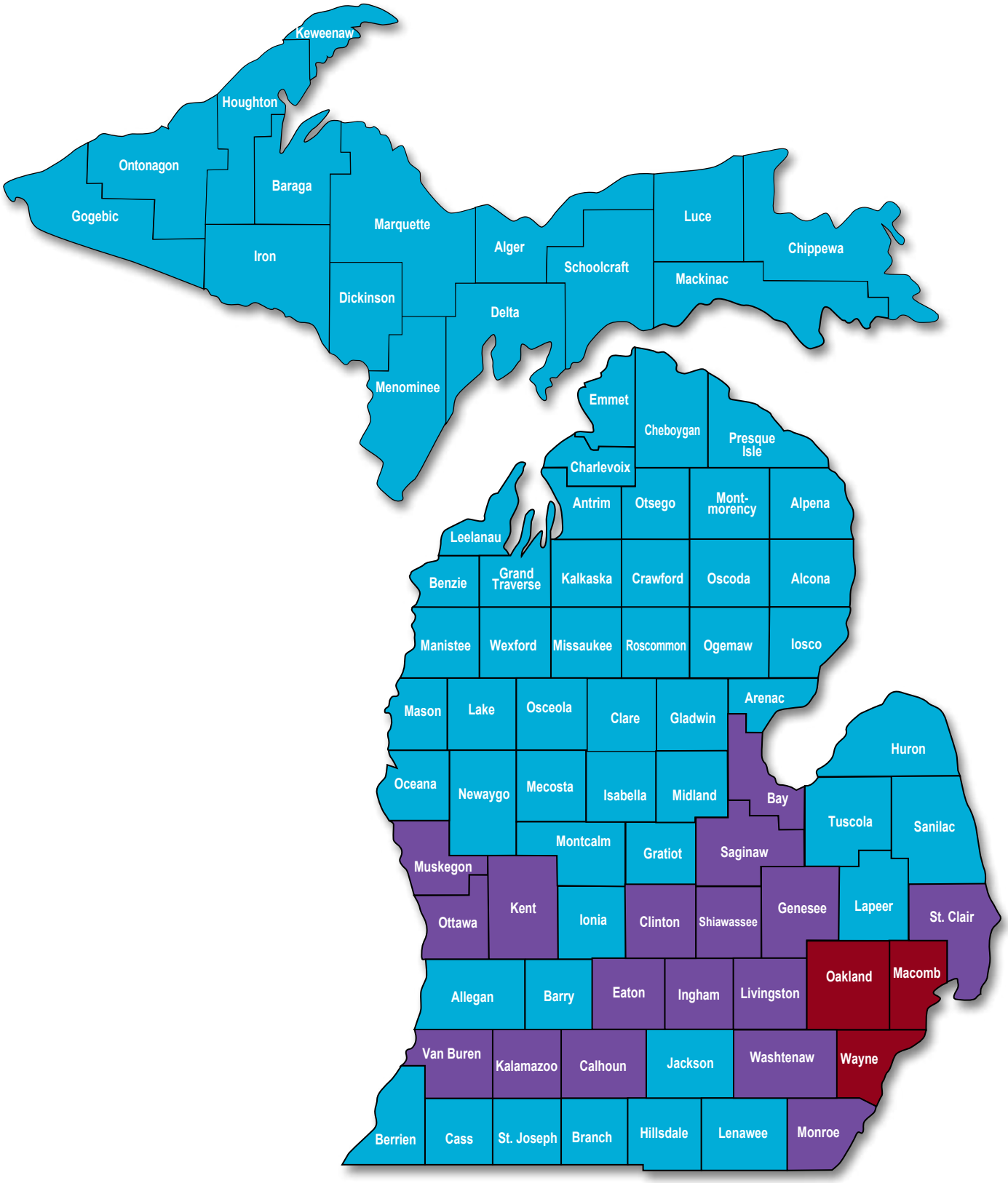
Blue Cross® Preferred
Gold
Silver/Silver Extra/Silver Saver/Silver Off Marketplace
Bronze Saver

Blue Cross® Select
Silver/Silver Extra/Silver Saver/Silver Off Marketplace
Bronze/Bronze Saver
Value

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

Health Plan offering map

This map shows which plans are available in your county.



Network comparison chart

	PPO
Network type	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.
Network name	**Premier**
Network description	You will have a broad choice of doctors and hospitals within Blue Cross' statewide PPO network including nationwide coverage for emergency or urgent services. You may receive services from hospitals or doctors outside the network within Michigan, but you will pay less if you use providers within the network.
Plan offered by	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
Coverage outside of Michigan Includes traveling abroad	Emergencies and accidental injuries have in-network cost-sharing. Scheduled services from a participating provider will apply out of network cost-sharing (2x in-network cost-sharing plus providers will be able to balance bill members the difference between the BCBSM approved amount and the provider's charges.)
Participating primary care physicians Numbers are estimates and subject to change.	32,032
Participating hospitals and systems Numbers are estimates and subject to change.	All 152 Michigan hospitals.

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
This plan offers a broad choice of doctors and hospitals from BCN's entire network, the largest HMO network in Michigan. Your primary care physician will coordinate 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 care and refer you to specialists when necessary. Other than emergency services and accidental injuries, care outside the network is not covered.	This plan offers care within a select network of quality doctors and hospitals in **Wayne, Oakland** and **Macomb counties**. A 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.
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
5,732	3,783	865
141 participating hospitals	141 participating hospitals	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

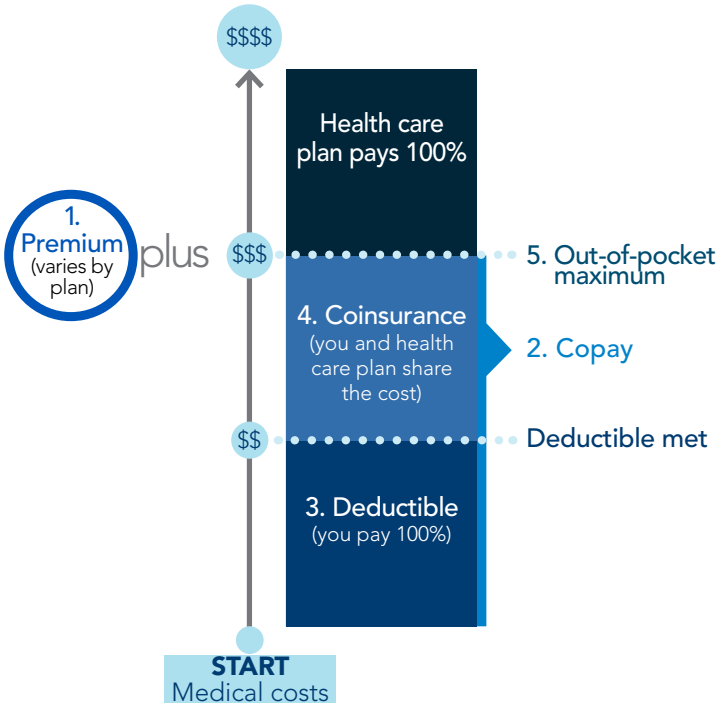
Gold health plan comparison

Network Type	PPO
Plan name	**Blue Cross® Premier PPO Gold**
	In–network
Annual deductible Medical and drug expenses are combined to meet the integrated deductible	$500 per individual plan $1,000 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	$5,500 per individual plan $11,000 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 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 clinic 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 after deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance
Blue Cross Online Visits℠ Blue Cross' enhanced 24/7 online health care, accessed through smartphone, tablet or computer, includes visits with medical doctors and behavioral health therapists.	$10 copay with no deductible for medical visits, $30 copay after deductible for mental health online visits
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 deductible, then covered 80% Copay waived if admitted
Transportation by ambulance	Covered 80% after in-network deductible
Urgent care visits at urgent care centers or outpatient locations	$75 copay after deductible, then covered 80% Diagnostic and laboratory services are subject to the plan's deductible and coinsurance
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
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: 40% coinsurance after in-network integrated deductible **Tier 5** – Nonpreferred specialty: 45% coinsurance after in-network integrated deductible

HMO
Blue Cross® Preferred HMO Gold
In–network
$500 per individual plan $1,000 per family plan
20% after deductible for most services
$5,500 per individual plan $11,000 per family plan
No
Covered 100% with no deductible
$30 copay per primary care office visit with no deductible $50 copay per specialist office visit after deductible Radiology and 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
$30 copay with no deductible for medical and mental health online visits
Covered 100% with no deductible
Covered 80% after deductible
Covered 80% after deductible
Covered 80% after deductible
$250 copay after deductible, then covered 80% Copay waived if admitted
Covered 80% after deductible
$40 copay with no deductible Radiology services are subject to the plan's deductible and coinsurance
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
Tier 1a – Preferred 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: 40% coinsurance after integrated deductible **Tier 5** – Nonpreferred specialty: 45% coinsurance after integrated deductible

Insurance cost basics

Understanding how your costs work will help you know when and how much you need to pay for care.



Five costs that make up a health plan

1. **Premium:** The monthly amount you pay Blue Cross to keep your coverage.
2. **Copayment (or copay):** A fixed amount you pay for a covered health care service, usually when you get the service, such as a doctor visit.
3. **Deductible:** The amount you owe for covered health care services before Blue Cross begins to pay.
4. **Coinsurance:** Your share, or percentage, of the allowable cost for a covered health care service.
5. **Out-of-pocket maximum:** It's the most you'll pay in deductibles, copayments and coinsurance during the year.

Silver health plan comparison

Network type	PPO			
Plan name	**Blue Cross® Premier PPO Silver Extra**	**Blue Cross® Premier PPO Silver**	**Blue Cross® Premier PPO Silver Off Marketplace**	**Blue Cross® Premier PPO Silver Saver HSA**
	In–network	**In–network**	**In–network**	**In–network**
Annual deductible Medical and drug expenses are combined to meet the integrated deductible. (not including Blue Cross PPO and HMO Silver Extra plans)	$3,500 per individual plan $500 specialty drug deductible per individual plan $7,000 per family plan $1,000 specialty drug deductible per family plan	$2,000 per individual plan $4,000 per family plan	$1,800 per individual deductible $3,600 per family deductible	$3,100 per individual plan $6,200 per family plan
Coinsurance	20% after deductible for most services	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	$7,350 per individual plan $14,700 per family plan	$7,350 per individual plan $14,700 per family plan	$7,000 per individual plan $14,000 per family plan	$6,650 per individual plan $13,300 per family plan
HSA qualified	No	No	No	Yes
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible	Covered 100% with no deductible	Covered 100% with no deductible	Covered 100% with no deductible
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	$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 clinic 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	$30 copay after deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance
Blue Cross Online Visits℠ Blue Cross' enhanced 24/7 online health care, accessed through smartphone, tablet or computer, includes visits with medical doctors and behavioral health therapists.	$10 copay with no deductible for medical visits, $30 copay with no deductible for mental health online visits	$10 copay with no deductible for medical visits, $30 copay after deductible for mental health online visits	$10 copay with no deductible for medical visits, $30 copay after deductible for mental health online visits	$10 copay after deductible for medical visits, $30 copay after deductible for mental health online visits
Laboratory tests and pathology	Covered 80% after deductible	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	Covered 80% after deductible
Inpatient hospital care – semi-private room	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible

HMO			
Blue Cross® Preferred HMO Silver Extra **Blue Cross® Select HMO Silver Extra** **Blue Cross® Metro Detroit HMO Silver Extra**	**Blue Cross® Preferred HMO Silver** **Blue Cross® Select HMO Silver** **Blue Cross® Metro Detroit HMO Silver**	**Blue Cross® Preferred HMO Silver Off Marketplace** **Blue Cross® Select HMO Silver Off Marketplace** **Blue Cross® Metro Detroit HMO Silver Off Marketplace**	**Blue Cross® Preferred HMO Silver Saver** **Blue Cross® Select HMO Silver Saver** **Blue Cross® Metro Detroit HMO Silver Saver**
In–network	**In–network**	**In–network**	**In–network**
$3,500 per individual plan $500 specialty drug deductible per individual plan $7,000 per family plan $1,000 specialty drug deductible per family plan	$2,000 per individual plan $4,000 per family plan	$1,800 per individual plan $3,600 per family plan	$3,250 per individual plan $6,500 per family plan
20% after deductible for most services	30% after deductible for most services	30% after deductible for most services	30% after deductible for most services
$7,350 per individual plan $14,700 per family plan	$7,350 per individual plan $14,700 per family plan	$7,000 per individual plan $14,000 per family plan	$6,550 per individual plan $13,100 per family plan
No	No	No	No
Covered 100% with no deductible	Covered 100% with no deductible	Covered 100% with no deductible	Covered 100% with no deductible
$30 copay per primary care office visit with no deductible $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 with no deductible $50 copay per specialist office visit after deductible Radiology and 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 and 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 and diagnostic 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 Radiology and diagnostic services are subject to the plan's deductible and coinsurance	$40 copay with no deductible Radiology and diagnostic services are subject to the plan's deductible and coinsurance	$40 copay with no deductible Radiology diagnostic services are subject to the plan's deductible and coinsurance
$30 copay with no deductible for medical and mental health online visits	$30 copay with no deductible for medical and mental health online visits	$30 copay with no deductible for medical and mental health online visits	$30 copay with no deductible for medical and mental health online visits
Covered 80% after deductible	Covered 100% with no deductible	Covered 100% with no deductible	Covered 100% with no deductible
Covered 80% after deductible	Covered 70% after deductible	Covered 70% after deductible	Covered 70% after deductible
Covered 80% after deductible	Covered 70% after deductible	Covered 70% after deductible	Covered 70% after deductible

Silver health plan comparison (continued)

Network type	PPO			
Plan name	**Blue Cross® Premier PPO Silver Extra**	**Blue Cross® Premier PPO Silver**	**Blue Cross® Premier PPO Silver Off Marketplace**	**Blue Cross® Premier PPO Silver Saver HSA**
	In–network	**In–network**	**In–network**	**In–network**
Surgical care	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible	Covered 80% after deductible
Emergency room	Covered 80% after deductible	$250 copay after in-network deductible, then covered 80% Copay waived if admitted	$250 copay after in-network deductible, then covered 80% 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	Covered 80% after deductible
Urgent care visits at urgent care centers or outpatient locations	$75 copay with no deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance	$75 copay after deductible, then covered 80% Diagnostic and laboratory services are subject to the plan's deductible and coinsurance	$75 copay after deductible, then covered 80% Diagnostic and laboratory services are subject to the plan's deductible and coinsurance	$75 copay after deductible, then covered 80% Diagnostic and laboratory services are subject to the plan's deductible and coinsurance
Maternity benefit	Covered 80% after deductible	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	Covered 100%: One vision exam per pediatric member per calendar year Covered 100%: Standard lenses and frames or contact lenses Frequency limits apply
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 after specialty drug 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: 40% coinsurance after in-network integrated deductible **Tier 5** – Nonpreferred specialty: 45% 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: 40% coinsurance after in-network integrated deductible **Tier 5** – Nonpreferred specialty: 45% 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: 40% coinsurance after in-network integrated deductible **Tier 5** – Nonpreferred specialty: 45% coinsurance after in-network integrated deductible

HMO			
Blue Cross® Preferred HMO Silver Extra **Blue Cross® Select HMO Silver Extra** **Blue Cross® Metro Detroit HMO Silver Extra**	**Blue Cross® Preferred HMO Silver** **Blue Cross® Select HMO Silver** **Blue Cross® Metro Detroit HMO Silver**	**Blue Cross® Preferred HMO Silver Off Marketplace** **Blue Cross® Select HMO Silver Off Marketplace** **Blue Cross® Metro Detroit HMO Silver Off Marketplace**	**Blue Cross® Preferred HMO Silver Saver** **Blue Cross® Select HMO Silver Saver** **Blue Cross® Metro Detroit HMO Silver Saver**
In–network	**In–network**	**In–network**	**In–network**
Covered 80% after deductible	Covered 70% after deductible	Covered 70% after deductible	Covered 70% after deductible
Covered 80% after deductible	$250 copay after deductible, then covered 70% 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 70% after deductible	Covered 70% after deductible	Covered 70% after deductible
$75 copay with no deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance	$40 copay with no deductible Radiology and diagnostic services subject to the plan's deductible and coinsurance	$40 copay with no deductible Radiology and diagnostic services subject to the plan's deductible and coinsurance	$40 copay with no deductible Radiology and diagnostic services are subject to the plan's deductible and coinsurance
Covered 80% after deductible	Covered 70% 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
Tier 1 – Preferred 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 after specialty drug deductible	**Tier 1a** – Preferred 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: 40% coinsurance after integrated deductible **Tier 5** – Nonpreferred specialty: 45% coinsurance after integrated deductible	**Tier 1a** – Preferred 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: 40% coinsurance after integrated deductible **Tier 5** – Nonpreferred specialty: 45% coinsurance after integrated deductible	**Tier 1a** – Preferred 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: 40% coinsurance after integrated deductible **Tier 5** – Nonpreferred specialty: 45% coinsurance after integrated deductible

Bronze health plan comparison

Network type	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	$6,650 per individual plan $13,300 per family plan	$7,350 per individual plan $14,700 per family plan
Coinsurance	40% 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	$7,350 per individual plan $14,700 per family plan	$6,650 per individual plan $13,300 per family plan	$7,350 per individual plan $14,700 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	$35 copay per primary care visit with no deductible $75 copay per specialty visit with no deductible Diagnostic and laboratory services are subject to the plan's deductible	Primary care and specialist office visits are covered 100% after deductible Diagnostic and laboratory services are subject to the deductible	Primary care and specialist office visits are covered 100% after deductible Diagnostic and laboratory services are subject to the plan's deductible
Retail health clinic visit Ex: Going to the clinic at a major pharmacy or retail store for basic health care services on a walk-in basis	$35 copay with no 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 Diagnostic and laboratory services are subject to the plan's deductible
Blue Cross Online Visits℠ Blue Cross' enhanced 24/7 online health care, accessed through smartphone, tablet or computer, includes visits with medical doctors and behavioral health therapists.	$10 copay with no deductible for online medical visits, $35 copay with no deductible for mental health online visits	Covered 100% after deductible	Covered 100% after deductible
Laboratory tests and pathology	Covered 60% 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 60% after deductible	Covered 100% after deductible	Covered 100% after deductible
Inpatient hospital care – semi-private room	Covered 60% after deductible	Covered 100% after deductible	Covered 100% after deductible
Surgical care	Covered 60% after deductible	Covered 100% after deductible	Covered 100% after deductible

HMO	
Blue Cross® Select HMO Bronze **Blue Cross® Metro Detroit HMO Bronze**	**Blue Cross Preferred HMO Bronze Saver HSA** **Blue Cross® Select HMO Bronze Saver HSA** **Blue Cross® Metro Detroit HMO Bronze Saver HSA**
In-network	**In-network**
$7,350 per individual plan $14,700 per family plan	$6,650 per individual plan $13,300 per family plan
None	None
$7,350 per individual plan $14,700 per family plan	$6,650 per individual plan $13,300 per family plan
No	Yes
Covered 100% with no deductible	Covered 100% with no deductible
$30 copay per primary care visit with no deductible Specialist office visits are covered 100% after deductible Diagnostic and radiology services are subject to the plan's deductible	Primary care and specialist office visits are covered 100% after deductible Diagnostic and radiology services are subject to the plan's deductible
$40 copay with no 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
$30 copay with no deductible	Covered 100% after deductible
Covered 100% with no deductible	Covered 100% after deductible
Covered 100% after deductible	Covered 100% after deductible
Covered 100% after deductible	Covered 100% after deductible
Covered 100% after deductible	Covered 100% after deductible

Blue Cross online member account. It's simple and convenient.

Blue Cross offers its members an online account where they can find details on their health care plans such as claims information, deductibles, copayments and so much more. Register today at **bcbsm.com/register**.

Bronze health plan comparison (continued)

Network type	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**
Emergency room	Covered 60% after in-network deductible	Covered 100% after in-network deductible	Covered 100% after in-network deductible
Transportation by ambulance	Covered 60% after in-network deductible	Covered 100% after in-network deductible	Covered 100% after in-network deductible
Urgent care visits at urgent care centers or outpatient locations	Covered $75 copay with no deductible	Covered 100% after deductible	Covered 100% after deductible
Maternity benefit	Covered 60% after 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
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% coinsurance after in-network integrated deductible **Tier 3** – Nonpreferred brand: 40% coinsurance after in-network integrated deductible **Tier 4** – Preferred/ Nonpreferred specialty: 45% coinsurance 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

HMO	
Blue Cross® Select HMO Bronze **Blue Cross® Metro Detroit HMO Bronze**	**Blue Cross Preferred HMO Bronze Saver HSA** **Blue Cross® Select HMO Bronze Saver HSA** **Blue Cross® Metro Detroit HMO Bronze Saver HSA**
In-network	**In-network**
Covered 100% after deductible	Covered 100% after deductible
Covered 100% after deductible	Covered 100% after deductible
$40 copay with no deductible Radiology and diagnostic services are subject to the plan's deductible	Covered 100% after deductible Diagnostic and laboratory services are subject to the plan's 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	Covered 100%: One vision exam per pediatric member per calendar year Covered 100%: Standard lenses and frames or contact lenses Frequency limits apply
Tier 1a – Preferred 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	**Tier 1a** – Preferred 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

Have a non-emergency or illness? See a doctor or therapist live and online now with Blue Cross Online Visits℠.

- Use any time your doctor isn't available
- You have the option to call or video chat
- With Blue Cross Online Visits, your care is provided by doctors or therapists through your smartphone, tablet or computer

Value health plan comparison

Network type	PPO
Plan name	**Blue Cross® Premier PPO Value**
	In-network
Annual deductible Medical and drug expenses are combined to meet the integrated deductible	$7,350 per individual plan $14,700 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	$7,350 per individual plan $14,700 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 deductible Specialist office visits are subject to the deductible Diagnostic and laboratory services are subject to the plan's deductible After deductible is met, office visits are covered at 100%
Retail health clinic 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 clinic visits, per member per calendar year Additional retail health clinic visits and diagnostic and laboratory services are subject to plan's deductible
Blue Cross Online Visits℠ Blue Cross' enhanced 24/7 online health care, accessed through smartphone, tablet or computer, includes visits with medical doctors and behavioral health therapists.	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 centers or outpatient locations	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
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	
$7,350 per individual plan $14,700 per family plan	
None	
$7,350 per individual plan $14,700 per family plan	
No	
Covered 100% with no deductible	
$30 copay per primary care visit with no deductible Specialist office visits are covered 100% after deductible Diagnostic and radiology services are subject to the plan's deductible	
$40 copay with no deductible Diagnostic services are subject to plan's deductible	
$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	
Tier 1a – Preferred 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	

Take advantage of savings with Blue365®

- **Detroit Zoo**
  Save $2 on general admission
- **LEGOLAND® Discovery Center Michigan**
  Save $6 on standard admission
- **SEA LIFE Michigan Aquarium**
  Save $6 on standard admission

BlueDental℠ and Blue Cross Vision plans

Quality dental and vision care from Blue Cross

Blue Cross offers you and your family a variety of choices including stand-alone dental plans, a stand-alone vision plan, and the convenience of dental plans combined with vision coverage, which you can buy directly from us rather than through 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. New enrollment is available year-round for off Marketplace dental, vision, and dental with vision plans.

Choosing your dentist

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

Depending on whether you choose a PPO or an EPO dental plan, your monthly premiums and how you pay for services will vary. It's important to know which plan is right for you.

- **PPO network dentists:** When you visit dentists in-network, or within the preferred dental professional network, you can save up to 20 percent on services.
- **EPO network dentists:** EPO stands for exclusive provider organization. A Blue Dental EPO plan only covers services from dentists in our preferred network. Because EPO plans only cover care received in-network, costs are reduced and monthly payments are lower.
- **Blue Par Select℠ dentists:** Although not part of our network, you'll still save between 8 and 10 percent if you see one of these dentists. As Blue Par Select dentists are not a part of our preferred dental network, EPO plans don't cover their services.
- **Out-of-network dentists:** For dental visits completely outside the Blue Cross network, the process is somewhat different. You cover the cost of care upfront, then file a claim and we would reimburse you for the share of the cost your dental plan covers. Keep in mind that if the dentist charges more than we pay for a service, you may be responsible for the difference.

Looking for a dentist? To find a dentist in your area, go to **mibluedentist.com**, or call us at 1-888-826-8152.

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	
Deductible (1 person/2 person/3 person) Applies to class II & class III services only	In network: $25/$50/$75	Out of network: Not covered	In network: $25/$50/$75	Out of network: $50/$100/$150
Class I Preventive Services				
Coinsurance	In network: 20%	Out of network: Not covered	In network: 20%	Out of network: 50%
Dental check up – Child	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 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 age 18 or younger when their coverage begins	
Routine dental – 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*				
Coinsurance	In network: 50%	Out of network: Not covered	In network: 50%	Out of network: 50%
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 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 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 nonpediatric 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 nonpediatric 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	
In network: $0/$0/$0	Out of network: $50/$100/$150	In network: $75/$150/$225	Out of network: $75/$150/$225	In network: $25/$50/$75	Out of network: $50/$100/$150
In network: Covered	Out of network: 20%	In network: 20%	Out of network: 20%	In network: 20%	Out of network: 50%
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 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 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 age 18 or younger when their coverage begins	
Prophylaxis (Cleaning) – 2x per calendar year (3rd is covered for members with adverse medical conditions) 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 conditions) 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	
In network: 30%	Out of network: 40%	In network: 40%	Out of network: 40%	In network: 50%	Out of network: 50%
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 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 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 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 conditions) 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 nonpediatric 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 conditions) 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 nonpediatric members except for sealants and emergency palliative treatments		Not covered	

Plan Name	Blue Dental EPO Standard		Blue Dental PPO Standard	
Deductible (1 person/2 person/3 person)	In network: $25/$50/$75	Out of network: Not covered	In network: $25/$50/$75	Out of network: $50/$100/$150
Class III Major Restorative services*				
Coinsurance	In network: 50%	Out of network: Not covered	In network: 50%	Out of network: 50%
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 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 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 nonpediatric 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 nonpediatric members	
Annual Maximum – Adult	$1,200	N/A	$1,200	$800
ClassIV Orthodontic services				
Orthodontic services	Not covered		Not covered	

Note: Pediatric Out of Pocket maximum for all dental plans is $350 for one pediatric member and $700 for 2 or more pediatric members. Out of pocket maximum applies only to essential health benefits for pediatric members.

*Services are subject to waiting periods as follows; Class II services = 6 month waiting period for non-pediatric members.
Class III services = 12 month waiting period for non-pediatric members.

Blue Dental members have access to over 450,000 dental locations around the country.

Blue Dental PPO Extra		Blue Dental PPO Plus Standard		Blue Dental PPO Pediatric	
In network: $0/$0/$0	Out of network: $50/$100/$150	In network: $75/$150/$225	Out of network: $75/$150/$225	In network: $25/$50/$75	Out of network: $50/$100/$150
In network: 50%	Out of network: 50%	In network: 50%	Out of network: 50%	In network: 50%	Out of network: 50%
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 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 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 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 nonpediatric 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 nonpediatric members		Not covered	
$1,200	$1,000	$1,000	$1,000	N/A	N/A
Not covered		Not covered		Not covered	

Individual vision plan comparison

Choosing your eye doctor

A benefit of having Blue Cross coverage are the plan options for not just medical, but dental and vision. With Blue Cross vision and dental plans, members are able to purchase a packaged dental with vision plan or purchase a standalone vision plan by itself.

Also, to save big on vision care, visit a VSP Choice in-network eye doctor. If you choose a provider that doesn't participate with VSP, you're responsible for additional charges. This may include the difference between our approved amount and the doctor's charge and copayments required by your plan.

Choosing a doctor who participates in the VSP Choice network is easy. Visit **bcbsm.com**, click *Find a Doctor* and then choose VSP. You can also call VSP member services at **1-800-877-7195.**

Plan Name	Blue Cross® Vision for Adults	
	In network	Out of network
Eye exam Covered once every 12 months	$15 copay	$15 copay plus you pay any costs over $34
Standard lenses A single copay applies to both lenses and frames. One pair of standard lenses and frames or contact lenses covered every 12 months.	$25 copay	$25 copay plus you pay any costs over $17 for single vision lenses, $30 for bifocal lenses, or $43 for trifocal lenses.
Standard frames A single copay applies to both lenses and frames. One pair of standard lenses and frames or contact lenses covered every 12 months.	$25 copay plus you pay any costs over $150	$25 copay plus you pay any costs over $38.25
Elective contact lenses One pair of standard lenses and frames or contact lenses covered every 12 months.	You pay any costs over $150	You pay any costs over $100
Medically necessary contact lenses One pair of standard lenses and frames or contact lenses covered every 12 months.	$25 copay	$25 copay plus you pay any costs over $210
Allowance	$150 allowance for frames or elective contact lenses every 12 months.	Varies depending on service

IMPORTANT NOTE: For the BlueDental plans, Blue Cross Blue Shield of Michigan uses the Dental Network of America Preferred Network.

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

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

Individual dental with vision comparison

Plan Name	Blue Dental℠ PPO Standard with Vision, Blue Dental℠ PPO Plus Standard with Vision, Blue Dental℠ PPO Extra with Vision, Blue Dental℠ EPO Standard with Vision	
	In network	Out of network
Eye exam Covered every 12 months.	$10 copay	$10 copay plus you pay any costs over $34
Standard lenses A single copay applies to both lenses and frames. One pair of standard lenses and frames or contact lenses covered every 12 months.	$25 copay	$25 copay plus you pay any costs over $17 for single vision lenses, $30 for bifocal lenses, or $43 for trifocal lenses.
Standard frames A single copay applies to both lenses and frames. One pair of standard lenses and frames or contact lenses covered every 24 months.	$25 copay plus you pay any costs over $130	$25 copay plus you pay any costs over $38.25
Elective contact lenses One pair of standard lenses and frames or contact lenses covered every 12 months.	You pay any costs over $130	You pay any costs over $100
Medically necessary contact lenses One pair of standard lenses and frames or contact lenses covered every 12 months.	$25 copay	$25 copay plus you pay any costs over $210
Allowance	$130 allowance for frames or elective contact lenses every 24 months	Varies depending on service

See dental coverage on page 22

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

Find a dentist:
mibluedentist.com

Summary of benefits and coverage:
bcbsm.com/sbc

Billing, claims and benefits:
Look for the Customer Service number on the back of your member ID card

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

Selecting a primary care physician (for HMO plans):
bcbsm.com/selectpcp

See a doctor now with Blue Cross Online Visits. Go to **onlinevisits.bcbsm.com** to log in, or create an account.

Packed the app? You can download our Blue Cross mobile app at **bcbsm.com/app**. Use it to select your primary care physician and many more useful features.

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 2018, 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.

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