

# Blue Cross<sup>®</sup> Premier Bronze with Primary Care Visits



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](https://bcbsm.com/find-a-doctor) to see if your doctor is in the network.

Benefits	In-network	Out-of-network
<b>Annual deductible</b>	<b>Individual plan (one member)</b>	
	\$6,750 per individual plan per calendar year	\$13,500 per individual plan per calendar year
	<b>Family plan (two or more members)</b>	
	\$13,500 per family plan per calendar year. Medical and drug expenses are combined to meet the integrated deductible.	\$27,000 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, 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.</i>	
<b>Coinsurance</b>	None	None
<b>Out-of-pocket maximum</b> The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out-of-pocket maximum.	<b>Individual plan (one member)</b>	
	\$6,750 per individual plan per calendar year	\$13,500 per individual plan per calendar year
	<b>Family plan (two or more members)</b>	
	\$13,500 per family plan per calendar year	\$27,000 per family plan 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, 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>	

Find other important information about Blues benefits and membership at [bcbsm.com/importantinfo](https://bcbsm.com/importantinfo).

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

Benefits	In-network	Out-of-network
<b>Preventive care</b>		
<b>Preventive medical, prescription drugs and immunizations include:</b> 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
<b>Screening colonoscopy</b>	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
<b>Pediatric services</b>		
<b>Well baby and child</b>	Covered 100% with no deductible, copay or coinsurance	Not covered
<b>Pediatric dental</b>	Stand-alone plan available for purchase	
<b>Pediatric vision</b>	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
<b>Ambulatory services</b>		
<b>Physician office visits, presurgical consultations and office consultations, and retail health clinic visits</b>	\$25 copay per primary care office visit, or retail health clinic visit with no deductible. Specialist office visits subject to deductible. Diagnostic and laboratory services are subject to the deductible. After the deductible is met, office visits are covered at 100%.	Not covered
<b>Urgent care — physician's office and retail health clinic</b>	\$25 copay per primary care office visit, or retail health clinic visit with no deductible. Specialist office visits subject to deductible. Diagnostic and laboratory services are subject to the deductible. After the deductible is met, office visits are covered at 100%.	Not covered
<b>Laboratory and diagnostic services</b>		
<b>Laboratory tests and pathology</b>	Covered 100% after deductible	Covered 100% after deductible
<b>Diagnostic tests and X-rays (including electrocardiogram, chest X-ray)</b>	Covered 100% after deductible	Covered 100% after deductible
<b>Imaging Services: CT scans, MRIs, PET, etc.</b> Prior authorization required	Covered 100% after deductible	Covered 100% after deductible

Benefits	In-network	Out-of-network
<b>Laboratory and diagnostic services</b> <i>continued</i>		
<b>Allergy testing and therapy in a physician's office</b>	Covered 100% after deductible	Not covered
<b>Maternity and newborn care</b>		
<b>Maternity benefit</b>	Covered 100% after deductible	Covered 100% after deductible
<b>Prenatal visits</b>	Covered 100% with no deductible, copay or coinsurance. Diagnostic and laboratory services are subject to the deductible.	Covered 100% after deductible. Diagnostic and laboratory services are subject to the deductible.
<b>Postnatal visits</b>	Covered 100% after deductible. Diagnostic and laboratory services are subject to the deductible.	Covered 100% after deductible. Diagnostic and laboratory services are subject to the deductible.
<b>Emergency services</b>		
<b>Emergency room</b>	Covered 100% after in-network deductible	
<b>Ambulance services</b>	Covered 100% after in-network deductible	
<b>Urgent care visits</b> Urgent care center or outpatient location	Covered 100% after deductible	Covered 100% after deductible
<b>Hospitalization and other services</b>		
<b>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</b> BCBSM-participating facilities only	Covered 100% after deductible	Covered 100% after deductible
<b>Physician surgical services</b>	Covered 100% after deductible	Covered 100% after deductible
<b>Home health care</b> BCBSM-participating agencies only	Covered 100% after deductible	Not covered
<b>Chemotherapy</b>	Covered 100% after deductible	Covered 100% after deductible
<b>Organ transplant and specified organ transplant</b> BCBSM-designated facilities only	Covered 100% after deductible	Covered 100% after deductible
<b>Sleep studies including testing and surgeries</b>	Covered 100% after deductible	Covered 100% after deductible
<b>Bariatric surgery — once per lifetime</b>	Covered 100% after deductible	Covered 100% after deductible
<b>Male voluntary sterilization</b>	Covered 100% after deductible	Covered 100% after deductible
<b>Rehabilitative and habilitative services and devices</b>		
<b>Outpatient physical and occupational therapy</b>	Covered 100% after deductible	Covered 100% after deductible
<b>Chiropractic spinal manipulation and osteopathic manipulative therapy</b>	Limited to a combined maximum of 30 visits per member per calendar year	Limited to a combined maximum of 30 visits per member per calendar year

Benefits	In-network	Out-of-network
<b>Rehabilitative and habilitative services and devices</b> <i>continued</i>		
<b>Speech therapy</b>	Covered 100% after deductible Limited to a maximum of 30 visits per member per calendar year	Covered 100% after deductible Limited to a maximum of 30 visits per member per calendar year
<b>Cardiac and pulmonary rehabilitation</b>	Covered 100% after deductible Limited to a combined maximum of 30 visits per member per calendar year	Covered 100% after deductible Limited to a combined maximum of 30 visits per member per calendar year
<b>Specified autism spectrum disorder — applied behavioral analysis</b>	Covered 100% after deductible. Services must be preauthorized by Blue Cross.	Covered 100% after deductible. Services must be preauthorized by Blue Cross.
<b>Durable medical equipment and prosthetic and orthotic appliances</b> BCBSM-participating providers only	Covered 100% after deductible	Covered 100% after deductible
<b>Diabetes supplies and outpatient diabetes self-management training</b>	Covered 100% after deductible	Covered 100% after deductible
<b>Mental health and substance abuse</b>		
<b>Inpatient and residential mental health</b> BCBSM-participating facilities only	Covered 100% after deductible	Covered 100% after deductible
<b>Outpatient mental health</b>	Covered 100% after deductible	Covered 100% after deductible
<b>Inpatient and residential substance abuse</b> BCBSM-participating facilities only	Covered 100% after deductible	Not covered
<b>Outpatient substance abuse</b> BCBSM-participating programs only	Covered 100% after deductible	Not covered
<b>Prescription drugs</b>		
<b>Prescription drugs 1 to 30 days</b> (retail network pharmacy and mail-order provider)	<b>Tier 1 — Generic:</b> Covered 100% after in-network integrated deductible <b>Tier 2 — Preferred brand:</b> Covered 100% after in-network integrated deductible <b>Tier 3 — Nonpreferred brand:</b> Covered 100% after in-network integrated deductible <b>Tier 4 — Preferred specialty:</b> Covered 100% after in-network integrated deductible (30 day supply only) <b>Tier 5 — Nonpreferred specialty:</b> Covered 100% after in-network integrated deductible (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 difference between the out-of-network pharmacy's charge and the Blue Cross-approved amount for the drug.

Benefits	In-network	Out-of-network
<b>Prescription drugs</b> <i>continued</i>		
<b>Prescription drugs 31 to 60 days</b> Note: Specialty drugs (Tier 4 and 5) are limited to a 30-day supply. <b>(mail order only)</b>	<b>Tier 1 — Generic:</b> Covered 100% after in-network integrated deductible <b>Tier 2 — Preferred brand:</b> Covered 100% after in-network integrated deductible <b>Tier 3 — Nonpreferred brand:</b> Covered 100% after in-network integrated deductible <b>Tier 4 - Preferred specialty:</b> Not covered <b>Tier 5 – Nonpreferred specialty:</b> Not covered	Not covered
<b>Prescription drugs 61-90 days</b> <b>Note:</b> Specialty drugs (Tier 4 and 5) are limited to a 30-day supply. <b>(90 day retail network pharmacy and mail order only)</b>	<b>Tier 1 — Generic:</b> Covered 100% after in-network integrated deductible <b>Tier 2 — Preferred brand:</b> Covered 100% after in-network integrated deductible <b>Tier 3 — Nonpreferred brand:</b> Covered 100% after in-network integrated deductible <b>Tier 4 - Preferred specialty:</b> Not covered <b>Tier 5 – Nonpreferred specialty:</b> Not covered	Not covered
<b>Notes</b> 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 BCN'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 BCN 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, PRK 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 Care Network 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 BCN-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.**



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