Pending CMS approval

Blue Cross® Premier Silver

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

You will have a broad choice of doctors and hospitals within Blue Cross Blue Shield of Michigan'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)**	
	$1,400 per individual plan per calendar year	$2,800 per individual plan per calendar year
	Family plan (two or more members)	
	$2,800 per family plan per calendar year. Medical and drug expenses are combined to meet the integrated deductible.	$5,600 per family plan per calendar year. 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, BCBSM 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 BCBSM will begin paying covered benefits for the rest of the members on the family contract.	
Coinsurance	20% after deductible for most services 50% after deductible for bariatric, temporomandibular joint, infertility, prosthetics and orthotics and durable medical equipment services	40% after deductible for most services 70% 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)**	
	$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
	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.	

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	Out-of-network
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	Not covered
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%.	Not covered
Pediatric services		
Well baby and child	Covered 100% with no deductible, copay or coinsurance	Not covered
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	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 Blue Cross approved amount and the provider's charge.
Ambulatory services		
Physician office visits, presurgical consultations, office consultations, retail health clinic 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 plan's deductible and coinsurance.	Not covered
Urgent care — physician's office and retail health clinic	Covered 80% after deductible, then $75 copay	Not covered
Laboratory and diagnostic services		
Laboratory tests and pathology	Covered 80% after deductible	Covered 60% after deductible
Diagnostic tests and X-rays (including electrocardiogram, chest X-rays)	Covered 80% after deductible	Covered 60% after deductible
Imaging services: CT scans, MRIs, PET, etc. Prior authorization required	Covered 80% after deductible, then $200 copay	Covered 60% after deductible, then $200 copay

Laboratory and diagnostic services *continued*		
Allergy testing and therapy in a physician's office	Covered 80% after deductible	Not covered
Maternity and newborn care		
Maternity benefit	Covered 80% after deductible, then $500 copay	Covered 60% after deductible, then $500 copay
Prenatal visits	Covered 100% with no deductible, copay or coinsurance. Diagnostic and laboratory services are subject to the plan's deductible and coinsurance.	Covered 60% after deductible. Diagnostic and laboratory services are subject to the plan's deductible and coinsurance.
Postnatal visits	Covered 80% after deductible Diagnostic and laboratory services are subject to the plan's deductible and coinsurance.	Covered 60% after deductible. Diagnostic and laboratory services are subject to the plan's deductible and coinsurance.
Emergency services		
Emergency room	Covered 80% after in-network deductible, then $250 copay. Copay waived if admitted.	
Ambulance services	Covered 80% after in-network deductible	
Urgent care visits Urgent care center or outpatient location	Covered 80% after deductible, then $75 copay	Covered 60% after deductible, then $75 copay
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 80% after deductible, then $500 copay	Covered 60% after deductible, then $500 copay
Physician surgical services	Covered 80% after deductible	Covered 60% after deductible
Home health care BCBSM-participating agencies only	Covered 80% after deductible	Not covered
Chemotherapy	Covered 80% after deductible	Covered 60% after deductible
Organ transplant and specified organ transplant BCBSM-designated facilities only	Covered 80% after deductible	Covered 60% after deductible
Sleep studies including testing and surgeries	Covered 80% after deductible	Covered 60% after deductible
Bariatric surgery — once per lifetime	Covered 50% after deductible	Covered 30% after deductible
Male voluntary sterilization	Covered 80% after deductible	Covered 60% after deductible

Benefits	In-network	Out-of-network
Rehabilitative and habilitative services and devices		
Outpatient physical and occupational therapy **Chiropractic spinal manipulation and osteopathic manipulative therapy**	Covered 80% after deductible Limited to a combined maximum of 30 visits per member per calendar year	Covered 60% 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	Covered 60% 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	Covered 60% 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 BCBSM.	Covered 60% after deductible Services must be preauthorized by BCBSM.
Durable medical equipment and prosthetic and orthotic appliances BCBSM-participating providers only	Covered 50% after deductible	Covered 30% after deductible
Diabetes supplies and outpatient diabetes self-management training	Covered 80% after deductible	Covered 60% after deductible
Mental health and substance abuse		
Inpatient and residential mental health BCBSM-participating facilities only	Covered 80% after deductible, then $500 copay	Covered 60% after deductible, then $500 copay
Outpatient mental health	Covered 80% after deductible	Covered 60% after deductible
Inpatient and residential substance abuse BCBSM-participating facilities only	Covered 80% after deductible, then $500 copay	Not covered
Outpatient substance abuse BCBSM-participating programs only	Covered 80% after deductible	Not covered

Benefits	In-network	Out-of-network
Prescription drugs		
Prescription drugs 1 to 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:** 20% coinsurance after in-network integrated deductible, no minimum and $200 maximum copay (30 day supply only) **Tier 5 — Nonpreferred specialty:** 25% coinsurance after in-network integrated deductible, no minimum and $300 maximum copay (30 day supply only)	Members must pay the pharmacist the full cost of the drug. After the in-network integrated deductible, Blue Cross will reimburse 80% of the Blue Cross-approved amount for covered drugs, less the copay and the difference between the out-of-network pharmacy's charge and the Blue Cross-approved amount for the drug.
Prescription drugs 31 to 60 days Note: Specialty drugs (Tier 4 and 5) are limited to a 30-day supply. (mail order only)	**Tier 1 — Generic:** $30 copay after in-network integrated deductible **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	Not covered
Prescription drugs 61 to 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 1 — Generic:** $45 copay after in-network integrated deductible **Tier 2 — Preferred brand:** 25% coinsurance after in-network integrated deductible, $120 minimum and $300 maximum copay **Tier 3 — Nonpreferred brand:** 50% coinsurance after in-network integrated deductible, $240 minimum and $300 maximum copay **Tier 4 — Preferred specialty:** Not covered **Tier 5 – Nonpreferred specialty:** Not covered	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.

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 Blue Cross 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.

Blue Cross
Blue Shield
Blue Care Network
of Michigan

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