

Blue Cross[®] Metro Detroit HMO Gold Extra



An individual HMO health plan from Blue Care Network of Michigan

You will receive care within a select network of quality doctors and hospitals located in Wayne, Oakland and Macomb counties. Your primary care doctor will coordinate your care. Care within BCN's entire HMO network, but outside the Metro Detroit HMO network, will require primary care doctor and plan authorization. Other than emergency services and accidental injuries, care outside BCN's network is not covered. Use our *Find a Doctor* tool at bcbsm.com/find-a-doctor to see if your doctor is in the Metro Detroit HMO network.

Benefits	In-network
Annual deductible	Individual plan (one member)
	\$775 per individual plan per calendar year
	Family plan (two or more members)
	\$1,550 per family plan per calendar year Medical and drug expenses are combined to meet the integrated deductible. <i>NOTE: If the contract is a family contract, and one member on the contract meets the individual deductible, BCN will begin paying covered benefits for that member only. The remainder of the family deductible must be met by one or more family members before BCN will begin paying covered benefits for the rest of the members on the family contract.</i>
Coinsurance	20% after deductible for most services. 50% after deductible for bariatric, temporomandibular joint, infertility, prosthetics and orthotics, and durable medical equipment services.
Out-of-pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum	Individual plan (one member)
	\$3,000 per individual plan (one member) per calendar year
	Family plan (two or more members)
	\$6,000 per family plan (two or more members) per calendar year <i>NOTE: If the contract is a family contract, and one member on the contract meets the individual out-of-pocket maximum, BCN 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 BCN will begin paying 100% of the approved amount for covered benefits for the rest of the members on the family contract.</i>
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 deductible, copay or coinsurance
Screening colonoscopy	Covered 100% with no deductible, copay or coinsurance The first routine or medically necessary colonoscopy of the calendar year will be covered at 100%.

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

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

Benefits		In-network
Pediatric services		
Well baby and child		Covered 100% with no deductible, copay or coinsurance
Pediatric dental		Stand alone plan available for purchase
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
Ambulatory services		
Physician office visits, presurgical consultations, office consultations, and online visits		\$20 copay per primary care office visit or online visit with no deductible. Up to four specialist office visits with a \$50 copay per visit with no deductible per member per calendar year. After four specialist office visits, additional specialist office visits are subject to the deductible. After the deductible is met, a \$50 copay applies to additional specialist office visits. Radiology services are subject to the plan's deductible and coinsurance.
Urgent care — physician's office		\$20 copay per primary care office visit with no deductible. Up to four specialist office visits with a \$50 copay per visit with no deductible per member per calendar year. After four specialist office visits, additional specialist office visits are subject to the deductible. After the deductible is met, a \$50 copay applies to additional specialist office visits. Radiology services are subject to the plan's deductible and coinsurance.
Laboratory and diagnostic services		
Laboratory tests and pathology		Covered 100% before deductible
Diagnostic tests and X-rays (including electrocardiogram, chest X-rays)		Covered 80% after deductible
Imaging services: CT scans, MRIs, PET, etc. Prior authorization required		Covered 80% after deductible
Allergy testing and therapy in a physicians office		Covered 80% after deductible
Maternity and newborn care		
Maternity benefit		Covered 80% after deductible
Prenatal visits		Covered 100% with no deductible, copay or coinsurance. Radiology services are subject to the plan's deductible and coinsurance.
Postnatal visits		\$20 copay per office visit after deductible. Radiology services are subject to the plan's deductible and coinsurance.
Emergency services		
Emergency room		\$250 copay after deductible, then covered 80%. Copay waived if admitted.
Ambulance services		Covered 80% after deductible
Urgent care visits Urgent care center or outpatient location		\$40 copay before deductible. Radiology services are subject to the plan's deductible and coinsurance.

Benefits	In-network
Hospitalization and other services	
Inpatient hospital care, long-term acute care hospital (semi-private room); skilled nursing facility — Limited to a maximum of 45 days per member per calendar year	Covered 80% after deductible
Physician surgical services	Covered 80% after deductible
Home health care	Covered 80% after deductible
Chemotherapy	Covered 80% after deductible
Organ transplant and specified organ transplant BCN-designated facilities only	Covered 80% after deductible
Sleep studies including testing and surgeries	Covered 80% after deductible
Bariatric surgery — once per lifetime	Covered 50% after deductible
Male voluntary sterilization	Covered 80% after deductible
Rehabilitative and habilitative services and devices	
Outpatient physical and occupational therapy	Covered 80% after deductible — Limited to a combined maximum of 30 visits per member per calendar year
Chiropractic spinal manipulation and osteopathic manipulative therapy	Covered 80% after deductible — Limited to a combined maximum of 30 visits per member per calendar year
Speech therapy	Covered 80% after deductible — Limited to a maximum of 30 visits per member per calendar year
Cardiac and pulmonary rehabilitation	Covered 80% after deductible — Limited to a combined maximum of 30 visits per member per calendar year
Specified autism spectrum disorder — applied behavioral analysis	Covered 80% after deductible — Services must be preauthorized by BCN.
Durable medical equipment and prosthetic and orthotic appliances BCN-approved suppliers only	Covered 50% after deductible
Diabetes supplies and outpatient diabetes self management training	Covered 80% after deductible
Mental health and substance abuse	
Inpatient and residential mental health	Covered 80% after deductible
Outpatient mental health	Covered 80% after deductible. Radiology services are subject to the plan's deductible and coinsurance.
Inpatient and residential substance abuse	Covered 80% after deductible
Outpatient substance abuse	Covered 80% after deductible. Radiology services are subject to the plan's deductible and coinsurance.

Prescription drugs

Prescription drugs 1-30 days

(Retail network pharmacy
and mail-order provider)

Tier 1a — Preferred generic: \$4 copay with no deductible

Tier 1b — Nonpreferred generic: \$20 copay with no deductible

Tier 2 — Preferred brand: 25% coinsurance after integrated deductible,
\$40 minimum and \$100 maximum copay

Tier 3 — Nonpreferred brand: 50% coinsurance after integrated
deductible,
\$80 minimum and \$100 maximum copay

Tier 4 — Preferred specialty: 20% coinsurance after integrated deductible,
no minimum and \$200 maximum copay (30 day supply only)

Tier 5 — Nonpreferred specialty: 25% coinsurance after integrated
deductible, no minimum and \$300 maximum copay (30 day supply only)

Prescription drugs 31-90 days

Note: Specialty drugs (Tier 4 and 5) are limited
to a 30-day supply.

(90-day retail network pharmacy
and mail-order only)

Tier 1a — Preferred generic: \$12 copay with no deductible

Tier 1b — Nonpreferred generic: \$60 copay with no deductible

Tier 2 — Preferred brand: 25% coinsurance after integrated deductible,
\$120 minimum and \$300 maximum copay

Tier 3 — Nonpreferred brand: 50% coinsurance after integrated
deductible,
\$240 minimum and \$300 maximum copay

Tier 4 — Preferred specialty: Not covered

Tier 5 — Nonpreferred specialty: Not covered

Notes

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.

Pricing information for various procedures by in-network providers can be obtained by calling the Customer Service number listed on the back of your BCN ID card and providing the procedure code. Your provider can also provide this information upon request.

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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Blue Shield
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of Michigan

Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association