

[2019 plans](#) | [2018 plans](#)

# Blue Cross® Preferred HMO Silver - 87

2019 plan year

## Overview

### About this plan

With this plan, you choose a primary care doctor who refers you to other doctors in our wide HMO network. It's good for people who want to pay a little more each month in order to pay less at the doctor. If you're eligible for a subsidy, this plan could be more affordable than you think.

### Coverage level

[70 percent](#) [73 percent](#) [87 percent](#) [94 percent](#)

This is a Silver 87 plan. That means it covers about 87 percent of your health care costs. Depending on your income, you may be eligible for a silver plan that covers more of your costs. [Find a plan](#) to see if you qualify.

### Availability

You can buy this plan if you live in any Michigan county. [Look for doctors and hospitals that take this plan.](#)

### Plan type

**Preferred HMO.** You'll choose a primary care physician from our largest HMO network to coordinate your care. Except for emergencies or accidental injuries, you aren't covered out-of-network. [What's the difference between HMO and PPO plans?](#)

### Monthly premiums

To give you an accurate price, we'll need some information. [Find a plan](#) to get a quote.

### Deductible

If you have a family plan, and one member meets the individual deductible, Blue Cross will start paying covered benefits for that member only. The remainder of the family deductible has to be met by the remaining family members before Blue Cross will start paying covered benefits for the rest of the members on the plan.

In network  
Individual: \$600  
Family: \$1,200

Out of network  
Not covered

### Coinsurance

**In network**

You pay 10% for most services after deductible.

You pay 50% after deductible for bariatric, temporomandibular joint, infertility, prosthetic and orthotic, and durable medical equipment services.

**Out of network**

Not covered

### Out-of-pocket maximum

If you have a family plan, and one member meets the individual out-of-pocket maximum, Blue Cross will start paying 100% of the approved amount for covered benefits for that member only. The remainder of the family out-of-pocket maximum has to be met by the remaining family members before Blue Cross will start paying 100% of the approved amount for covered benefits for the rest of the members on the plan.

**In network**

Individual: \$2,200  
Family: \$4,400

**Out of network**

Not covered

### Office visits

**Primary care**

You pay \$30.

**Specialist**

You pay \$50 after deductible.

**Urgent care center**

You pay \$40.

**Emergency room**

You pay \$250 after deductible, then 10%.

### Prescriptions

Copays start at \$4 after deductible.

### Dental

This plan doesn't include dental coverage.

### Vision

This plan only includes vision coverage for children.

### Related documents

For this plan's most-used benefits, see the [Summary of Benefits \(PDF\)](#).

For even more details about this plan, see the [Certificate of Coverage \(PDF\)](#). Certificates are legal documents that describe the benefits of a health insurance plan. Your plan might have different benefits and limitations than those listed in this document.

## Medical

### In-network benefits

When you go to a doctor or hospital that accepts this plan, that's called getting your care in-network. [Look for doctors and hospitals that take this plan.](#)

Other care isn't covered except in an emergency, or when you get a referral from your primary care physician and authorization from your plan.

If you have an emergency or accidental injury outside of Michigan, your care is covered with in-network cost sharing. Any scheduled services you receive outside of Michigan are not covered.

Online visits have nationwide coverage with in-network cost-sharing.

### Preventive care

Medical exams, prescription drugs and immunizations

Preventive medical care includes but is not limited to certain prescription drugs, immunizations, health maintenance exams, certain laboratory services, gynecologic exams, pap smear screening, mammogram screening, certain female contraceptives and female voluntary sterilization.

In network

You pay \$0.

Out of network

Not covered

Screening colonoscopy

Applies to the first routine or medically necessary colonoscopy of the calendar year.

In network

You pay \$0.

Out of network

Not covered

Well-baby and well-child visits

Children can get pediatric benefits until the end of the calendar year in which they turn 19.

In network

You pay \$0.

Out of network

Not covered

### Office visits

This plan's deductible and coinsurance apply to any diagnostic and laboratory services you get during the office visit.

In network

Primary care: You pay \$30.

Specialist: You pay \$50 after deductible.

Out of network

Not covered

### Retail health clinic visits

This plan's deductible and coinsurance apply to any diagnostic and laboratory services you get during the office visit.

In network

You pay \$40.

Out of network

Not covered

### Online visits

This plan includes [online health care](#).

In network

You pay \$30.

Out of network

Not covered

### Laboratory and diagnostic services

Lab tests

In network

You pay \$0.

Out of network

Not covered

Radiology services like X-rays, EKGs and ultrasounds

In network

You pay 10% after deductible.

Out of network

Not covered

Imaging services like MRIs

Need prior authorization.

In network

You pay 10% after deductible.

Out of network

Not covered

Allergy tests and shots

In network

You pay 10% after deductible.

Out of network

Not covered

### Maternity and newborn care

Hospital delivery and nursery care

In network

You pay 10% after deductible.

Out of network

Not covered

Prenatal visits

This plan's deductible and coinsurance apply to any tests and ultrasounds you get during the office visit.

In network	Out of network
You pay \$0.	Not covered

#### Postnatal visits

This plan's deductible and coinsurance apply to any tests you get during the office visit.

In network	Out of network
You pay \$30 after deductible.	Not covered

### Emergency services

#### Emergency room visit

You pay \$250 after deductible, then 10%. Copay waived if you're admitted to the hospital.

#### Transportation by ambulance

You pay 10% after deductible.

#### Urgent care center visits

You pay \$40. You aren't covered out of network, except for emergencies or accidental injuries.  
This plan's deductible and coinsurance apply to radiology services you get during the office visit.

### Hospitalization and other services

#### Inpatient hospital care

Semi-private room. Blue Cross-participating facilities only. Needs prior authorization.

In network	Out of network
You pay 10% after deductible.	Not covered

#### Surgery

In network	Out of network
You pay 10% after deductible.	Not covered

#### Home health care

Blue Cross-participating agencies only.

In network	Out of network
You pay 10% after deductible.	Not covered

#### Hospice care

Blue Cross-participating facilities only.

In network	Out of network
You pay \$0 after deductible.	Not covered

#### Skilled nursing facility

Limited to a maximum of 45 days per member each calendar year. Blue Care Network-participating facilities only.  
Needs prior authorization.

In network	Out of network
You pay 10% after deductible.	Not covered

#### Chemotherapy

In network	Out of network
You pay 10% after deductible.	Not covered

#### Organ transplants, including bone marrow, kidney, cornea and skin

Blue Care Network-participating facilities only.

In network	Out of network
You pay 10% after deductible.	Not covered

#### Specified organ transplant, including heart, lung and liver

Blue Care Network-participating facilities only.

In network	Out of network
You pay 10% after deductible.	Not covered

#### Sleep studies

Need prior authorization.

In network	Out of network
You pay 10% after deductible.	Not covered

#### Bariatric surgery

Covered once per lifetime.

In network	Out of network
You pay 50% after deductible.	Not covered

#### Male voluntary sterilization

In network	Out of network
You pay 10% after deductible.	Not covered

## Artificial insemination

This plan doesn't cover artificial insemination.

### Rehabilitative services

#### Outpatient physical and occupational therapy

Physical and occupational therapy limited to a combined maximum of 30 visits per member each calendar year. Needs prior authorization.

In network	Out of network
You pay 10% after deductible.	Not covered

#### Chiropractic spinal manipulation and osteopathic manipulative therapy

Chiropractic and osteopathic manipulative therapy limited to a combined maximum of 30 visits per member each calendar year. Needs prior authorization.

In network	Out of network
You pay 10% after deductible.	Not covered

#### Speech therapy

Limited to a maximum of 30 visits per member each calendar year.

In network	Out of network
You pay 10% after deductible.	Not covered

#### Cardiac and pulmonary rehabilitation

Limited to a combined maximum of 30 visits per member each calendar year.

In network	Out of network
You pay 10% after deductible.	Not covered

### Habilitative services

#### Outpatient physical and occupational therapy

Limited to a combined maximum of 30 visits per member each calendar year. Needs prior authorization.

In network	Out of network
You pay 10% after deductible.	Not covered

#### Speech therapy

Limited to a maximum of 30 visits per member each calendar year.

In network	Out of network
You pay 10% after deductible.	Not covered

Applied Behavior Analysis for specified autism spectrum disorder

Needs prior authorization.

In network	Out of network
You pay 10% after deductible.	Not covered

## Rehabilitative and habilitative devices

Prosthetics and orthotics

Blue Care Network-participating providers only.

In network	Out of network
You pay 50% after deductible.	Not covered

Durable medical equipment

For example, a wheelchair, walker or oxygen tank. Blue Care Network-approved suppliers only.

In network	Out of network
You pay 50% after deductible.	Not covered

Diabetes supplies

In network	Out of network
You pay 10%.	Not covered

Outpatient diabetes self-management training

In network	Out of network
You pay 10% after deductible.	Not covered

## Mental health/substance use

Inpatient and residential mental health

Blue Care Network-participating facilities only. Needs prior authorization.

In network	Out of network
You pay 10% after deductible.	Not covered

Outpatient mental health services

Copay applies to office visit only. This plan's deductible and coinsurance apply to any additional services you get during the office visit. Includes Blue Cross online visits.

In network	Out of network
You pay \$30.	Not covered



### Inpatient and residential substance use

Blue Care Network-approved facilities only. Needs prior authorization.

In network	Out of network
You pay 10% after deductible.	Not covered

### Outpatient substance use services

Copay applies to office visit only. Additional services are subject to the plan's deductible and coinsurance. Blue Care Network-approved providers and facilities only.

In network	Out of network
You pay \$30.	Not covered

## Prescriptions

### In-network benefits

Using an in-network pharmacy will help keep your costs as low as possible.

You can get 30- or 90-day prescriptions from retail or mail-order pharmacies. Quantity limits may apply. Select opioids are limited to a five-day supply for the first order. Opioid refills are limited to a 30-day supply.

[Find a pharmacy.](#)

### Out-of-network benefits

This plan doesn't cover prescriptions you get at an out-of-network pharmacy.

### Covered drugs

What you pay for your medication depends on whether your plan covers the drug and which cost tier it falls under. Certain drugs may need prior authorization. [Look on this list to find a drug \(PDF\).](#)

#### Tier 1a - Preferred generic

Commonly prescribed, generic versions of brand-name medications available for the lowest copay.

**30-day supply:** You pay \$4 after deductible.

**90-day supply:** You pay \$12 after deductible.

#### Tier 1b - Nonpreferred generic

Although these generic drugs have a higher copay, they're less expensive than brand-name drugs.

**30-day supply:** You pay \$20 after deductible.

**90-day supply:** You pay \$60 after deductible.

#### Tier 2 - Preferred brand

Brand-name drugs not yet available as a generic.

**30-day supply:** You pay 25% after deductible (at least \$40 and no more than \$100).

**90-day supply:** You pay 25% after deductible (at least \$120 and no more than \$300).

#### Tier 3 - Nonpreferred brand

Brand-name drugs that have generic or preferred brand alternatives.

**30-day supply:** You pay 50% after deductible (at least \$80 and no more than \$100).

**90-day supply:** You pay 50% after deductible (at least \$240 and no more than \$300).

#### Tier 4 - Preferred specialty

Generic and brand-name drugs used to treat complex health conditions. They usually need special handling and approval. You'll need to use AllianceRx Walgreens Prime to fill prescriptions within this tier.

**You pay 40% after deductible.** Specialty drugs are limited to a 30-day supply. Some specialty drugs are limited to a 15-day supply.

#### Tier 5 - Nonpreferred specialty

Because there are less expensive alternatives available for the drugs in this tier, you'll pay more for them at the pharmacy. You'll need to use AllianceRx Walgreens Prime to fill prescriptions within this tier.

**You pay 45% after deductible.** Specialty drugs are limited to a 30-day supply. Some specialty drugs are limited to a 15-day supply.

## Dental

Not included

This plan **doesn't include dental coverage**. We offer separate dental plans that cover adults and children and help pay for exams, cleanings, fillings and more. [See our Blue Dental plans.](#)

## Vision

For children

**You pay \$0.** This includes one eye exam each calendar year, standard lenses and frames or contact lenses. Children can get pediatric benefits until the end of the calendar year in which they turn 19.

For adults

This plan **doesn't include adult vision coverage**. We offer a separate [vision plan](#) that helps pay for eye exams, glasses and more. We also offer dental plans that [include vision coverage](#).

## Features

Discounts

Through [Blue365®](#), Blue Cross members can save on a variety of products and services, including:

- Weight management programs, organic groceries and fresh produce
- Yoga classes, workout gear and gym memberships
- Discounted admission to Michigan attractions

Online doctor visits

This plan includes [online health care](#).

Health and wellness

As part of your plan, you can:

- Call our [24-Hour Nurse Line](#) to get help and advice from a registered nurse
- Use the many tools and resources available online through [Blue Cross Health and Wellness, powered by WebMD®](#)

## Notes

Depending on the health care services you need, your provider might have to get approval before providing that service. Use our website to find more information and a list of [services that need approval](#).

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 BCN ID card and providing the procedure code. Your provider can also provide this information upon request.

## Exclusions and limitations

Conditions covered by workers' compensation or similar law; services or supplies not specifically listed as covered under your benefit plan; services received before your effective date or after coverage ends; services you wouldn't have to pay for if you did not have this coverage; services or supplies that are not medically necessary; physical exams for insurance, employment, sports or school; any amounts in excess of BCN's approved amount; cosmetic surgery, admissions and hospitalizations; 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, PRRK, or Lasik; services provided by a professional provider to a family member; services provided by any person who ordinarily resides in the covered person's home or who is a family member; any drug, medicine or device that is not approved by the Food and Drug Administration, unless required by law; vitamins, dietary products and any other nonprescription supplements except as specifically stated in your benefit plan; dental services, except for dental injury; appliances, supplies or services as a result of war or any act of war, whether declared or not; communication or travel time, lodging or transportation, except as stated in your benefit plan; foot care services, except as stated in your benefit plan; health clubs or health spas, aerobic and strength conditioning, work-hardening programs and related material and products for these programs; hair prosthesis, hair transplants or implants; experimental treatments, except as stated in your benefit plan; and alternative medicines or therapies.

This document is intended to be an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. A complete description of benefits is contained in the applicable Blue 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.

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