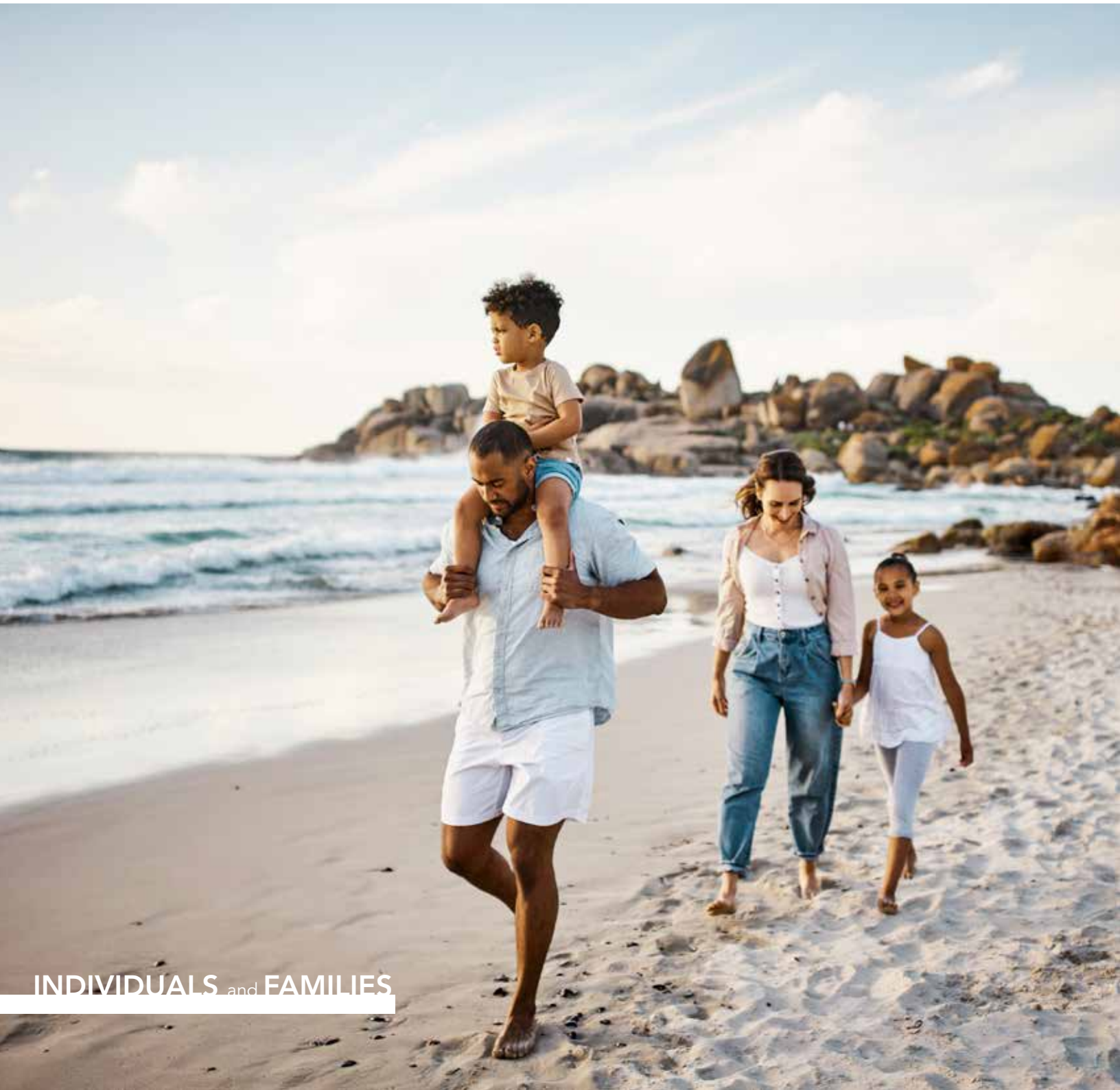
MyBlue℠

2023

Health care plan comparison guide



INDIVIDUALS and FAMILIES

The Blue Cross difference

There should be more to your health care coverage than deductibles, copays and out-of-pocket costs. The experience, reputation and resources behind that coverage should make you feel confident every time you use your plan's ID card.

As the largest and one of the most reputable and reliable health care companies in Michigan, Blue Cross Blue Shield of Michigan and our HMO partner, Blue Care Network, are confident that we can help you get the most from your health care plan. Throughout our 84-year history, we've worked to maintain this promise by building a hard-earned reputation, in-depth experience, and quality selection of health care plans. That's why we're the right choice for your health plan needs.

What other health care company in Michigan can give you first-class coverage that's universally recognized around the country? **Only Blue Cross.** This reputation is one of the many reasons people in this state choose us more than any other health care company.

The numbers add up:

- Blue Cross is Michigan's largest health care company, serving **4.65 million people** here and almost 1.3 million more in other states. We have the **largest network of doctors and hospitals in Michigan** with 136 hospitals and more than 25,000 doctors.
- Blue Care Network is the largest HMO in Michigan with more than **832,000 members**, and a provider network that includes more than **5,000 primary care providers**, over **26,000 specialists** and most of the state's leading hospitals.
- Blue Dental℠ members have access to **130,000 dentists** around the country, including 3,600 in Michigan.

We're here to help

When you have questions about your plan, we want to answer them as quickly and simply as possible. We offer a variety of resources you can use to get answers, find information and talk to experts.

These resources include:

Our comprehensive website, **bcbsm.com**

- Blue Cross health plan advisors who can help you narrow your plan choices and help determine if you're eligible for a subsidy on the Marketplace. We're here to help. Just call **1-877-4MY-BLUE** (469-2583)
- More than **3,000 agents** throughout Michigan who are trained and certified to help you choose and enroll in a health care plan
- Your Blue Cross or Blue Care Network member ID card, where you can find our toll-free **Customer Service** number on the back

Inside:

Highlights for 2023

New services and savings

- New virtual plans with $1 copay
- Postnatal visits are treated same as preventative prenatal visits
- Livongo® Whole Person Solutions
- New Local HMO network in Southeast Michigan
- HMO plans will have Blue Cross personalized medicine
- New Maternity Foundation program

BCBSM mobile app

Your health information is secure when you use the BCBSM mobile app. **Protecting your information is our top priority.** You can be sure that using the mobile app is a safe and secure way to access information about your health plan.

We protect all information through secured connections, and regularly update our information systems to stay current and ensure the security of your data.

What you can do with the app:

- View deductible and other plan balances
- Check claims and explanation of benefits statements
- See medical, dental and vision coverage
- Research drug prices
- Access HealthEquity® spending account balances
- View and share member ID card
- Find doctors and hospitals and compare costs for services
- Access to Blue365® member discounts

As part of your plan, you can:

- Call our 24-Hour Nurse Line and speak to a registered nurse.
- View our weekly Virtual Well-Being℠ webinars. Topics include mindfulness, finances, emotional health and more.
- Use our online well-being tools and resources through Blue Cross Health & Well-Being powered by WebMD®.
- Take part in our Tobacco Coaching program.
- Sign up for paperless billing and explanation of benefits statements in your member account.

Download the app now
Get the BCBSM mobile app wherever you normally download apps for your device. For more information, visit **bcbsm.com/app**.

WebMD Health Services is an independent company supporting Blue Cross Blue Shield of Michigan and Blue Care Network by providing health and well-being services.

Blue Cross Coordinated Care℠ – Care that's centered around you

What is it?

This program identifies members with complex or chronic conditions that could benefit from care management support and connects them to care.

How does it work?

A registered nurse leads a Blue Cross care team that works with members to help them develop a plan to better manage their conditions.

Doctors, dietitians and social workers are among the specialists that make up the Blue Cross care team. Together, they help members:

- Identify health risks
- Connect with support in local communities
- Better understand treatment options
- Find behavioral health services and other care.

Members can conveniently stay connected to their care plans through the BCBSM Coordinated Care app, powered by Wellframe[1].

Where do I start?

Members identified for the program will receive a call from a BCBSM registered nurse to get started.

[1]*Wellframe is an independent company supporting Blue Cross Blue Shield of Michigan by providing the BCBSM Coordinated Care mobile app.*

Key plan benefits for 2023

	HSA-plans	*PPO non-HSA plans*	*HMO non-HSA plans*
Free Annual visit	X	X	X
Free Wellness visits for kids	X	X	X
Free Vaccinations	X	X	X
Free Health Savings Accounts (HSAs)	X		
Free diabetes test strips, lancets and connected devices with diabetes, pre-diabetes and hypertension management programs	X	X	X
Free app - myStrength by Livongo® for Behavioral Health	X	X	X
Free online visits	X (after deductible)	X	X
Free app — access to cost and transparency tools	X	X	X
Discounts at gyms	X	X	X
Blue 365 Discounts on vitamins, food, retailers, etc.	X	X	X
Access to virtual visits and retail health clinics	X	X	X
Free Health Equity HSA bank	X		
Urgent care with a copay before deductible		X	X
Free laboratory and pathology tests			X*
Primary and behavioral health office visits including virtual with a copay before deductible		X**	X
Retail health visit with a copay before deductible (same as primary office visit copay)		X**	X
Free Blue Cross Personalized Medicine Program	X***		X
Free Maternity Foundation program	X	X	X

*HMO Bronze plans have a $10 copay and HMO Extra plans apply deductible and coinsurance
**PPO Extra Plans Only
***Only for HMO plans, not PPO

Additional health benefits and support programs available at no cost to you

Maternity program

Working together with **Maven**, this program provides pregnant members and spouses on their health plan full virtual support for nine months of pregnancy and three months of postpartum. It includes:

A care advocate	Personalized resources	24/7 on-demand video appointments*
You'll be matched to a care advocate based on personal preferences who can: • Provide personalized, one-on-one support to answer questions • Recommend the right types of virtual coaches for specific needs • Help find high quality, in-network providers	Access a library of content personalized to your specific journey: • Content includes prenatal health, postpartum depression, returning to work with confidence and more • Articles are trustworthy and clinically approved • Community forums are available to engage with members on similar journeys	Schedule video appointments with top-rated virtual coaches: • Speak with coaches from more than 30 specialties, including OB-GYNs, mental health specialists, lactation consultants, nutritionists, doulas, and career and sleep coaches • Coaches are available to speak with in more than 35 languages

*Maven virtual coaches don't replace in-person care or relationships with your established care teams and providers. They're additional resources for you to schedule appointments when your providers aren't available.

You'll get support:

- For prenatal and postpartum time periods
- For high-risk pregnancy management
- To help reduce preterm births, low birth weight and C-sections
- If you have an infant in the NICU
- To prepare for returning to work

You can download the Maven app and register when this program is available on January 1, 2023.

Maven is an independent company supporting Blue Cross Blue Shield of Michigan and Blue Care Network by providing family building and maternity support services.

Livongo® Whole Person Solutions

This program combines advanced technology, coaching and support for mental health and chronic medical conditions to help people live happier, healthier lives.

Available personalized plans:

- Diabetes
- Hypertension
- Diabetes prevention

By participating, you and covered family members get access to:

- **Connected devices:** Depending on your health goals, you could receive a free blood glucose meter, blood pressure monitor and smart scale; each sends readings to your private account on an easy-to-use app.
- **Coaching anytime and anywhere:** Ask expert coaches your questions on nutrition, medications or anything else related to your health. Together, you'll create a custom plan to meet your needs and focus on health areas that are important to you.
- **Digital behavioral health support:** Get 24/7 access to practical tips and techniques that help you better manage stress, sleep, anxiety, depression, weight and more.

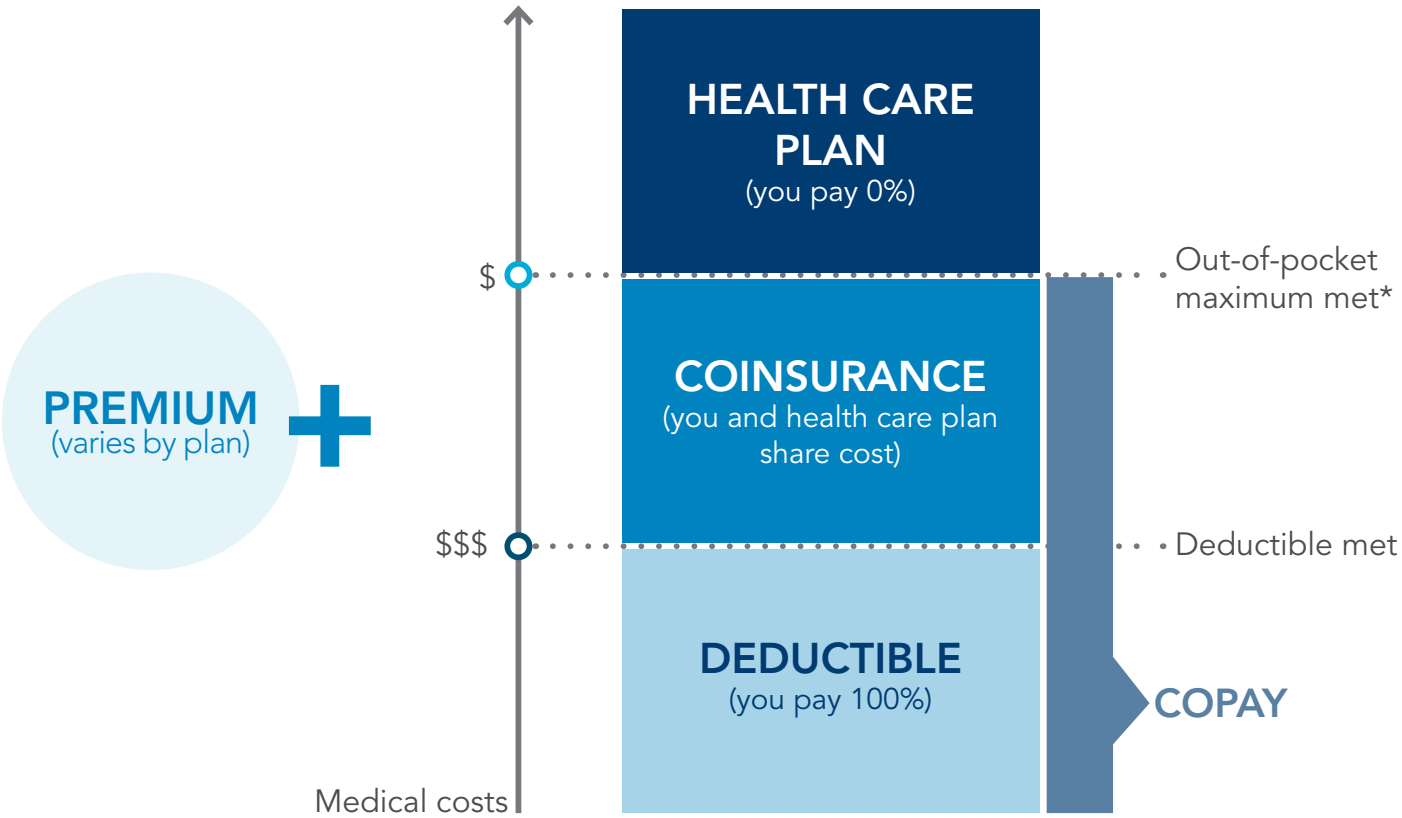
Learn more and join today at **hi.livongo.com/BLUECROSSMI/new** or call **1-800-945-4355**.

Use registration code: **BLUECROSSMI**

Livongo® is an independent company that provides diabetes management services on behalf of Blue Cross Blue Shield of Michigan and Blue Care Network.

Health plan costs explained

Understanding how your costs work will help you know when and how much you need to pay for care.



Premium: The monthly amount you pay Blue Cross to keep your coverage

Copayment (or copay): A fixed amount you pay for a covered health care service, usually when you get the service, such as a doctor visit

Deductible: The amount you owe for covered health care services before Blue Cross begins to pay

Coinsurance: Your share, or percentage, of the allowable costs for a covered health care service

Out-of-pocket maximum: The most you'll pay in deductibles, copayments and coinsurance during the year

* Learn about gold plans on page 10, bronze plans on page 16.

We have provider networks to fit your needs

Network types

PPO

A PPO, or preferred provider organization, has a broad network of doctors and hospitals. You can choose any doctor you want, both in and out of network, and don't need referrals from a primary care provider to see a specialist. With a PPO, you'll pay less out of pocket when you use an in-network provider.

Below you will find your choice of network options. Within the chart, look at how each of the plans might fit into your health care journey.

Network name	***Premier PPO***	***Preferred HMO***
Network description	You'll have a broad choice of doctors and hospitals within Blue Cross' statewide PPO network, including nationwide coverage for medical emergency, accidental injury or urgent care. You may receive services from hospitals or doctors outside the network within Michigan, but you'll pay less if you use providers within the network.	This plan offers a broad choice of doctors and hospitals from BCN's entire network, the largest HMO network in Michigan. Your primary care provider will coordinate care and refer you to specialists when necessary. Other than emergency services and accidental injuries, care outside the network isn't covered.
Plan offered by	Blue Cross Blue Shield of Michigan	Blue Care Network
Out-of-network coverage Care you receive from an out-of-network hospital or doctor while traveling within Michigan	Yes	Emergencies and accidental injuries only
Coverage outside of Michigan Includes traveling abroad	Emergencies and accidental injuries have in-network cost sharing. Scheduled services from a participating provider will apply out-of-network cost sharing (2x in-network cost sharing).	Emergencies and accidental injuries only
Participating primary care providers Numbers are estimates and subject to change	6,488*	6,400
Participating hospitals and systems Numbers are subject to change	136 Michigan hospitals	134 participating hospitals

*PPO Here are some changes that reduced the # of PCP s in PPO:

1) Only doctors self-reported as PCPs are included for the network. Prior to June 2019, PCPs with traditional primary care specialties (internal medicine, family practice, pediatrics, etc.) were used to calculate PCPs. This new method has led to greater accuracy of those serving as PCPs. Although the methodology for counting our PCP's has changed, we still review our PCPs multiple times a year against NCQA, DIFS and CMS access standards to ensure we continually meet standards. Effective June 2019, we began using PCP Selectable to identify PCP providers.

2) Effective August 2019, we count OB-GYNs as specialists, not PCPs.

3) Effective August 2019, nurse practitioners are no longer counted as PCPs.

HMO

With an HMO, or health maintenance organization, you choose a primary care provider who coordinates your care and provides referrals to specialists. You'll need to pick a Blue Care Network primary care provider in the HMO network and only use hospitals that participate in your plan's network. Other than emergency services and accidental injuries, health care services provided outside the network aren't covered.

Select HMO	***Metro Detroit HMO***	***Local HMO***
You may choose from a select network of quality, primary care providers and have complete access to specialists and hospitals within BCN's network, the largest HMO network in Michigan. Your primary care provider will coordinate care and refer you to specialists when necessary. Other than emergency services and accidental injuries, care outside the network isn't covered.	This plan offers care within a network of quality doctors and hospitals in Wayne, Oakland and Macomb counties. A primary care provider will coordinate your care. Care within BCN's entire HMO network, but outside the Metro Detroit HMO network, will require primary care provider and plan authorization. Other than emergency services and accidental injuries, care outside the network isn't covered.	This plan offers care within a network of quality doctors and hospitals in Wayne, Oakland and Macomb counties. A primary care provider will coordinate your care. Care with BCN's entire HMO network, but outside the Local HMO network, will require primary care provider and plan authorization. Other than emergency services and accidental injuries, care outside the network isn't covered.
Blue Care Network	Blue Care Network	Blue Care Network
Emergencies and accidental injuries only	Emergencies and accidental injuries only	Emergencies and accidental injuries only
Emergencies and accidental injuries only	Emergencies and accidental injuries only	Emergencies and accidental injuries only
4,701	998	1,054
134 participating hospitals	27 participating hospitals, including: • Beaumont Hospital (Botsford) • Beaumont Hospital (Oakwood) • Children's Hospital of Michigan • DMC • Providence Hospital • St. Joseph Mercy Hospital • St. Mary Mercy Hospital • St. John Hospital	12 participating hospitals with Ascension and Trinity Health systems

– Location was limited to MI and each NPI number was counted only once

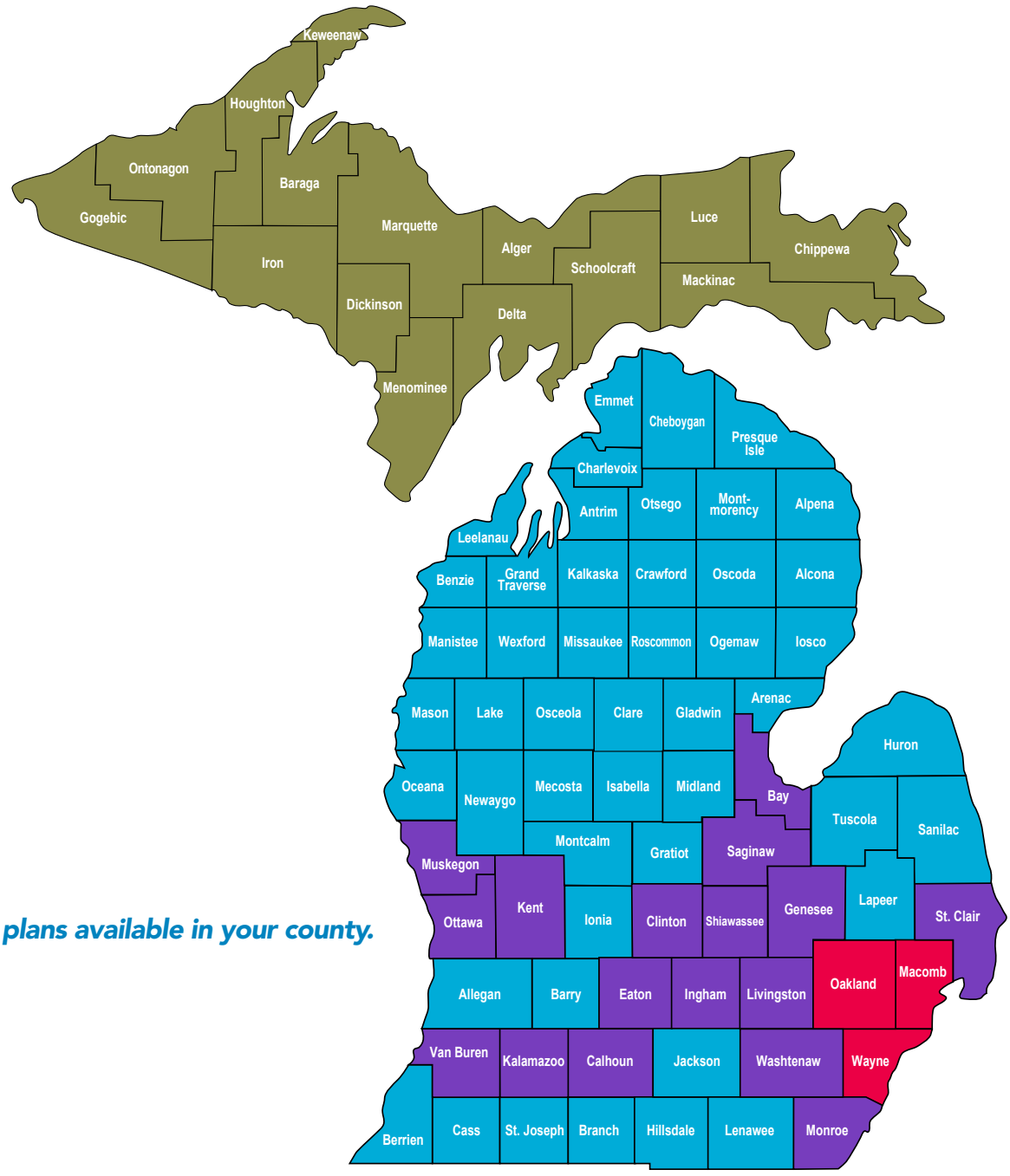
– Data was limited to primary and specialty only

2023 health plans available in Michigan by county

In 2023, Blue Cross offers plan choices that meet Affordable Care Act standards in all 83 Michigan counties. Use this map to see which plans are available in your area.

PPO options	PPO options	PPO options	PPO options
Blue Cross® Premier Gold Gold Extra Silver Saver/Silver Extra/Silver Off Marketplace Bronze/Bronze Extra/ Bronze Secure Value	**Blue Cross® Premier** Gold Gold Extra Silver/Silver Extra/Silver Saver/ Silver Off Marketplace Bronze/Bronze Extra/ Bronze Secure Value	**Blue Cross® Premier** Gold Gold Extra Silver/Silver Extra/Silver Saver/ Silver Off Marketplace Bronze/Bronze Extra/ Bronze Secure Value	**Blue Cross® Premier** Gold Gold Extra Silver/Silver Extra/Silver Saver/ Silver Off Marketplace Bronze/Bronze Extra/ Bronze Secure Value

HMO options	HMO options	HMO options	HMO options
Blue Cross® Preferred Gold Gold Extra Silver Saver/Silver Extra/ Silver Off Marketplace Bronze/Bronze Saver/ Virtual Primary Care Bronze/ Bronze Extra/Bronze Secure Value	**Blue Cross® Preferred** Gold Gold Extra Silver/Silver Extra/Silver Saver/ Silver Off Marketplace/ Virtual Primary Care Silver Bronze/Bronze Saver/ Virtual Primary Care Bronze/ Bronze Extra/Bronze Secure Value	**Blue Cross® Preferred** Gold Gold Extra Silver/Silver Extra/Silver Saver/ Silver Off Marketplace/ Virtual Primary Care Silver Bronze/Bronze Saver/ Virtual Primary Care Bronze/ Bronze Extra/Bronze Secure **Blue Cross® Select** Silver/Silver Extra/Silver Saver/ Silver Off Marketplace Bronze/Bronze Saver/ Bronze Extra/Bronze Secure Value	**Blue Cross® Preferred** Gold Gold Extra Silver/Silver Extra/Silver Saver/ Silver Off Marketplace/ Virtual Primary Care Silver Bronze/Bronze Extra/ Bronze Saver/Virtual Primary Care Bronze/Bronze Secure **Blue Cross® Select** Silver/Silver Extra/Silver Saver/ Silver Off Marketplace Bronze/Bronze Extra/ Bronze Secure/Bronze Saver Value **Blue Cross® Metro Detroit HMO** Silver/Silver Extra/Silver Saver/ Silver Off Marketplace Bronze/Bronze Saver/ Bronze Extra/Bronze Secure **Blue Cross® Local HMO** Silver/Silver Extra/Silver Saver/ Silver Off Marketplace Bronze/Bronze Saver/Bronze Secure/Bronze Extra



Map of health plans available in your county.

Gold health plan comparison

PPO

	Blue Cross® Premier PPO Gold	Blue Cross® Premier PPO Gold Extra
Annual deductible Medical and drug expenses are combined to meet the integrated deductible.	$1,050 per individual plan $2,100 per family plan	$2,000 per individual plan $4,000 per family plan
Coinsurance	20% after deductible for most services	25% after deductible for most services
Out–of–pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out–of–pocket maximum.	$8,000 per individual plan $16,000 per family plan	$8,700 per individual plan $17,400 per family plan
HSA qualified	No	No
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible	Covered 100% with no deductible
Physician office visits	$30 copay per primary care visit after deductible; $50 copay per specialist visit after deductible Diagnostic and laboratory services are subject to deductible and coinsurance	$30 copay per primary care office visit with no deductible and a $60 copay per specialist office visit with no deductible. Diagnostic and laboratory services are subject to deductible and coinsurance
Retail health clinic visit Ex: Going to the clinic at a major pharmacy or retail store for basic health care services on a walk-in basis.	$30 copay after deductible Diagnostic and laboratory services are subject to deductible and coinsurance	$30 copay with no deductible Diagnostic and laboratory services are subject to deductible and coinsurance
Blue Cross Online Visits℠ Blue Cross' enhanced 24/7 online health care, accessed through smartphone, tablet or computer, includes visits with medical doctors and behavioral health therapists.	$0 copay with no deductible for medical online visits, $30 copay after deductible for behavioral health online visits	$0 copay with no deductible for medical online visits, $30 copay with no deductible for behavioral health online visits
Laboratory tests and pathology	Covered 80% after deductible	Covered 75% after deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for certain services.	Covered 80% after deductible	Covered 75% after deductible
Inpatient hospital care – semi-private room	Covered 80% after deductible	Covered 75% after deductible
Surgical care	Covered 80% after deductible	Covered 75% after deductible
Emergency room	$250 copay after deductible, then covered 80% Copay waived if admitted	Covered 75% after deductible
Transportation by ambulance	Covered 80% after deductible	Covered 75% after deductible
Urgent care visits at urgent care centers or outpatient locations	$75 copay with no deductible Diagnostic and laboratory services are subject to deductible and coinsurance	$45 copay with no deductible Diagnostic and laboratory services are subject to deductible and coinsurance
Pediatric vision	Covered 100%: One vision exam per pediatric member per year Covered 100%: Standard lenses and frames or contact lenses Frequency limits apply	Covered 100%: One vision exam per pediatric member per year. Covered 100%: Standard lenses and frames or contact lenses. Frequency limits apply
Prescription drugs 1–30 days Includes retail network pharmacies and mail-order providers. *Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to deductibles, cost-sharing or out of pocket maximums.*	**Generic:** $15 copay after integrated deductible **Preferred brand:** $100 copay after integrated deductible **Nonpreferred brand:** $150 copay after integrated deductible **Preferred specialty:** 40% coinsurance after integrated deductible **Nonpreferred specialty:** 45% coinsurance after integrated deductible	**Generic:** $15 copay with no deductible **Preferred brand:** $30 copay with no deductible **Nonpreferred brand:** $60 copay with no deductible **Preferred specialty:** $250 copay with no deductible **Nonpreferred specialty:** $250 copay with no deductible

HMO

Blue Cross® Preferred HMO Gold	Blue Cross® Preferred HMO Gold Extra
$1,600 per individual plan $3,200 per family plan	$2,000 per individual plan $4,000 per family plan
20% after deductible for most services	25% after deductible for most services
$9,100 per individual plan $18,200 per family plan	$8,700 per individual plan $17,400 per family plan
No	No
Covered 100% with no deductible	Covered 100% with no deductible
$30 copay per primary care office visit with no deductible $50 copay per specialist office visit after deductible Radiology and diagnostic services are subject to deductible and coinsurance	$30 copay per primary care office visit with no deductible and a $60 copay per specialist office visit with no deductible. Diagnostic and laboratory services subject to deductible and coinsurance
$30 copay with no deductible Radiology and diagnostic services are subject to deductible and coinsurance	$30 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance
$0 copay with no deductible for medical online visits, $30 copay with no deductible for behavioral health online visits	$0 copay with no deductible for medical online visits, $30 copay with no deductible for behavioral health online visits
Covered 100% with no deductible	Covered 75% after deductible
Covered 80% after deductible	Covered 75% after deductible
Covered 80% after deductible	Covered 75% after deductible
Covered 80% after deductible	Covered 75% after deductible
$250 copay after deductible, then covered 80% Copay waived if admitted	Covered 75% after deductible
Covered 80% after deductible	Covered 75% after deductible
$40 copay with no deductible Radiology services are subject to deductible and coinsurance	$45 copay with no deductible Diagnostic and laboratory services are subject to deductible and coinsurance
Covered 100%: One vision exam per pediatric member per year Covered 100%: Standard lenses and frames or contact lenses Frequency limits apply	Covered 100%: One vision exam per pediatric member per year Covered 100%: Standard lenses and frames or contact lenses Frequency limits apply
Preferred generic: $4 copay after integrated deductible **Generic:** $20 copay after integrated deductible **Preferred brand:** $100 copay after integrated deductible **Nonpreferred brand:** $150 copay after integrated deductible **Preferred specialty:** 40% coinsurance after integrated deductible **Nonpreferred specialty:** 45% coinsurance after integrated deductible	**Preferred Generic:** $15 copay with no deductible **Nonpreferred Generic:** $15 copay with no deductible **Preferred brand:** $30 copay with no deductible **Nonpreferred brand:** $60 copay with no deductible **Preferred specialty:** $250 copay with no deductible **Nonpreferred specialty:** $250 copay with no deductible

The plan information shown is for in-network benefits. Please visit **bcbsm.com/sbc** or log in to your account at **bcbsm.com** to view additional plan details and documentation.

PPO

	Blue Cross® Premier PPO Silver Extra	Blue Cross® Premier PPO Silver
Annual deductible Medical and drug expenses are combined to meet the integrated deductible.	$5,800 per individual plan $11,600 per family plan	$2,875 per individual plan $5,750 per family plan
Coinsurance	40% after deductible for most services	20% after deductible for most services
Out–of–pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out–of–pocket maximum.	$8,900 per individual plan $17,800 per family plan	$8,800 per individual plan $17,600 per family plan
HSA qualified	No	No
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible	Covered 100% with no deductible
Physician office visits	$40 copay per primary care office visit with no deductible and a $80 copay per specialist office visit with no deductible Diagnostic and laboratory services subject to deductible and coinsurance	$30 copay per primary care office visit after deductible and a $50 copay per specialist office visit after deductible Diagnostic and laboratory services subject to deductible and coinsurance
Retail health clinic visit Ex: Going to the clinic at a major pharmacy or retail store for basic health care services on a walk-in basis.	$40 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance	$30 copay after deductible Diagnostic and laboratory services subject to deductible and coinsurance
Blue Cross Online Visits℠ Blue Cross' enhanced 24/7 online health care, accessed through smartphone, tablet or computer, includes visits with medical doctors and behavioral health therapists.	$0 copay with no deductible for medical online visits, $40 copay with no deductible for behavioral health online visits	$0 copay with no deductible for medical online visits, $30 copay after deductible for behavioral health online visits
Laboratory tests and pathology	Covered 60% after deductible	Covered 80% after deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for certain services.	Covered 60% after deductible	Covered 80% after deductible
Inpatient hospital care – semi-private room	Covered 60% after deductible	Covered 80% after deductible
Surgical care	Covered 60% after deductible	Covered 80% after deductible
Emergency room	Covered 60% after deductible	$250 copay after deductible, then covered 80% Copay waived if admitted
Transportation by ambulance	Covered 60% after deductible	Covered 80% after deductible
Urgent care visits at urgent care centers or outpatient locations	$60 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance	$75 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance
Maternity benefit	Covered 60% after deductible	Covered 80% after deductible
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
Prescription drugs 1–30 days Includes retail network pharmacies and mail-order providers. *Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to deductibles, cost-sharing or out of pocket maximums.*	**Generic:** $20 copay with no deductible **Preferred brand:** $40 copay with no deductible **Nonpreferred brand:** $80 copay after integrated deductible **Preferred specialty:** $350 copay after integrated deductible **Nonpreferred specialty:** $350 copay after integrated deductible	**Generic:** $15 copay after deductible **Preferred brand:** $100 copay after deductible **Nonpreferred brand:** $150 copay after deductible **Preferred specialty:** 40% coinsurance after integrated deductible **Nonpreferred specialty:** 45% coinsurance after integrated deductible

Blue Cross® Premier PPO Silver Off Marketplace	Blue Cross® Premier PPO Silver Saver HSA
$3,600 per individual plan $7,200 per family plan	$3,400 per individual plan $6,800 per family plan
20% after deductible for most services	20% after deductible for most services
$9,100 per individual plan $18,200 per family plan	$7,050 per individual plan $14,100 per family plan
No	Yes
Covered 100% with no deductible	100% with no deductible
$30 copay per primary care office visit after deductible and a $50 copay per specialist office visit after deductible Diagnostic and laboratory services subject to deductible and coinsurance	$30 copay per primary care office visit after deductible and a $50 copay per specialist office visit after deductible Diagnostic and laboratory services subject to deductible and coinsurance
$30 copay after deductible Diagnostic and laboratory services subject to deductible and coinsurance	$30 copay after deductible Diagnostic and laboratory services subject to deductible and coinsurance
$0 copay with no deductible for medical online visits, $30 copay after deductible for behavioral health online visits	$0 copay after deductible for medical online visits, $30 copay after deductible for behavioral health online visits
Covered 80% after deductible	Covered 80% after deductible
Covered 80% after deductible	Covered 80% after deductible
Covered 80% after deductible	Covered 80% after deductible
Covered 80% after deductible	Covered 80% after deductible
$250 copay after deductible, then covered 80% Copay waived if admitted	$250 copay after deductible, then covered 80% Copay waived if admitted
Covered 80% after deductible	Covered 80% after deductible
$75 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance	$75 copay after deductible Diagnostic and laboratory services subject to deductible and coinsurance
Covered 80% after deductible	Covered 80% after deductible
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The plan information shown is for in-network benefits. Please visit **bcbsm.com/sbc** or log in to your account at **bcbsm.com** to view additional plan details and documentation.

HMO

	Blue Cross® Preferred HMO Silver Extra Blue Cross® Select HMO Silver Extra Blue Cross® Metro Detroit HMO Silver Extra Blue Cross® Local HMO Silver Extra	Blue Cross® Preferred HMO Silver Blue Cross® Select HMO Silver Blue Cross® Metro Detroit HMO Silver Blue Cross® Local HMO Silver
Annual deductible Medical and drug expenses are combined to meet the integrated deductible.	$5,800 per individual plan $11,600 per family plan	$4,650 per individual plan $9,300 per family plan
Coinsurance	40% after deductible for most services	20% after deductible for most services
Out–of–pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out–of–pocket maximum.	$8,900 per individual plan $17,800 per family plan	$9,100 per individual plan $18,200 per family plan
HSA qualified	No	No
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible	Covered 100% with no deductible
Physician office visits	$40 copay per primary care office visit with no deductible $80 copay per specialist office visit with no deductible Radiology and diagnostic services subject to deductible and coinsurance	$30 copay per primary care office visit with no deductible $50 copay per specialist office visit after deductible Radiology and diagnostic services subject to deductible and coinsurance
Retail health clinic visit Ex: Going to the clinic at a major pharmacy or retail store for basic health care services on a walk-in basis.	$40 copay with no deductible Radiology and diagnostic services subject to deductible and coinsurance	$30 copay with no deductible Radiology and diagnostic services subject to deductible and coinsurance
Blue Cross Online Visits℠ Blue Cross' enhanced 24/7 online health care, accessed through smartphone, tablet or computer, includes visits with medical doctors and behavioral health therapists.	$0 copay with no deductible for medical online visits, $40 copay with no deductible for behavioral health online visits	$0 copay with no deductible for medical online visits, $30 copay with no deductible for behavioral health online visits
Laboratory tests and pathology	Covered 60% after deductible	Covered 100% with no deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for certain services.	Covered 60% after deductible	Covered 80% after deductible
Inpatient hospital care – semi-private room	Covered 60% after deductible	Covered 80% after deductible
Surgical care	Covered 60% after deductible	Covered 80% after deductible
Emergency room	Covered 60% after deductible	$250 copay after deductible, then covered 80% Copay waived if admitted
Transportation by ambulance	Covered 60% after deductible	Covered 80% after deductible
Urgent care visits at urgent care centers or outpatient locations	$60 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance	$40 copay with no deductible Radiology and diagnostic services subject to deductible and coinsurance
Maternity benefit	Covered 60% after deductible	Covered 80% after deductible
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
Prescription drugs 1–30 days Includes retail network pharmacies and mail-order providers. *Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to deductibles, cost-sharing or out of pocket maximums.*	**Preferred generic:** $20 copay with no deductible **Generic** $20 copay with no deductible **Preferred brand:** $40 copay with no deductible **Nonpreferred brand:** $80 after integrated deductible **Preferred specialty:** $350 copay after integrated deductible **Nonpreferred specialty:** $350 copay after integrated deductible	**Preferred generic:** $4 copay after integrated deductible **Generic:** $20 copay after integrated deductible **Preferred brand:** $100 copay after integrated deductible **Nonpreferred brand:** $150 copay after integrated deductible **Preferred specialty:** 40% coinsurance after integrated deductible **Nonpreferred specialty:** 45% coinsurance after integrated deductible

Blue Cross® Preferred HMO Silver Off Marketplace **Blue Cross® Select HMO Silver Off Marketplace** **Blue Cross® Metro Detroit HMO Silver Off Marketplace** **Blue Cross® Local HMO Silver Off Marketplace**	**Blue Cross® Preferred HMO Silver Saver** **Blue Cross® Select HMO Silver Saver** **Blue Cross® Metro Detroit HMO Silver Saver** **Blue Cross® Local HMO Silver Saver**
$6,000 per individual plan $12,000 per family plan	$5,500 per individual plan $11,000 per family plan
20% after deductible for most services	20% after deductible for most services
$9,100 per individual plan $18,200 per family plan	$8,000 per individual plan $16,000 per family plan
No	No
Covered 100% with no deductible	Covered 100% with no deductible
$30 copay per primary care office visit with no deductible $50 copay per specialist office visit after deductible Radiology and diagnostic services subject to deductible and coinsurance	$45 copay per primary care office visit with no deductible $90 copay per specialist office visit with no deductible Radiology and diagnostic services subject to deductible and coinsurance
$30 copay with no deductible Radiology and diagnostic services subject to deductible and coinsurance	$45 copay with no deductible Radiology and diagnostic services subject to deductible and coinsurance
$0 copay with no deductible for medical online visits, $30 copay with no deductible for behavioral health online visits	$0 copay with no deductible for medical online visits, $45 copay with no deductible for behavioral health online visits
Covered 100% with no deductible	Covered 100% with no deductible
Covered 80% after deductible	Covered 80% after deductible
Covered 80% after deductible	Covered 80% after deductible
Covered 80% after deductible	Covered 80% after deductible
$250 copay after deductible, then covered 80% Copay waived if admitted	$250 copay after deductible, then covered 80% Copay waived if admitted
Covered 80% after deductible	Covered 80% after deductible
$40 copay with no deductible Radiology and diagnostic services subject to deductible and coinsurance	$45 copay with no deductible Radiology and diagnostic services subject to deductible and coinsurance
Covered 80% after deductible	Covered 80% after deductible
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
Preferred generic: $4 copay after integrated deductible **Generic:** $20 copay after integrated deductible **Preferred brand:** $100 copay after integrated deductible **Nonpreferred brand:** $150 copay after integrated deductible **Preferred specialty:** 40% coinsurance after integrated deductible **Nonpreferred specialty:** 45% coinsurance after integrated deductible	**Preferred generic:** $4 copay after integrated deductible **Generic:** $20 copay after integrated deductible **Preferred brand:** $100 copay after integrated deductible **Nonpreferred brand:** $150 copay after integrated deductible **Preferred specialty:** 40% coinsurance after integrated deductible **Nonpreferred specialty:** 45% coinsurance after integrated deductible

PPO

	Blue Cross® Premier PPO Bronze Extra
Annual deductible Medical and drug expenses are combined to meet the integrated deductible.	$7,500 per individual plan $15,000 per family plan
Coinsurance	50% after deductible for most services
Out–of–pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out–of–pocket maximum.	$9,000 per individual plan $18,000 per family plan
HSA qualified	No
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible
Physician office visits	$50 copay per primary care visit with no deductible $100 copay per specialty visit with no deductible Diagnostic and laboratory services subject to deductible
Retail health clinic visit Ex: Going to the clinic at a major pharmacy or retail store for basic health care services on a walk-in basis.	$50 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance
Blue Cross Online Visits℠ Blue Cross' enhanced 24/7 online health care, accessed through smartphone, tablet or computer, includes visits with medical doctors and behavioral health therapists.	$0 copay with no deductible for medical online visits, $50 copay with no deductible for behavioral health online visits
Laboratory tests and pathology	Covered 50% after deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for certain services.	Covered 50% after deductible
Inpatient hospital care – semi-private room	Covered 50% after deductible
Surgical care	Covered 50% after deductible
Emergency room	Covered 50% after deductible
Transportation by ambulance	Covered 50% after deductible
Urgent care visits at urgent care centers or outpatient locations	Covered $75 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance
Maternity benefit	Covered 50% after deductible
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
Prescription drugs 1–30 days Includes retail network pharmacies and mail-order providers. *Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to deductibles, cost-sharing or out of pocket maximums.*	**Generic:** $25 copay with no deductible **Preferred brand:** $50 copay after integrated deductible **Nonpreferred brand:** $100 copay after integrated deductible **Preferred specialty:** $500 copay after integrated deductible **Nonpreferred specialty:** $500 copay after integrated deductible

Blue Cross® Premier PPO Bronze HSA	Blue Cross® Premier PPO Bronze Secure
$7,500 per individual plan $15,000 per family plan	$9,100 per individual plan $18,200 per family plan
None	None
$7,500 per individual plan $15,000 per family plan	$9,100 per individual plan $18,200 per family plan
Yes	No
Covered 100% with no deductible	Covered 100% with no deductible
Primary care and specialist office visits are covered 100% after deductible Diagnostic and laboratory services subject to deductible	Primary care and specialist office visits are covered 100% after deductible Diagnostic and laboratory services subject to deductible
Covered 100% after deductible Diagnostic and laboratory services subject to deductible	Covered 100% after deductible Diagnostic and laboratory services subject to deductible
Covered 100% after deductible	$0 copay with no deductible for medical online visits, $0 copay after deductible for behavioral health online visits
Covered 100% after deductible	Covered 100% after deductible
Covered 100% after deductible	Covered 100% after deductible
Covered 100% after deductible	Covered 100% after deductible
Covered 100% after deductible	Covered 100% after deductible
Covered 100% after deductible	Covered 100% after deductible
Covered 100% after deductible	Covered 100% after deductible
Covered 100% after deductible	Covered 100% after deductible Diagnostic and laboratory services subject to deductible and coinsurance
Covered 100% after deductible	Covered 100% after deductible
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
Generic: Covered 100% after integrated deductible **Preferred brand:** Covered 100% after integrated deductible **Nonpreferred brand:** Covered 100% after integrated deductible **Preferred specialty:** Covered 100% after integrated deductible **Nonpreferred specialty:** Covered 100% after integrated deductible	**Generic:** Covered 100% after integrated deductible **Preferred brand:** Covered 100% after integrated deductible **Nonpreferred brand:** Covered 100% after integrated deductible **Preferred specialty:** Covered 100% after integrated deductible **Nonpreferred specialty:** Covered 100% after integrated deductible

The plan information shown is for in-network benefits. Please visit **bcbsm.com/sbc** or log in to your account at **bcbsm.com** to view additional plan details and documentation.

HMO

	Blue Cross® Preferred HMO Bronze Blue Cross® Select HMO Bronze Blue Cross® Metro Detroit HMO Bronze Blue Cross® Local HMO Bronze	Blue Cross® Preferred HMO Bronze Saver HSA Blue Cross® Select HMO Bronze Saver HSA Blue Cross® Metro Detroit HMO Bronze Saver HSA Blue Cross® Local HMO Bronze Saver HSA
Annual deductible Medical and drug expenses are combined to meet the integrated deductible.	$9,100 per individual plan $18,200 per family plan	$7,500 per individual plan $15,000 per family plan
Coinsurance	None	None
Out–of–pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out–of–pocket maximum.	$9,100 per individual plan $18,200 per family plan	$7,500 per individual plan $15,000 per family plan
HSA qualified	No	Yes
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible	Covered 100% with no deductible
Physician office visits	$30 copay per primary care visit with no deductible Specialist office visits covered 100% after deductible Diagnostic and radiology services subject to deductible	Primary care and specialist office visits covered 100% after deductible Diagnostic and radiology services subject to deductible
Retail health clinic visit Ex: Going to the clinic at a major pharmacy or retail store for basic health care services on a walk-in basis.	$30 copay with no deductible Diagnostic services subject to deductible and coinsurance	Covered 100% after deductible Diagnostic services subject to deductible and coinsurance
Blue Cross Online Visits℠ Blue Cross' enhanced 24/7 online health care, accessed through smartphone, tablet or computer, includes visits with medical doctors and behavioral health therapists.	$0 copay with no deductible for medical online visits, $30 copay with no deductible for behavioral health online visits	Covered 100% after deductible
Laboratory tests and pathology	$10 copay with no deductible	Covered 100% after deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for certain services.	Covered 100% after deductible	Covered 100% after deductible
Inpatient hospital care – semi-private room	Covered 100% after deductible	Covered 100% after deductible
Surgical care	Covered 100% after deductible	Covered 100% after deductible
Emergency room	Covered 100% after deductible	Covered 100% after deductible
Transportation by ambulance	Covered 100% after deductible	Covered 100% after deductible
Urgent care visits at urgent care centers or outpatient locations	$40 copay with no deductible Radiology and diagnostic services subject to deductible	Covered 100% after deductible
Maternity benefit	Covered 100% after deductible	Covered 100% after deductible
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
Prescription drugs 1–30 days Includes retail network pharmacies and mail-order providers. *Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to deductibles, cost-sharing or out of pocket maximums.*	**Preferred generic:** $35 copay with no deductible **Generic:** $35 copay with no deductible **Preferred brand:** Covered 100% after integrated deductible **Nonpreferred brand:** Covered 100% after integrated deductible **Preferred specialty:** Covered 100% after integrated deductible **Nonpreferred specialty:** Covered 100% after integrated deductible	**Preferred generic:** Covered 100% after integrated deductible **Generic:** Covered 100% after integrated deductible **Preferred brand:** Covered 100% after integrated deductible **Nonpreferred brand:** Covered 100% after integrated deductible **Preferred specialty:** Covered 100% after integrated deductible **Nonpreferred specialty:** Covered 100% after integrated deductible

Blue Cross® Preferred HMO Bronze Secure Blue Cross® Select HMO Bronze Secure Blue Cross® Metro Detroit HMO Bronze Secure Blue Cross® Local HMO Bronze Secure	Blue Cross® Preferred HMO Bronze Extra Blue Cross® Select HMO Bronze Extra Blue Cross® Metro Detroit HMO Bronze Extra Blue Cross® Local HMO Bronze Extra
$9,100 per individual plan $18,200 per family plan	$7,500 per individual plan $15,000 per family plan
0%	50%
$9,100 per individual plan $18,200 per family plan	$9,000 per individual plan $18,000 per family plan
No	No
Covered 100% with no deductible	Covered 100% with no deductible
$0 copay per primary care office visit after deductible and a $0 copay per specialist office visit after deductible. Diagnostic and laboratory services subject to deductible and coinsurance	$50 copay per primary care office visit with no deductible and a $100 copay per specialist office visit with no deductible. Diagnostic and laboratory services subject to deductible and coinsurance
$0 copay after deductible. Diagnostic and laboratory services subject to deductible and coinsurance	$50 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance
$0 copay with no deductible for medical online visits, $0 copay after deductible for behavioral health online visits	$0 copay with no deductible for medical online visits, $50 copay with no deductible for behavioral health online visits
Covered 100% after deductible	Covered 50% after deductible
Covered 100% after deductible	Covered 50% after deductible
Covered 100% after deductible	Covered 50% after deductible
Covered 100% after deductible	Covered 50% after deductible
Covered 100% after deductible	Covered 50% after deductible
Covered 100% after deductible	Covered 50% after deductible
Covered 100% after deductible	$75 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance
Covered 100% after deductible	Covered 50% after deductible
Covered 100%: One vision exam per pediatric member per year Covered 100%: Standard lenses and frames or contact lenses Frequency limits apply	Covered 100%: One vision exam per pediatric member per year Covered 100%: Standard lenses and frames or contact lenses Frequency limits apply
Generic: Covered 100% after integrated deductible **Preferred brand:** Covered 100% after integrated deductible **Nonpreferred brand:** Covered 100% after integrated deductible **Preferred specialty:** Covered 100% after integrated deductible **Nonpreferred specialty:** Covered 100% after integrated deductible	**Preferred Generic:** $25 copay with no deductible **Nonpreferred Generic:** $25 copay with no deductible **Preferred brand:** $50 after integrated deductible **Nonpreferred brand:** $100 after integrated deductible **Preferred specialty:** $500 after integrated deductible **Nonpreferred specialty:** $500 after integrated deductible

Value health plan comparison

	PPO
	Blue Cross® Premier PPO Value
Annual deductible Medical and drug expenses are combined to meet the integrated deductible.	$9,100 per individual plan $18,200 per family plan
Coinsurance	None
Out–of–pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out–of–pocket maximum.	$9,100 per individual plan $18,200 per family plan
HSA qualified	No
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible
Physician office visits	$30 copay per primary care visit (applies to the first three primary care visits per member per calendar year) Additional primary care visits subject to the deductible Specialist office visits subject to the deductible Diagnostic and laboratory services subject to deductible After deductible is met, office visits covered at 100%
Retail health clinic visit Ex: Going to the clinic at a major pharmacy or retail store for basic health care services on a walk-in basis.	$30 copay with no deductible for the first three visits, including primary care and retail health clinic visits, per member per calendar year Additional visits and diagnostic and laboratory services subject to deductible
Blue Cross Online Visits℠ Blue Cross' enhanced 24/7 online health care, accessed through smartphone, tablet or computer, includes visits with medical doctors and behavioral health therapists.	$0 copay with no deductible online medical visits $30 copay behavioral health online visits with no deductible for the first three visits, including primary care and retail health clinic visits, per member per calendar year Additional visits and diagnostic and laboratory services subject to deductible
Laboratory tests and pathology	Covered 100% after deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for certain services.	Covered 100% after deductible
Urgent care visits at urgent care centers or outpatient locations	Covered 100% after deductible
Inpatient and surgical care	Covered 100% after deductible
Transportation by ambulance and emergency room visit	Covered 100% after deductible
Maternity benefit	Covered 100% after deductible
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
Prescription drugs 1–30 days Includes retail network pharmacies and mail-order providers. *Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to deductibles, cost-sharing or out of pocket maximums.*	**Generic:** Covered 100% after integrated deductible **Preferred brand:** Covered 100% after integrated deductible **Nonpreferred brand:** Covered 100% after integrated deductible **Preferred specialty:** Covered 100% after integrated deductible **Nonpreferred specialty:** Covered 100% after integrated deductible

HMO

Blue Cross® Select HMO Value Blue Cross® Preferred HMO Value
$9,100 per individual plan $18,200 per family plan
None
$9,100 per individual plan $18,200 per family plan
No
Covered 100% with no deductible
$30 copay per primary care visit with no deductible Specialist office visits covered 100% after deductible Diagnostic and radiology services subject to deductible
$30 copay with no deductible Diagnostic services subject to deductible
$0 copay with no deductible for online medical visits, $30 copay with no deductible for behavioral health online visits
Covered 100% with no deductible
Covered 100% after deductible
$40 copay with no deductible
Covered 100% after deductible
Covered 100% after deductible
Covered 100% after deductible
Covered 100%: One vision exam per pediatric member per calendar year Covered 100%: Standard lenses and frames or contact lenses Frequency limits apply
Preferred generic: Covered 100% after integrated deductible **Generic:** Covered 100% after integrated deductible **Preferred brand:** Covered 100% after integrated deductible **Nonpreferred brand:** Covered 100% after integrated deductible **Preferred specialty:** Covered 100% after integrated deductible **Nonpreferred specialty:** Covered 100% after integrated deductible

Virtual care plan comparison

HMO

	Blue Cross® Preferred HMO Virtual Primary Care Silver	Blue Cross® Preferred HMO Virtual Primary Care Bronze
Annual deductible Medical and drug expenses are combined to meet the integrated deductible.	$6,050 per individual plan $12,100 per family plan	$9,000 per individual plan $18,000 per family plan
Coinsurance	20%	0%
Out–of–pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the out–of–pocket maximum.	$9,100 per individual plan $18,200 per family plan	$9,000 per individual plan $18,000 per family plan
HSA qualified	No	No
Preventive medical, prescription drugs and immunizations	Covered 100% with no deductible	Covered 100% with no deductible
Physician office visits	**Primary care:** You pay $1 for a virtual primary care visit by a BCN selected vendor. You pay $30 for in-person office visits for pediatrician, ob-gyn and retail health visits. **Specialist**: You pay $50 after deductible. Referral required.	**Primary care**: You pay $1 for a virtual primary care visit by a BCN selected vendor. You pay $30 for in-person office visits for pediatrician, ob-gyn and retail health visits. **Specialist:** You pay $0 after deductible. Referral required.
Retail health clinic visit Ex: Going to the clinic at a major pharmacy or retail store for basic health care services on a walk-in basis.	$30 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance	$30 copay with no deductible Diagnostic and laboratory services subject to deductible and coinsurance
Blue Cross Online Visits℠ Blue Cross' enhanced 24/7 online health care, accessed through smartphone, tablet or computer, includes visits with medical doctors and behavioral health therapists.	$0 copay with no deductible for medical online urgent care visits, $30 copay with no deductible for behavioral health online visits	$0 copay with no deductible for medical online urgent care visits, $30 copay with no deductible for behavioral health online visits
Laboratory tests and pathology	Covered 100% with no deductible	$10 copay with no deductible
Diagnostic tests, X-rays, imaging services, CT scans, MRIs Approval required for certain services.	Covered 80% after deductible	Covered 100% after deductible
Inpatient hospital care — semi-private room	Covered 80% after deductible	Covered 100% after deductible
Emergency room	$250 copay after deductible, then covered 80%. Copay waived if admitted	Covered 100% after deductible
Transportation by ambulance	Covered 80% after deductible	Covered 100% after deductible
Urgent care visits at urgent care centers or outpatient locations	$40 copay with no deductible Diagnostic and laboratory services are subject to deductible and coinsurance	$40 copay with no deductible Diagnostic and laboratory services are subject to deductible and coinsurance
Pediatric vision	Covered 100%: One vision exam per pediatric member per year Covered 100%: Standard lenses and frames or contact lenses Frequency limits apply	Covered 100%: One vision exam per pediatric member per year Covered 100%: Standard lenses and frames or contact lenses Frequency limits apply
Prescription drugs 1–30 days Includes retail network pharmacies and mail-order providers. *Any coupon, rebate or other credits received directly or indirectly from the drug manufacturer may not be applied to deductibles, cost-sharing or out of pocket maximums.*	**Preferred Generic:** $4 copay with no deductible **Non-Preferred Generic:** $20 copay with no deductible **Preferred brand:** $100 copay after integrated deductible **Nonpreferred brand:** $150 copay after integrated deductible **Preferred specialty:** 40% coinsurance after integrated deductible **Nonpreferred specialty:** 45% coinsurance after integrated deductible	**Preferred Generic:** Covered $35 with no deductible **Non-Preferred Generic:** Covered $35 with no deductible **Preferred brand:** Covered 100% after integrated deductible **Nonpreferred brand:** Covered 100% after integrated deductible **Preferred specialty:** Covered 100% after integrated deductible **Nonpreferred specialty:** Covered 100% after integrated deductible

The plan information shown is for in-network benefits. Please visit **bcbsm.com/sbc** or log in to your account at **bcbsm.com** to view additional plan details and documentation.

Blue Dental℠ and Blue Vision℠ plans

Blue Cross offers you and your family a variety of choices, including stand-alone dental plans, a stand-alone vision plan, and the convenience of dental plans combined with vision coverage. You can buy these directly from us rather than through the Health Insurance Marketplace.

These dental and adult vision plans are comprehensive and include everything from routine cleanings and oral exams, to fillings and crowns, even eye exams and glasses for vision.

New enrollment is available year-round for off Marketplace dental, vision, and dental with vision plans.

Choosing your dentist

Blue Dental offers the broadest access to participating dentists for savings and choice with our two-tiered approach. Tier 1, our contracted Blue Dental PPO network, includes 130,000 dentists nationwide and 3,600 in Michigan. You get great care and cost savings, with discounts of up to 40% on covered services when you see Tier 1 PPO dentists. (Members in our EPO plans must choose PPO dentists.)

Non-PPO dentists can participate through our Tier 2 per-claim participation arrangement, with discounts on services ranging 15-18%. Dentists who participate in Tier 2 offer an easy experience for you and don't bill for any difference between our approved amounts and their normal charges for covered services.

This two-tiered access allows you to choose the dental care that's right for you and still save money.

Looking for a dentist in your area? Go to **mibluedentist.com**, or call us at **1-888-826-8152**.

Individual dental plan options

All of our Blue Dental plans offer the same quality benefits, but with different premiums and cost-sharing amounts, allowing you to choose the plan that best fits your needs and budget.

Plan name	Blue Dental EPO 80/50/50 (0/0/0)		Blue Dental PPO 80/50/50 (50/50/50)		Blue Dental PPO 100/50/50 (50/50/50)	
	In network	Out of network	In network	Out of network	In network	Out of network
Deductible (1 person/ 2 person/3 person) Applies to Class II & Class III services only	$25/$50/$75	Not covered	$25/$50/$75	$50/$100/$150	$25/$50/$75	$50/$100/$150
Class I Preventive services						
Coinsurance	20%	Not covered	20%	50%	0%	50%
Dental checkup – Child	**Cleaning –** 3x per calendar year; **Exams –** 2x per calendar year **Bitewing X-rays –** One set (up to 4) per calendar year; **Fluoride –** 2x per calendar year Pediatric members 18 or younger when coverage begins					
Routine dental – Adult	**Cleaning –** 2x per calendar year; **Exams –** 2x per calendar year; **Bitewing X-rays –** One set (up to 4) per calendar year; **Fluoride –** Not covered Members 19 or older when coverage begins are considered nonpediatric.					
Class II Minor restorative services*						
Coinsurance	50%	Not covered	50%	50%	50%	50%
Basic dental care – Child	**Sealants –** 1x per permanent molars, every three years **Fillings –** 1x per 24 months for primary teeth, 1x per 48 months for permanent teeth **Periodontal maintenance –** 3x per calendar year in combination with routine cleaning **Simple extractions –** 1x per lifetime per tooth; **Root canals –** 1x per lifetime per tooth Pediatric members 18 or younger when coverage begins.					
Basic dental care – Adult	**Periodontal maintenance –** 2x per calendar year in combination with routine cleaning; **Sealants –** Not covered; **Fillings –** 1x per 24 months for primary teeth, 1x per 48 months for permanent teeth **Simple extractions –** 1x per lifetime per tooth; **Root canals –** 1x per lifetime per tooth Members 19 or older when coverage begins are considered nonpediatric. Six-month waiting period on Class II services for nonpediatric members except for emergency palliative treatments.					
Class III Major restorative services*						
Coinsurance	50%	Not covered	50%	50%	50%	50%
Major dental care – Child	**Scaling and root planing –** 1x per quadrant, per 24 months; **Onlays, crowns, veneers –** 1x every 60 months; **Bridges and dentures –** 1x every 84 months; **Implants –** Not covered Pediatric members 18 or younger when coverage begins					
Major dental care – Adult	**Scaling and root planing –** 1x per quadrant, per 36 months; **Onlays, crowns, veneers –** 1x every 60 months; **Bridges and dentures –** 1x every 84 months; **Implants –** Not covered Members 19 or older when coverage begins are considered nonpediatric. Twelve-month waiting period on Class III services for nonpediatric members					
Annual maximum** –Adult	$1,200	N/A	$1,200	$800	$1,200	$800
Class IV Orthodontic services						
Orthodontic services	Not covered					

Note: Pediatric out-of-pocket maximum for all dental plans is $375 for one pediatric member and $750 for two or more pediatric members. Out-of-pocket maximum applies only to essential health benefits provided by PPO (in-network) dentists for pediatric members.

*Services are subject to waiting periods as follows; Class II services = six-month waiting period for nonpediatric members. Class III services = Twelve-month waiting period for nonpediatric members.

**The amount listed under In network is the total annual maximum available to members. The amount listed under Out of network is the portion of the total that can be used for services provided by non-PPO (out-of-network) dentists.

Blue Dental PPO Extra 100/70/50 (80/60/50)		Blue Dental PPO Plus 80/60/50		Blue Dental PPO Pediatric 80/50/50 (50/50/50)	
In network	Out of network	In network	Out of network	In network	Out of network
$0/$0/$0	$50/$100/$150	$75/$150/$225	$75/$150/$225	$25/$50/$75	$50/$100/$150
0%	20%	20%	20%	20%	50%
Cleaning – 3x per calendar year; **Exams –** 2x per calendar year **Bitewing X-rays –** One set (up to 4) per calendar year; **Fluoride –** 2x per calendar year Pediatric members 18 or younger when coverage begins					
Cleaning – 2x per calendar year; **Exams –** 2x per calendar year; **Bitewing X-rays –** One set (up to 4) per calendar year; **Fluoride –** Not covered Members 19 or older when coverage begins are considered nonpediatric.				Not covered	
30%	40%	40%	40%	50%	50%
Sealants – 1x per permanent molars, every three years **Fillings –** 1x per 24 months for primary teeth, 1x per 48 months for permanent teeth **Periodontal maintenance –** 3x per calendar year in combination with routine cleaning **Simple extractions –** 1x per lifetime per tooth; **Root canals** – 1x per lifetime per tooth Pediatric members 18 or younger when coverage begins.					
Periodontal maintenance – 2x per calendar year in combination with routine cleaning; **Sealants –** Not covered; **Fillings –** 1x per 24 months for primary teeth, 1x per 48 months for permanent teeth; **Simple extractions –** 1x per lifetime per tooth; **Root canals –** 1x per lifetime per tooth Members 19 or older when coverage begins are considered nonpediatric. Six-month waiting period on Class II services for nonpediatric members except for emergency palliative treatments				Not covered	
50%	50%	50%	50%	50%	50%
Scaling and root planing – 1x per quadrant, per 24 months; **Onlays, crowns, veneers –** 1x every 60 months; **Bridges and dentures –** 1x every 84 months; **Implants –** Not covered Pediatric members 18 or younger when coverage begins					
Scaling and root planing – 1x per quadrant, per 36 months; **Onlays, crowns, veneers –** 1x every 60 months; **Bridges and dentures –** 1x every 84 months; **Implants –** Not covered Members 19 or older when coverage begins are considered nonpediatric. Twelve-month waiting period on Class III services for nonpediatric members					
$1,200	$1,000	$1,000	$1,000	N/A	N/A
Not covered					

Blue Dental members can choose from 3,600 dentists throughout Michigan.

IMPORTANT NOTE: DentaQuest is an independent company that provides dental claims processing/payment and customer service for Blue Cross Blue Shield of Michigan and Blue Care Network.

Individual vision plan options

Choosing your eye doctor

Blue Cross members can purchase a packaged dental with adult vision plan, or a stand-alone adult vision plan by itself. (Kids 18 and under get pediatric vision coverage with their Blue medical coverage.)

And, if you see a VSP Choice in-network eye doctor, you can save big on vision care. If you choose a provider who doesn't participate with VSP, you're responsible for additional charges. This may include the difference between our approved amount and the doctor's charge and copayments required by your plan.

Choosing a doctor who participates in the VSP Choice network is easy. Visit **bcbsm.com**, then click *Find a Doctor*. You can also call VSP member services at **1-800-877-7195**.

Packaged individual dental and vision plans

	Packaged adult vision benefits **Benefits you receive if you purchase the following plans:** **Blue Dental℠ PPO 80/50/50 with Vision** **Blue Dental℠ PPO 80/60/50 with Vision** **Blue Dental℠ PPO 100/50/50 with Vision** **Blue Dental℠ PPO 100/70/50 with Vision** **Blue Dental℠ EPO 80/50/50 with Vision**	***Stand-alone adult vision benefits*** **Benefits you receive if you purchase the following plan:** **Blue Cross® Vision for Adults**
Eligibility	Nonpediatric members 19 or older have coverage on the start date of the plan	
Benefits	Exams every 12 months	
	Lenses every 12 months	
	Frames every 24 months	Frames every 12 months
Allowance	$130 allowance for frames or elective contact lenses	$150 allowance for frames or elective contact lenses
Copayments	$10 exam, $25 materials	$15 exam, $25 materials
Network	VSP Choice	
Notes	When purchasing a package, canceling dental will also cancel adult vision overage and vice versa	Stand-alone adult vision offers two premium payment options, monthly and annually

Take advantage of savings with Blue Cross Blue Shield Blue Care Network of Michigan | Blue365® Because health is a big deal℠

You can score big savings on a variety of health products and services with our member discount program, Blue365®. Get exclusive discounts on things like:

- **Fitness and wellness:** Health magazines, fitness gear and gym memberships
- **Healthy eating:** Cookbooks, cooking classes and weight-loss programs
- **Lifestyle:** Travel and recreation
- **Personal care:** Lasik and eye care services, dental care and hearing aids

*Log in to your member account or visit **bcbsm.com/discounts** to learn more.*

Helpful links

Enroll in a Blue Cross or Blue Care Network plan
bcbsm.com/myblue • 1-877-4MY-BLUE (469-2583)

Eligible for savings?
bcbsm.com/subsidy

Find a doctor or hospital:
bcbsm.com/findcare

Find a dentist:
mibluedentist.com

Summary of benefits and coverage:
bcbsm.com/sbc

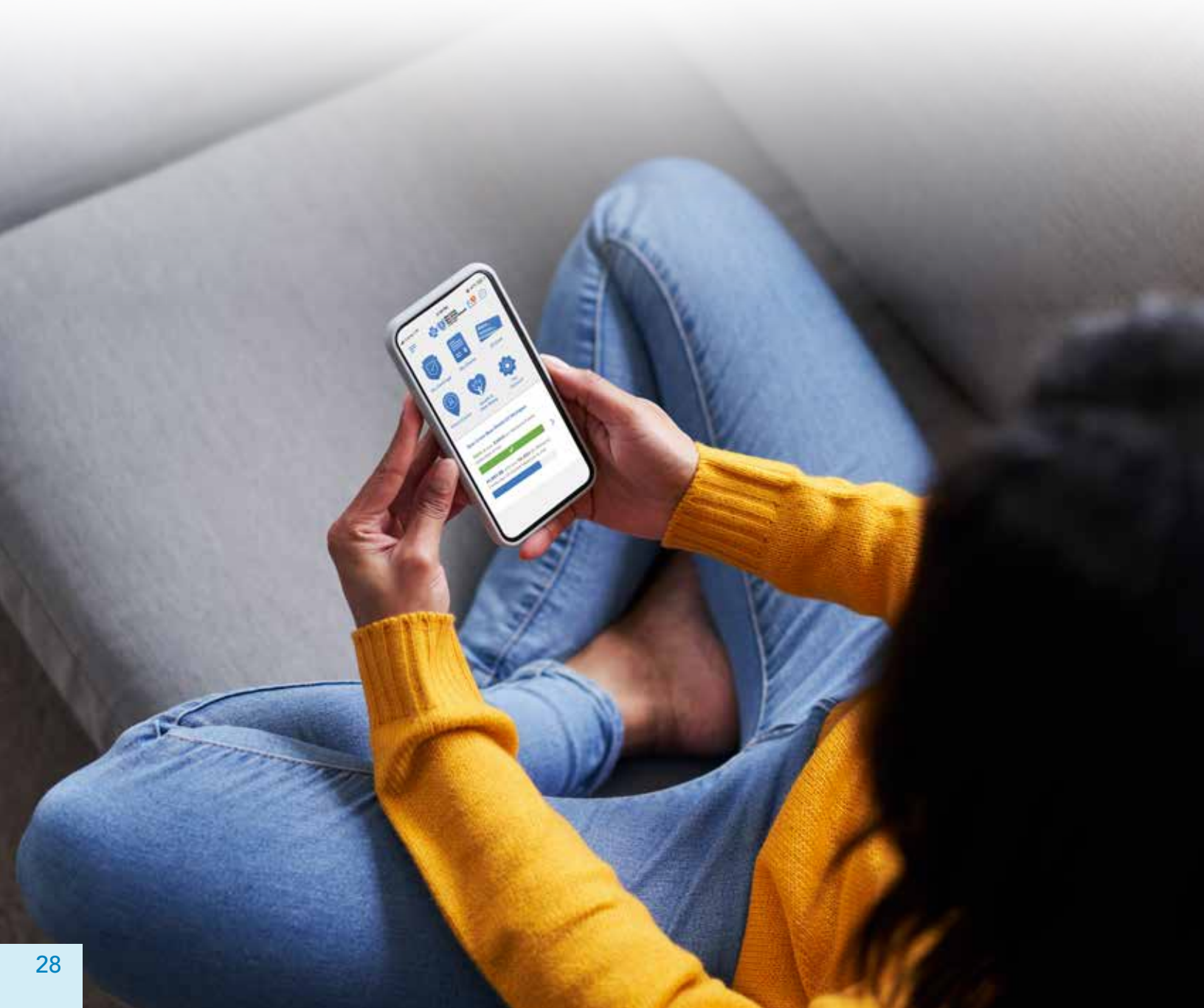
Billing, claims and benefits:
Look for the Customer Service number on the back of your member ID card

Pay my bill:
bcbsm.com/paybill
bcbsm.com/payments

Search or select a primary care provider:
bcbsm.com/find-a-doctor

See a doctor now with Blue Cross Online Visits. Go to **bcbsmonlinevisits.com** to login, or create an account.

Download our Blue Cross mobile app at **bcbsm.com/app**. Use it to select your primary care provider and many more useful features.



We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ܐܢ ܐܢܬܘܢ، ܝܢ ܚܕ ܦܠܢܝ ܦܩܐ ܕܗܝܪܘܬܘܢ، ܣܢܝܩ ܠܗ ܗܝܪܬܐ، ܐܢܬܘܢ ܐܝܬܠܘܟܘܢ ܙܕܩܐ ܕܫܩܠܝܬܘܢ ܗܝܪܬܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܕܠܐ ܡܦܩܬܐ. ܠܗܡܙܡܘܬܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܡܚܘܢ ܩܠ ܠܡܢܝܢܐ ܕܚܠܡܬܐ ܕܐܝܬܗ ܩܠ ܚܨܐ ܕܟܪܛܝܣܟܘܢ ܝܢ 877-469-2583 TTY:711 ܐܢ ܗܝ ܠܐ ܠܝܬܘܢ ܗܕܡܐ.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号(メンバーでない方は877-469-2583, TTY: 711)までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

YOU MADE THE RIGHT CHOICE

For cost information and to purchase your plans for 2023 go to **bcbsm.com/myblue**.

Call a health plan advisor at **1-877-4MY-BLUE (469-2583)**, or contact your Blue Cross or Blue Care Network agent.

Blue Cross Blue Shield Blue Care Network of Michigan