Blue Cross Blue Shield Blue Care Network of Michigan

2019 plans | 2018 plans

Blue Cross® Preferred HMO Silver Off Marketplace

2019 plan year

Overview

About this plan

This plan, which isn't offered on the Health Insurance Marketplace, is for people who don't qualify for subsidy. It's also good for people who have a doctor close to home. You'll be able to get referrals to specialists in our entire HMO network.

Availability

You can buy this plan if you live in any Michigan county. Find 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	Out of network
Individual: $2,400 Family: $4,800	Not covered

Coinsurance

In network	Out of network
You pay 30% after deductible. You pay 50% after deductible for for bariatric, temporomandibular joint, infertility, prosthetic and orthotic services, and for durable medical equipment services.	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	Out of network
Individual: $7,500 Family: $15,000	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 30%.

Prescriptions

Copays start at $4 after you meet your 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 see the primary care physician you chose from the plan's list, or get a referral to a doctor or hospital that takes this plan, that's called getting your care in network. Look for doctors and hospitals that take this plan.

Because this plan is an HMO 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	Out of network
You pay $0.	Not covered

Screening colonoscopy

Applies to the first routine colonoscopy of the calendar year that's billed as preventive.

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

Office visits

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

In network	Out of network
Primary care: You pay $30. Specialist: You pay $50 after deductible.	Not covered

Retail health clinic visits

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

In network	Out of network
You pay $40.	Not covered

Online visits

This plan includes online health care.

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

Laboratory and diagnostic services

Lab tests

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

Radiology services like X-rays, EKGs and ultrasounds

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

Imaging services like MRIs

Need prior authorization.

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

Allergy tests and shots

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

Maternity and newborn care

Hospital delivery and nursery care

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

Prenatal visits

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

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

Postnatal visits

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

Emergency services

Emergency room visit

You pay $250 after deductible, then 30%. Copay waived if you're admitted to the hospital.

Transportation by ambulance

You pay 30% after deductible.

Urgent care center visits

You pay $40. Except for emergencies or accidental injuries, you aren't covered out of network.
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 Care Network-participating facilities only. Needs prior authorization.

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

Surgery

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

Home health care

Blue Care Network-participating agencies only.

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

Hospice care

Blue Care Network-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 30% after deductible.	Not covered

Chemotherapy

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

Sleep studies

Need prior authorization.

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

Applied Behavior Analysis for specified autism spectrum disorder

Needs prior authorization.

In network	Out of network
You pay 30% 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-participating suppliers only.

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

Diabetes supplies

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

Outpatient diabetes self-management training

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

Outpatient mental health services

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

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 30% after deductible.	Not covered

Outpatient substance use services

Blue Care Network-approved providers and facilities only. Copay applies to office visit only. This plan's deductible and coinsurance apply to additional services you get during the office visit.

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

Prescriptions

In-network coverage

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 coverage

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.Generic and brand-name drugs used to treat complex health conditions. They usually need special handling and approval.

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.