

Pending CMS approval

Blue Cross[®] Premier Platinum with Dental and Vision



An individual PPO health plan from Blue Cross Blue Shield of Michigan

You will have a broad choice of doctors and hospitals within BCBSM's unsurpassed statewide PPO network including nationwide coverage. You may receive services from hospitals or doctors outside the network, but you will pay less if you use providers within the network. Use our *Find a Doctor* tool at bcbsm.com/find-a-doctor to see if your doctor is in the network.

Benefits	In-network	Out-of-network
Annual deductible	Individual plan (one member)	
	None	None
	Family plan (two or more members)	
	None	None
Coinsurance	10% for most services. 50% for bariatric, temporomandibular joint, infertility, prosthetics and orthotics, and durable medical equipment services.	30% for most services. 70% for bariatric, temporomandibular joint, infertility, prosthetics and orthotics, and durable medical equipment services.
Out-of-pocket maximum The coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum	Individual plan (one member)	
	\$6,000 per individual plan per calendar year	\$12,000 per individual plan per calendar year
	Family plan (two or more members)	
	\$12,000 per family plan per calendar year	\$24,000 per family plan per calendar year
<p><i>NOTE: If the contract is a family contract, and one member on the contract meets the individual out-of-pocket maximum, BCBSM will begin paying 100% of the approved amount for covered benefits for that member only. The remainder of the family out-of-pocket maximum must be met by one or more family members before BCBSM will begin paying 100% of the approved amount for covered benefits for the rest of the members on the family contract.</i></p>		
Preventive care		
Preventive medical, prescription drugs and immunizations include: health maintenance exam, select laboratory services, gynecologic exam, pap smear screening, mammogram screening, select female contraceptives, female voluntary sterilization and other adult and childhood preventive services and immunizations in compliance with the provisions of the Patient Protection and Affordable Care Act.	Covered 100% with no copay or coinsurance	Not covered

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

Call a health plan advisor at 1-877-469-2583 if you have any question

Benefits	In-network	Out-of-network
Preventive care <i>continued</i>		
Screening colonoscopy	Covered 100% with no copay or coinsurance The first routine or medically necessary colonoscopy of the calendar year will be covered at 100%.	Not covered
Pediatric services		
Well baby and child	Covered 100% with no copay or coinsurance	Not covered
Pediatric dental	Pediatric members (up to the age of 19): No waiting period. Out-of-pocket maximum: \$350 (one member); \$700 (2 or more members).	Pediatric members (up to the age of 19): No waiting period.
Class I — Preventive and diagnostic services	Covered 100%	Covered 100%
Class II — Minor restorative services	Covered 75%	Covered 75%
Class III — Major restorative services	Covered 50%	Covered 50%
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. Member responsible for the difference between the BCBSM-approved amount and the provider's charge.
Adult dental and vision services		
Adult dental	Annual benefit maximum: \$1,500 per adult member per calendar year.	Annual benefit maximum: \$1,500 per adult member per calendar year.
Class I — Preventive and diagnostic services	Covered 100%	Covered 100%
Class II — Minor restorative services	Covered 75% with a 6-month waiting period	Covered 75% with a 6-month waiting period
Class III — Major restorative services	Covered 50% with a 12-month waiting period	Covered 50% with a 12-month waiting period
Adult vision	\$10 copay, one vision exam per member per calendar year. \$25 copay with a \$130 annual benefit maximum: Standard lenses and frames or contact lenses. Frequency limits apply.	\$10 copay, one vision exam per member per calendar year. \$25 copay with a \$100 annual benefit maximum: Standard lenses and frames or contact lenses. Frequency limits apply. Member responsible for the difference between the BCBSM approved amount and the provider's charge, less copay.

Ambulatory services		
Physician office visits, presurgical consultations, office consultations, and retail health clinic visits	Covered 90%	Not covered
Urgent care — physician's office and retail health clinics	Covered 90%	Not covered
Laboratory and diagnostic services		
Laboratory tests and pathology	Covered 90%	Covered 70%
Diagnostic tests and X-rays (including electrocardiogram, chest X-rays)	Covered 90%	Covered 70%
Imaging services: CT scans, MRIs, PET, etc. Prior authorization required	Covered 90%	Covered 70%
Allergy testing and therapy in a physician's office	Covered 90%	Not covered
Maternity and newborn care		
Maternity benefit	Covered 90%	Covered 70%
Prenatal visits	Covered 100% with no copay or coinsurance. Diagnostic and laboratory services are subject to the plan's coinsurance.	Covered 70% —Diagnostic and laboratory services are subject to the plan's coinsurance.
Postnatal visits	Covered 90%. Diagnostic and laboratory services are subject to the plan's coinsurance.	Covered 70%. Diagnostic and laboratory services are subject to the plan's coinsurance.
Emergency services		
Emergency room	Covered 90%	
Ambulance services	Covered 90%	
Urgent care visits Urgent care center or outpatient location	Covered 90%	Covered 70%
Hospitalization and other services		
Inpatient hospital care, long-term acute care hospital (semiprivate room); skilled nursing facility — Limited to a maximum of 45 days per member per calendar year BCBSM-participating facilities only	Covered 90%	Covered 70%
Physician surgical services	Covered 90%	Covered 70%
Home health care BCBSM-participating agencies only	Covered 90%	Not covered
Chemotherapy	Covered 90%	Covered 70%
Organ transplant and specified organ transplant	Covered 90%	Covered 70%

Benefits	In-network	Out-of-network
Hospitalization and other services <i>continued</i>		
Sleep studies including testing and surgeries	Covered 90%	Covered 70%
Bariatric Surgery — once per lifetime	Covered 50%	Covered 30%
Male voluntary sterilization	Covered 90%	Covered 70%
Rehabilitative and habilitative services and devices		
Outpatient physical and occupational therapy	Covered 90% — Limited to a combined maximum of 30 visits per member per calendar year	Covered 70% — Limited to a combined maximum of 30 visits per member per calendar year
Chiropractic spinal manipulation and osteopathic manipulative therapy		
Speech therapy	Covered 90% — Limited to a maximum of 30 visits per member per calendar year	Covered 70% — Limited to a maximum of 30 visits per member per calendar year
Cardiac and pulmonary rehabilitation	Covered 90% — Limited to a combined maximum of 30 visits per member per calendar year	Covered 70% — Limited to a combined maximum of 30 visits per member per calendar year
Specified autism spectrum disorder — applied behavioral analysis	Covered 90% — Services must be preauthorized by BCBSM.	Covered 70% — Services must be preauthorized by BCBSM.
Durable medical equipment and prosthetic and orthotic appliances BCBSM-Participating providers only	Covered 50%	Covered 30%
Diabetes supplies and outpatient diabetes self management training	Covered 90%	Covered 70%
Mental health and substance abuse		
Inpatient and residential mental health BCBSM-participating facilities only	Covered 90%	Covered 70%
Outpatient mental health	Covered 90%	Covered 70%
Inpatient and residential substance abuse BCBSM-participating facilities only	Covered 90%	Not covered
Outpatient substance abuse BCBSM-participating programs only	Covered 90%	Not covered

Benefits	In-network	Out-of-network
Prescription drugs		
<p>Prescription drugs 1-30 days (Retail network pharmacy and mail-order provider)</p>	<p>Tier 1 — Generic: \$15 copay Tier 2 — Preferred brand: 25% coinsurance, \$40 minimum and \$100 maximum copay Tier 3 — Nonpreferred brand: 50% coinsurance, \$80 minimum and \$100 maximum copay Tier 4 — Preferred specialty: 20% coinsurance, no minimum and \$200 maximum copay (30 day supply only) Tier 5 — Nonpreferred specialty: 25% coinsurance, no minimum and \$300 maximum copay (30 day supply only)</p>	<p>Members must pay the pharmacist the full cost of the drug. BCBSM will reimburse 80% of the BCBSM-approved amount for covered drugs, less the copay and the difference between the out-of-network pharmacy's charge and the BCBSM-approved amount for the drug.</p>
<p>Prescription drugs 31-60 days Note: Specialty drugs (Tier 4 and 5) are limited to a 30-day supply. (mail order only)</p>	<p>Tier 1 — Generic: \$30 copay Tier 2 — Preferred brand: 25% coinsurance after in-network integrated deductible, \$80 minimum and \$200 maximum copay Tier 3 — Nonpreferred brand: 50% coinsurance after in-network integrated deductible, \$160 minimum and \$200 maximum copay Tier 4 — Preferred specialty: Not covered Tier 5 — Nonpreferred specialty: Not covered</p>	<p>Not covered</p>
<p>Prescription drugs 61-90 days Note: Specialty drugs (Tier 4 and 5) are limited to a 30-day supply. (90 day retail network pharmacy and mail order only)</p>	<p>Tier 1 — Generic: \$45 copay Tier 2 — Preferred brand: 25% coinsurance, \$120 minimum and \$300 maximum copay Tier 3 — Nonpreferred brand: 50% coinsurance, \$240 minimum and \$300 maximum copay Tier 4 — Preferred specialty: Not covered Tier 5 — Nonpreferred specialty: Not covered</p>	<p>Not covered</p>
<p>Notes To be eligible for coverage, the following services require approval before they are provided: inpatient acute care, rehabilitation services, some radiology services (CT, CTA, MRI, MRA, MRS, QCT bone densitometry, nuclear cardiology, PET and PET/CT fusion, diagnostic CT colonography, CT abdomen and pelvis), sleep studies, mental health and substance abuse, skilled nursing facilities, self- and physician-administered specialty drugs, applied behavioral analysis and human organ transplant services. Estimated pricing information for various procedures by in-network providers can be obtained by calling the Customer Service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.</p>		

Exclusions and limitations: Conditions covered by workers' compensation or similar law; services or supplies not specifically listed as covered under your benefit plan; services received before your effective date or after coverage ends; services you wouldn't have to pay for if you did not have this coverage; services or supplies that are not medically necessary; physical exams for insurance, employment, sports or school; any amounts in excess of BCBSM's approved amount; cosmetic surgery, admissions and hospitalizations; services for gender reassignment or for the treatment of gender identity disorder including hormonal therapy; dental care, dental implants or treatment to the teeth except as specifically stated in your benefit plan; hearing aids; infertility-related drugs; private duty nursing; telephone, fax machine or any other type of electronic consultation; educational services, except as specifically provided or arranged by BCBSM or specifically stated in your benefit plan; care or treatment furnished in a nonparticipating hospital, except as specifically stated in your benefit plan; personal comfort items; custodial care; services or supplies supplied to any person not covered under your benefit plan; services while confined in a hospital or other facility owned or operated by state or federal government, unless required by law; voluntary abortions or vasectomy reversals; RK, PRRK, or Lasik; services provided by a professional provider to a family member; services provided by any person who ordinarily resides in the covered person's home or who is a family member; any drug, medicine or device that is not approved by the Food and Drug Administration, unless required by law; vitamins, dietary products and any other nonprescription supplements except as specifically stated in your benefit plan; dental services, except for dental injury; appliances, supplies or services as a result of war or any act of war, whether declared or not; communication or travel time, lodging or transportation, except as stated in your benefit plan; foot care services, except as stated in your benefit plan; health clubs or health spas, aerobic and strength conditioning, work-hardening programs and related material and products for these programs; hair prosthesis, hair transplants or implants; experimental treatments, except as stated in your benefit plan; and alternative medicines or therapies.

This document is intended to be an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. A complete description of benefits is contained in the applicable Blue Cross Blue Shield of Michigan certificate and riders. In the event of a conflict between this document and the applicable certificate and riders, the certificate and riders will rule. Payment amounts are based on the BCBSM-approved amount, less any applicable deductible, copay and/or coinsurance amounts required by the plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.



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