Pending CMS approval

# Blue Cross® Metro Detroit HMO Silver 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)** |
| | $2,250 per individual plan per calendar year |
| | **Family plan (two or more members)** |
| | $4,500 per family plan per calendar year<br>Medical and drug expenses are combined to meet the integrated deductible. |
| | ***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.* |
| **Coinsurance** | 30% after deductible for most services.<br>50% after deductible for bariatric, temporomandibular joint, infertility, prosthetics and orthotics, and durable medical equipment services. |
| **Out-of-pocket maximum**<br>The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum | **Individual plan (one member)** |
| | $5,750 per individual plan per calendar year |
| | **Family plan (two or more members)** |
| | $11,500 per family plan per calendar year |
| | ***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.* |
| **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 |

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 |
|---|---|
| **Preventive care** *continued* | |
| **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%. |
| **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<br>Covered 100%, standard lenses and frames or contact lenses<br>Frequency limits apply |
| **Ambulatory services** | |
| **Physician office visits, presurgical consultations, office consultations, 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.<br>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.<br>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-ray)** | Covered 70% after deductible |
| **Imaging services: CT scans, MRIs, PET, etc.**<br>Prior authorization required | Covered 70% after deductible |
| **Allergy testing and therapy in a physician's office** | Covered 70% after deductible |
| **Maternity and newborn care** | |
| **Maternity benefit** | Covered 70% 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. |

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|---|---|
| **Emergency services** | |
| **Emergency room** | $250 copay after deductible, then covered 70%. Copay waived if admitted. |
| **Ambulance services** | Covered 70% after deductible |
| **Urgent care visits**<br>Urgent care center or outpatient location | $40 copay with no deductible. Radiology services are subject to the plan's deductible and coinsurance. |
| **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 | Covered 70% after deductible |
| **Physician surgical services** | Covered 70% after deductible |
| **Home health care** | Covered 70% after deductible |
| **Chemotherapy** | Covered 70% after deductible |
| **Organ transplant and specified organ transplant**<br>BCN-designated facilities only | Covered 70% after deductible |
| **Sleep studies including testing and surgeries** | Covered 70% after deductible |
| **Bariatric surgery — once per lifetime** | Covered 50% after deductible |
| **Male voluntary sterilization** | Covered 70% after deductible |
| **Rehabilitative and habilitative services and devices** | |
| **Outpatient physical & occupational therapy** | Covered 70% after deductible — Limited to a combined maximum of 30 visits per member per calendar year |
| **Chiropractic spinal manipulation and osteopathic manipulative therapy** | Covered 70% after deductible — Limited to a combined maximum of 30 visits per member per calendar year |
| **Speech therapy** | Covered 70% after deductible — Limited to a maximum of 30 visits per member per calendar year |
| **Cardiac and pulmonary rehabilitation** | Covered 70% after deductible — Limited to a combined maximum of 30 visits per member per calendar year |
| **Rehabilitative and habilitative services and devices** *continued* | |
| **Specified autism spectrum disorder — applied behavioral analysis** | Covered 70% after deductible — Services must be preauthorized by BCN |
| **Durable medical equipment and prosthetic and orthotic appliances**<br>BCN-approved suppliers only | Covered 50% after deductible |
| **Diabetes supplies and outpatient diabetes self management training** | Covered 70% after deductible |

| Benefits | In-network |
|---|---|
| **Mental health and substance abuse** | |
| **Inpatient and residential mental health** | Covered 70% after deductible |
| **Outpatient mental health** | Covered 70% after deductible. |
| **Inpatient and residential substance abuse** | Covered 70% after deductible |
| **Outpatient substance abuse** | Covered 70% after deductible. |
| **Prescription drugs** | |
| **Prescription drugs 1-30 days**<br>(Retail network pharmacy and mail-order provider) | **Tier 1a — Preferred generic:** $4 copay with no deductible<br>**Tier 1b — Nonpreferred generic:** $20 copay with no deductible<br>**Tier 2 — Preferred brand:** 25% coinsurance after integrated deductible, $40 minimum and $100 maximum copay<br>**Tier 3 — Nonpreferred brand:** 50% coinsurance after integrated deductible, $80 minimum and $100 maximum copay<br>**Tier 4 — Preferred specialty:** 20% coinsurance after integrated deductible, no minimum and $200 maximum copay (30 day supply only)<br>**Tier 5 – Nonpreferred specialty:** 25% coinsurance after integrated deductible, no minimum and $300 maximum copay (30 day supply only) |
| **Prescription drugs 31-90 days**<br>Note: Specialty drugs (Tier 4 and 5) are limited to a 30-day supply.<br>(90-day retail network pharmacy or mail-order provider) | **Tier 1a — Preferred generic:** $12 copay with no deductible<br>**Tier 1b — Nonpreferred generic:** $60 copay with no deductible<br>**Tier 2 – Preferred brand:** 25% coinsurance after integrated deductible, $120 minimum and $300 maximum copay<br>**Tier 3 — Nonpreferred brand:** 50% coinsurance after integrated deductible, $240 minimum and $300 maximum copay<br>**Tier 4 — Preferred specialty:** Not covered<br>**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.**