MyBlue℠ product comparison

Blue Cross Blue Shield of Michigan and Blue Care Network offer a variety of individual MyBlue plans for every budget. This guide will give you information to help you choose your new health plan.

All our new products include essential health benefits

All MyBlue health plans cover the 10 categories of essential health benefits that are required with all health care plans. These benefits are:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

We offer a choice of product lines

Blue Cross Blue Shield of Michigan and Blue Care Network offer four different product lines you can choose from:

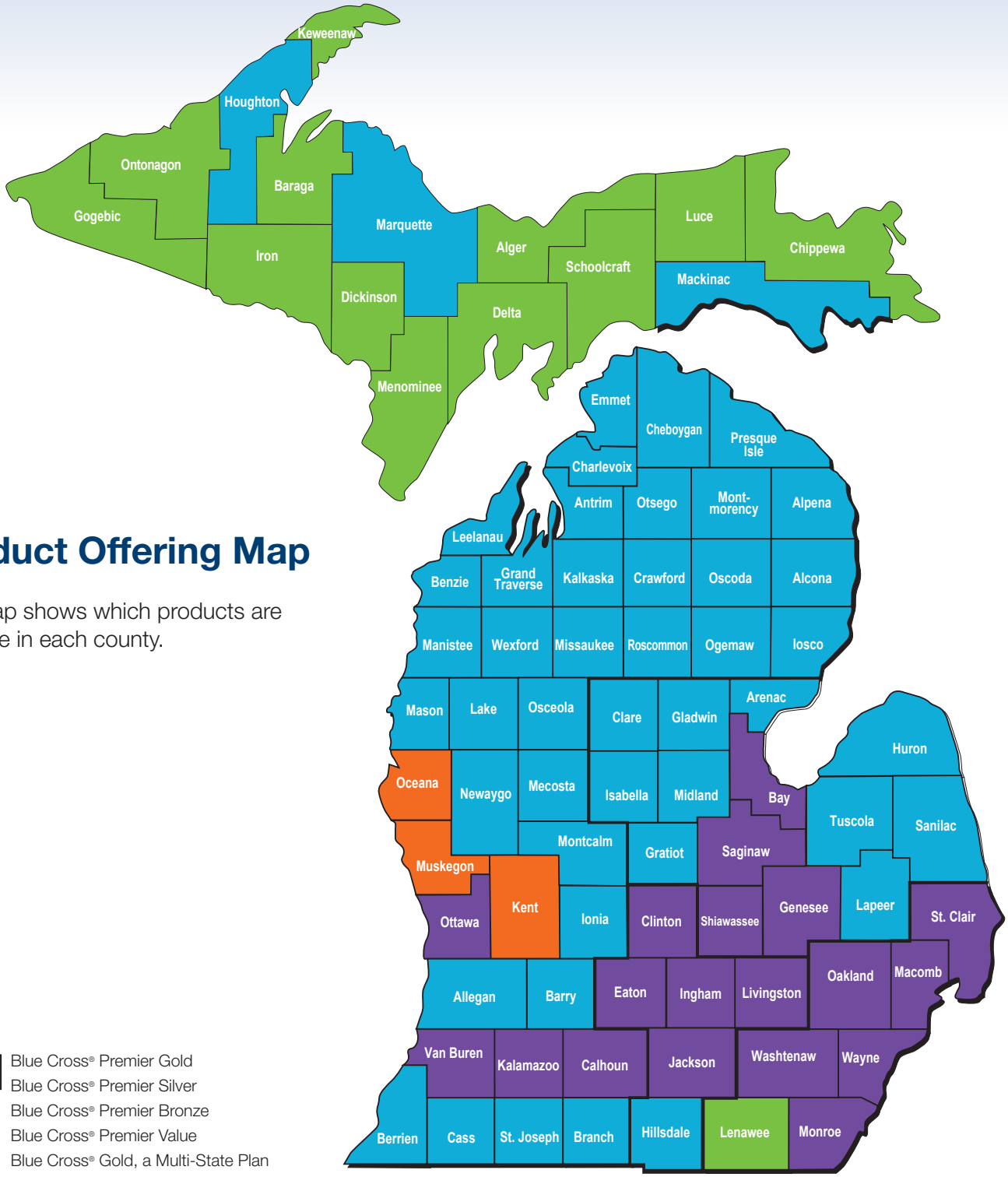
Blue Cross® Premier: You will have a broad choice of doctors and hospitals within BCBSM's unsurpassed statewide PPO network, plus nationwide coverage. You may receive services from hospitals or doctors outside the network, but you will pay less if you use providers within the network.

Blue Cross® Preferred: You will have a broad choice of doctors and hospitals from BCN's entire HMO network. Your primary care doctor will coordinate your care and refer you to specialists when necessary. Care outside the network is Not covered.

Blue Cross® Select: You may choose from a select network of quality primary care doctors with complete access to specialists and hospitals within BCN's entire HMO network. Your primary care doctor will coordinate your care and refer you to specialists when necessary. Care outside the network is Not covered.

Blue Cross® Partnered: You will receive care within the Mercy Health system of doctors and hospitals located in Kent, Muskegon and Oceana counties. Your primary care doctor will coordinate your care. Care within the BCN's entire HMO network, but outside the Mercy Health system, will require primary care doctor and plan approval. Care outside BCN's network is Not covered.

To find out if you doctor is in a particular network, go to **bcbsm.com** and click on *Find a Doctor*.



Product Offering Map

This map shows which products are available in each county.

Blue Cross® Premier Gold
Blue Cross® Premier Silver
Blue Cross® Premier Bronze
Blue Cross® Premier Value
Blue Cross® Gold, a Multi-State Plan
Blue Cross® Silver, a Multi-State Plan

Blue Cross® Premier Gold
Blue Cross® Premier Silver
Blue Cross® Premier Bronze
Blue Cross® Premier Value
Blue Cross® Gold, a Multi-State Plan
Blue Cross® Silver, a Multi-State Plan
Blue Cross® Preferred Gold
Blue Cross® Preferred Silver
Blue Cross® Preferred Bronze
Blue Cross® Preferred Value

Blue Cross® Premier Gold
Blue Cross® Premier Silver
Blue Cross® Premier Bronze
Blue Cross® Premier Value
Blue Cross® Gold, a Multi-State Plan
Blue Cross® Silver, a Multi-State Plan
Blue Cross® Preferred Silver
Blue Cross® Preferred Bronze
Blue Cross® Select Gold
Blue Cross® Select Silver
Blue Cross® Select Bronze
Blue Cross® Select Value

Blue Cross® Premier Gold
Blue Cross® Premier Silver
Blue Cross® Premier Bronze
Blue Cross® Premier Value
Blue Cross® Gold, a Multi-State Plan
Blue Cross® Silver, a Multi-State Plan
Blue Cross® Preferred Silver
Blue Cross® Preferred Bronze
Blue Cross® Partnered Gold
Blue Cross® Partnered Silver
Blue Cross® Partnered Bronze
Blue Cross® Partnered Value

Product comparison

Metal level (product category)	Catastrophic (Value)		Bronze	
On/off Marketplace	Available on and off Marketplace		Available on and off Marketplace	
Eligible for premium subsidy	No		Yes	
Eligible for reduced cost-sharing	No		No	
HSA-qualified	No		Yes	
Monthly premium	$		$	
Plans	**Blue Cross® Premier Value**	**Blue Cross® Preferred Value** **Blue Cross® Select Value** **Blue Cross® Partnered Value**	**Blue Cross® Premier Bronze**	**Blue Cross® Preferred Bronze** **Blue Cross® Select Bronze** **Blue Cross® Partnered Bronze**
Plan type	PPO	HMO	PPO	HMO
	In-network	In-network	In-network	In-network
Annual deductible	$6,350 per individual plan $12,700 per family plan	$6,350 per individual plan $12,700 per family plan	**Inpatient services:** $4,400 per individual plan $8,800 per family plan **Outpatient, emergency services and prescription drugs:** $6,350 per individual plan $12,700 per family plan	$5,950 per individual plan $11,900 per family plan
Coinsurance	0% after deductible	0% after deductible	40% after deductible for most services	40% after deductible for most services
Copay & coinsurance maximum	Not Applicable	Not Applicable	**Inpatient services:** $1,950 per individual plan $3,900 per family **Outpatient, emergency services and prescription drugs:** Not applicable	$400 per individual plan $800 per family plan
Out-of-pocket maximum The integrated deductible, coinsurance and copays for all medical and drug expenses accumulate to the OOP max	$6,350 per individual plan $12,700 per family plan	$6,350 per individual plan $12,700 per family plan	$6,350 per member $12,700 per family	$6,350 per member $12,700 per family
Preventive medical, prenatal visits, preventive prescription drugs and immunizations	Covered 100% with no deductible	Covered 100% with no deductible	Covered 100% with no deductible	Covered 100% with no deductible
Physician office visits	$30 copay per primary care visit with no deductible, 3 primary care visits per member per calendar year. Specialist office visits are subject to deductible. After deductible is met office visits are covered at 100%.	$30 copay per primary care visit with no deductible. Specialist office visits are subject to deductible. After deductible is met office visits are covered at 100%.	Covered 100% after outpatient deductible	$30 copay per primary care visit and $50 copay per specialist office visit after deductible
Laboratory tests and pathology	Covered 100% after deductible	Covered 100% before deductible	Covered 100% after outpatient deductible Covered 60% after inpatient deductible	Covered 60% after deductible
Diagnostic tests and X-rays (including EKG, Chest X-ray)	Covered 100% after deductible	Covered 100% after deductible	Covered 100% after outpatient deductible Covered 60% after inpatient deductible	Covered 60% after deductible
Imaging services: CT scans, MRIs, PET etc. - prior authorization required	Covered 100% after deductible	Covered 100% after deductible	Covered 100% after outpatient deductible. Covered 60% after inpatient deductible.	Covered 60% after deductible plus $200 copay
Inpatient hospital care - semi-private room	Covered 100% after deductible	Covered 100% after deductible	Covered 60% after inpatient deductible plus $500 copay	Covered 60% after deductible plus $500 copay
Surgical care	Covered 100% after deductible	Covered 100% after deductible	Covered 60% after inpatient deductible Covered 100% after outpatient deductible	Covered 60% after deductible
Emergency room	Covered 100% after deductible	Covered 100% after deductible	Covered 100% after in-network outpatient deductible	Covered 60% after deductible plus $250 copay (copay waived if admitted)
Urgent care visits - Urgent care center or outpatient location	Covered 100% after deductible	Covered with a $40 copay before deductible. Radiology services are subject to the plan's deductible.	Covered 100% after outpatient deductible	Covered with a $40 copay after deductible
Maternity benefit	Covered 100% after deductible	Covered 100% after deductible	Covered 100% after outpatient deductible Covered 60% after inpatient deductible plus $500 copay	Covered 60% after deductible plus $500 copay

Here's an overview of Blue Cross Blue Shield of Michigan's and Blue Care Network's individual products for 2014. All the health plans are broken down by "metal levels" of gold, silver and bronze, as well as catastrophic-level plans for adults younger than 30. In general, you'll pay a lower monthly premium but have higher cost-sharing if you choose a bronze plan; monthly premiums go up and cost-sharing goes down as you go to higher metal levels.

Silver		Gold	
Available on and off Marketplace; multi-state plans available on Marketplace only		Available on and off Marketplace; multi-state plans available on Marketplace only	
Yes		Yes	
Yes		No	
Yes - Blue Cross® Premier Silver-70 and Blue Cross Silver, a Multi-State Plan-70 only		No	
$$		$$$	
Blue Cross® Premier Silver **Blue Cross® Silver, a Multi-State Plan**	**Blue Cross® Preferred Silver** **Blue Cross® Select Silver** **Blue Cross® Partnered Silver**	**Blue Cross® Premier Gold** **Blue Cross® Gold, a Multi-State Plan**	**Blue Cross® Preferred Gold** **Blue Cross® Select Gold** **Blue Cross® Partnered Gold**
PPO	HMO	PPO	HMO
In-network	In-network	In-network	In-network
$1,400 per invidual plan $2,800 per family plan	$1,650 per individual plan $3,300 per family plan	$150 per individual plan $300 per family plan	$250 per individual plan $500 per family plan
20% after deductible for most services	30% after deductible for most services	20% after deductible for most services	20% after deductible for most services
$4,600 per individual plan $9,200 per family plan	$4,700 per individual plan $9,400 per family plan	$4,950 per individual plan $9,900 per family plan	$4,850 per individual plan $9,700 per family plan
$6,000 per individual plan $12,000 per family plan	$6,350 per individual plan $12,700 per family plan	$5,100 per individual plan $10,200 per family plan	$5,100 per individual plan $10,200 per family plan
Covered 100% with no deductible	Covered 100% with no deductible	Covered 100% with no deductible	Covered 100% with no deductible
$30 copay per primary care visit and $50 copay per specialist office visit after deductible	$30 copay per primary care visit with no deductible. $50 copay per specialist visit after deductible.	$30 copay per primary care visit and $50 copay per specialist office visit after deductible.	$30 copay per primary care visit with no deductible. $50 copay per specialist visit after deductible.
Covered 80% after deductible	Covered 100% before deductible	Covered 80% after deductible	Covered 100% before deductible
Covered 80% after deductible	Covered 70% after deductible	Covered 80% after deductible	Covered 80% after deductible
Covered 80% after deductible plus $200 copay	Covered 70% after deductible plus $200 copay	Covered 80% after deductible plus $200 copay	Covered 80% after deductible plus $200 copay
Covered 80% after deductible plus $500 copay	Covered 70% after deductible plus $500 copay	Covered 80% after deductible plus $500 copay	Covered 80% after deductible plus $500 copay
Covered 80% after deductible	Covered 70% after deductible	Covered 80% after deductible	Covered 80% after deductible
Covered 80% after deductible plus $250 copay (copay waived if admitted)	Covered 70% after deductible plus $250 copay (copay waived if admitted)	Covered 80% after deductible plus $250 copay (copay waived if admitted)	Covered 80% after deductible plus $250 copay (copay waived if admitted)
Covered 80% after deductible plus $75 copay	Covered with a $40 copay before deductible. Radiology services are subject to the plan's deductible and coinsurance.	Covered 80% after deductible plus $75 copay	Covered with a $40 copay before deductible
Covered 80% after deductible plus $500 copay	Covered 70% after deductible plus $500 copay	Covered 80% after deductible plus $500 copay	Covered 80% after deductible plus $500 copay

Product comparison (continued)

Metal level (product category)	**Catastrophic (Value)**		**Bronze**	
Pediatric vision	Covered 100%. One annual vision exam; standard lenses and frames; or contact lenses (frequency limits apply)	Covered 100%. One annual vision exam; standard lenses and frames; or contact lenses (frequency limits apply)	Covered 100%. One annual vision exam; standard lenses and frames; or contact lenses (frequency limits apply)	Covered 100%. One annual vision exam; standard lenses and frames; or contact lenses (frequency limits apply)
Adult vision	Not covered	Not covered	Not covered	Not covered
Pediatric dental	Stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase
Adult dental	Stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase	Stand-alone plan available for purchase
Prescription drugs 1-30 days (Retail or in-network mail order provider)	**Tier 1 - generic**: covered 100% after in-network integrated deductible **Tier 2 - preferred brand**: covered 100% after in-network integrated deductible **Tier 3 - nonpreferred brand**: covered 100% after in-network integrated deductible **Tier 4 - preferred specialty**: covered 100% after in-network integrated deductible **Tier 5 - nonpreferred specialty**: covered 100% after in-network integrated deductible	**Tier 1a - generic**: covered 100% after integrated deductible **Tier 1b - generic**: covered 100% after integrated deductible **Tier 2 - preferred brand**: covered 100% after integrated deductible **Tier 3 - nonpreferred brand**: covered 100% after integrated deductible **Tier 4 - preferred specialty**: covered 100% after integrated deductible **Tier 5 - nonpreferred specialty**: covered 100% after integrated deductible	**Tier 1 - generic**: covered 100% after in-network integrated outpatient deductible **Tier 2 - preferred brand**: covered 100% after in-network integrated outpatient deductible **Tier 3 - nonpreferred brand**: covered 100% after in-network integrated outpatient deductible **Tier 4 - preferred specialty**: covered 100% after in-network integrated outpatient deductible **Tier 5 - nonpreferred specialty**: covered 100% after in-network integrated outpatient deductible	**Tier 1a - generic**: $4 copay after integrated deductible **Tier 1b - generic**: $20 copay after integrated deductible **Tier 2 -preferred brand**: 25% coinsurance after integrated deductible, $40 minimum and $100 maximum copay **Tier 3 - nonpreferred brand**: 50% coinsurance after integrated deductible, $80 minimum and $100 maximum copay **Tier 4 - preferred specialty**: 20% coinsurance after integrated deductible, no minimum and $200 maximum copay **Tier 5 - nonpreferred specialty**: 25% coinsurance after integrated deductible, no minimum and $300 maximum copay
Prescription 84-90 days (90-day retail network pharmacy or in-network mail order provider) Note: Specialty drugs (tiers 4 and 5) are limited to a 30-day supply.	**Tier 1 - generic**: covered 100% after in-network integrated deductible **Tier 2 - preferred brand**: covered 100% after in-network integrated deductible **Tier 3 - nonpreferred brand**: covered 100% after in-network integrated deductible **Tier 4 - preferred specialty**: Not covered **Tier 5 - nonpreferred specialty**: Not covered	**Tier 1a - generic**: covered 100% after integrated deductible **Tier 1b - generic**: covered 100% after integrated deductible **Tier 2 - preferred brand**: covered 100% after integrated deductible **Tier 3 - nonpreferred brand**: covered 100% after integrated deductible **Tier 4 - preferred specialty**: covered 100% after integrated deductible **Tier 5 - nonpreferred specialty**: covered 100% after integrated deductible	**Tier 1 - generic**: covered 100% after in-network integrated outpatient deductible **Tier 2 - preferred brand**: covered 100% after in-network integrated outpatient deductible **Tier 3 - nonpreferred brand**: covered 100% after in-network integrated outpatient deductible **Tier 4 - preferred specialty**: Not covered **Tier 5 - nonpreferred specialty**: Not covered	**Tier 1a - generic**: $12 copay after integrated deductible **Tier 1b - generic**: $60 copay after integrated deductible **Tier 2 - preferred brand**: 25% coinsurance after integrated deductible, $120 minimum and $300 maximum copay **Tier 3 - nonpreferred brand**: 50% coinsurance after integrated deductible, $240 minimum and $300 maximum copay **Tier 4 - preferred specialty**: Not covered **Tier 5 - nonpreferred specialty**: Not covered

This brochure only displays in-network coverage and an overview of covered services; for detailed benefit information and out-of-network coverage, please see benefits-at-a-glance brochures.

Silver		Gold	
Covered 100%. One annual vision exam; standard lenses and frames; or contact lenses (frequency limits apply)	Covered 100%. One annual vision exam; standard lenses and frames; or contact lenses (frequency limits apply)	Covered 100%. One annual vision exam; standard lenses and frames; or contact lenses (frequency limits apply)	Covered 100%. One annual vision exam; standard lenses and frames; or contact lenses (frequency limits apply)
Multi-state plan only: One annual vision exam: $10 copay Standard lenses and frames; or contact lenses: $25 copay with a $130 annual benefit maximum. Frequency limits apply. All other silver plans, not covered.	Not covered	**Multi-state plan only**: One annual vision exam: $10 copay Standard lenses and frames; or contact lenses: $25 copay with a $130 annual benefit maximum. Frequency limits apply. All other gold plans, not covered.	Not covered
Multi-state plan only: Class I: covered 90% Class II: covered 50% Class III: covered 50%, no waiting period, $700 out-of-pocket maximum (one member) or $1,400 out-of-pocket maximum (2 or more members) up to the age of 19. All other silver plans, stand-alone plan available for purchase.	Stand-alone plan available for purchase	**Multi-state plan only:** Class I: covered 90% Class II: covered 50% Class III: covered 50%, no waiting period, $700 out-of-pocket maximum (one member) or $1,400 out-of-pocket maximum (2 or more members) up to the age of 19. All other gold plans, stand-alone plan available for purchase.	Stand-alone plan available for purchase
Multi-state plan only: Class I: covered 90% Class II: covered 50% with a 6 month waiting period Class III: covered 50% with a 12 month waiting period, no deductible, $1,200 annual maximum per adult member. All other silver plans, stand-alone plan available for purchase.	Stand-alone plan available for purchase	**Multi-state plan only:** Class I: covered 90% Class II: covered 50% with a 6 month waiting period Class III: covered 50% with a 12 month waiting period, no deductible, $1,200 annual maximum per adult member. All other gold plans, stand-alone plan available for purchase.	Stand-alone plan available for purchase
Tier 1 - generic: $15 copay after in-network integrated deductible **Tier 2 - preferred brand**: 25% coinsurance after in-network integrated deductible, $40 minimum and $100 maximum copay **Tier 3 - nonpreferred brand**: 50% coinsurance after in-network integrated deductible, $80 minimum and $100 maximum copay **Tier 4 - preferred specialty**: 20% coinsurance after in-network integrated deductible, no minimum and $200 maximum copay **Tier 5 - nonpreferred specialty**: 25% coinsurance after in-network integrated deductible, no minimum and $300 maximum copay	**Tier 1a - generic**: $4 copay after integrated deductible **Tier 1b - generic**: $20 copay after integrated deductible **Tier 2 - preferred brand**: 25% coinsurance after integrated deductible, $40 minimum and $100 maximum copay **Tier 3 - nonpreferred brand**: 50% coinsurance after integrated deductible, $80 minimum and $100 maximum copay **Tier 4 - preferred specialty**: 20% coinsurance after integrated deductible, no minimum and $200 maximum copay **Tier 5 - nonpreferred specialty**: 25% coinsurance after integrated deductible, no minimum and $300 maximum copay	**Tier 1 - generic**: $15 copay after in-network integrated deductible **Tier 2 - preferred brand**: 25% coinsurance after in-network integrated deductible, $40 minimum and $100 maximum copay **Tier 3 - nonpreferred brand**: 50% coinsurance after in-network integrated deductible, $80 minimum and $100 maximum copay **Tier 4 - preferred specialty**: 20% coinsurance after in-network integrated deductible, no minimum and $200 maximum copay **Tier 5 - nonpreferred specialty**: 25% coinsurance after in-network integrated deductible, no minimum and $300 maximum copay	**Tier 1a - generic**: $4 copay after integrated deductible **Tier 1b - generic**: $20 copay after integrated deductible **Tier 2 - preferred brand**: 25% coinsurance after integrated deductible, $40 minimum and $100 maximum copay **Tier 3 - nonpreferred brand**: 50% coinsurance after integrated deductible, $80 minimum and $100 maximum copay **Tier 4 - preferred specialty**: 20% coinsurance after integrated deductible, no minimum and $200 maximum copay **Tier 5 - nonpreferred specialty**: 25% coinsurance after integrated deductible, no minimum and $300 maximum copay
Tier 1 - generic: $45 copay after in-network integrated deductible **Tier 2 - preferred brand**: 25% coinsurance after in-network integrated deductible, $120 minimum and $300 maximum copay **Tier 3 - nonpreferred brand**: 50% coinsurance after in-network integrated deductible, $240 minimum and $300 maximum copay **Tier 4 - preferred specialty**: Not covered **Tier 5 - nonpreferred specialty**: Not covered	**Tier 1a - generic**: $12 copay after integrated deductible **Tier 1b - generic**: $60 copay after integrated deductible **Tier 2 - preferred brand**: 25% coinsurance after integrated deductible, $120 minimum and $300 maximum copay **Tier 3 - nonpreferred brand**: 50% coinsurance after integrated deductible, $240 minimum and $300 maximum copay **Tier 4 - preferred specialty**: Not covered **Tier 5 - nonpreferred specialty**: Not covered	**Tier 1 - generic**: $45 copay after in-network integrated deductible **Tier 2 - preferred brand**: 25% coinsurance after in-network integrated deductible, $120 minimum and $300 maximum copay **Tier 3 - nonpreferred brand**: 50% coinsurance after in-network integrated deductible, $240 minimum and $300 maximum copay **Tier 4 - preferred specialty**: Not covered **Tier 5 - nonpreferred specialty**: Not covered	**Tier 1a - generic**: $12 copay after integrated deductible **Tier 1b - generic**: $60 copay after integrated deductible **Tier 2 - preferred brand**: 25% coinsurance after integrated deductible, $120 minimum and $300 maximum copay **Tier 3 - nonpreferred brand**: 50% coinsurance after integrated deductible, $240 minimum and $300 maximum copay **Tier 4 - preferred specialty**: Not covered **Tier 5 - nonpreferred specialty**: Not covered

For pricing information and to purchase your MyBlue health care plan for 2014, you can:

- Go online to **bcbsm.com/myblue**
- Call a Blues Health Plan Advisor at 877-4MY-BLUE (469-2583)
- Contact a Blues-contracted agent

MyBlue℠

bcbsm.com/myblue

Blue Cross Blue Shield Blue Care Network of Michigan

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