MyBlue℠ Plan Comparison Chart

PLANS	PLAN TYPE	RX PLAN	IN-NETWORK						OUT-OF-NETWORK					
			Deductible	Coinsurance	Coinsurance and Copay Max	Out-of-Pocket Max	Office Visits Specialist Office Visits Urgent Care Physician's Office	ER Visits Ambulance Services Urgent Care Center or Outpatient Location	Deductible	Coinsurance	Coinsurance and Copay Max	Out-of-Pocket Max	Office Visits Specialist Office Visits Urgent Care Physician's Office	ER Visits Ambulance Services Urgent Care Center or Outpatient Location
BLUE CROSS® PREMIER GOLD	Statewide PPO	5-Tier	$150 $300	20% after deductible for most services	$4,950 $9,900	$5,100 $10,200	$30 after deductible $50 after deductible Covered 80% after deductible plus $75 copay	Covered 80% after deductible plus $250 copay Covered 80% after deductible Covered 80% after deductible plus $75 copay	$300 $600	40% after deductible for most services	$9,900 $19,800	$10,200 $20,400	Not Covered	Covered 80% after deductible plus $250 copay Covered 80% after deductible Covered 60% after deductible plus $75 copay
BLUE CROSS® PREMIER SILVER	Statewide PPO *HSA Qualified Plan*	5-Tier	$1,400 $2,800	20% after deductible for most services	$4,600 $9,200	$6,000 $12,000	$30 after deductible $50 after deductible Covered 80% after deductible plus $75 copay	Covered 80% after deductible plus $250 copay Covered 80% after deductible Covered 80% after deductible plus $75 copay	$2,800 $5,600	40% after deductible for most services	$9,200 $18,400	$12,000 $24,000	Not Covered	Covered 80% after deductible plus $250 copay Covered 80% after deductible Covered 60% after deductible plus $75 copay
BLUE CROSS® PREMIER BRONZE	Statewide PPO *HSA Qualified Plan*	5-Tier	Inpatient $4,400 $8,800 Outpatient $6,350 $12,700	Inpatient 40% after deductible Outpatient Not Applicable	Inpatient $1,950 $3,900 Outpatient Not Applicable	$6,350 $12,700	Subject to outpatient deductible Subject to outpatient deductible Covered 100% after outpatient deductible	Covered 100% after in-network outpatient deductible Covered 100% after in-network outpatient deductible Covered 100% after outpatient deductible	Inpatient $8,800 $17,600 Outpatient $12,700 $25,400	Inpatient 60% after deductible Outpatient Not Applicable	Inpatient $3,900 $7,800 Outpatient Not Applicable	$12,700 $25,400	Not Covered	Covered 100% after in-network outpatient deductible Covered 100% after in-network outpatient deductible Covered 100% after outpatient deductible
BLUE CROSS® PREMIER VALUE (CATASTROPHIC)	Statewide PPO	5-Tier	$6,350 $12,700	0% after deductible	Not Applicable	$6,350 $12,700	$30 no deductible for 3 primary care visits. Additional office visits are subject to deductible. Speciaist subject to deductible Covered 100% after deductible	100% after in-network deductible 100% after in-network deductible 100% after deductible	$12,700 $25,400	0% after deductible	Not Applicable	$12,700 $25,400	Not Covered	100% after in-network deductible 100% after in-network deductible 100% after deductible

PLANS	PLAN TYPE	RX PLAN	IN-NETWORK					
			Deductible	Coinsurance	Coinsurance and Copay Max	Out-of-Pocket Max	Office Visits Specialist Office Visits Urgent Care - Physician's Office	ER Visits Ambulance Services Urgent Care Center or Outpatient Location
BLUE CROSS® GOLD **PREFERRED SELECT PARTNERED**	Blue Care Network HMO	6-Tier	$250 $500	20% after deductible for most services	$4,850 $9,700	$5,100 $10,200	$30 no deductible $50 after deductible $30 before deductible for PCP urgent care visit	Covered 80% after deductible plus $250 copay Covered 80% after deductible $40 before deductible
BLUE CROSS® SILVER* **PREFERRED SELECT PARTNERED**	Blue Care Network HMO	6-Tier	$1,650 $3,300	30% after deductible for most services	$4,700 $9,400	$6,350 $12,700	$30 no deductible $50 after deductible $30 before deductible for PCP urgent care visit	Covered 70% after deductible plus $250 copay Covered 70% after deductible $40 before deductible
BLUE CROSS® BRONZE* **PREFERRED SELECT PARTNERED**	Blue Care Network HMO *HSA Qualified Plan*	6-Tier	$5,950 $11,900	40% after deductible for most services	$400 $800	$6,350 $12,700	$30 after deductible $50 after deductible $30 after deductible for PCP urgent care visit	Covered 60% after deductible plus $250 copay Covered 60% after deductible $40 after deductible
BLUE CROSS® VALUE (CATASTROPHIC) **PREFERRED SELECT PARTNERED**	Blue Care Network HMO	6-Tier	$6,350 $12,700	0% after deductible	Not Applicable	$6,350 $12,700	$30 no deductible Specialists are subject to deductible $30 before deductible for PCP urgent care visit	Covered 100% after deductible Covered 100% after deductible $40 before deductible

PREFERRED PLANS (48 COUNTIES FOR GOLD AND VALUE/70 COUNTIES FOR SILVER AND BRONZE)

Broad choice of doctors and hospitals from BCN's entire HMO network. Primary care doctor will coordinate your care and refer you to a specialists when necessary. *Care outside the network is not covered.*

PARTNERED PLANS (3 COUNTIES)

Care within the Mercy Health system of doctors and hospitals located in Kent, Muskegon and Oceana counties. Primary care doctor will coordinate your care. Care within BCN's entire HMO network, but outside the Mercy Health system, will require primary care doctor and plan authorization. *Care outside the network is not covered.*

SELECT PLANS (19 COUNTIES)

Choose from a select network of quality primary care doctors with complete access to specialists and hospitals within BCN's entire HMO network. Primary care doctor will coordinate your care and refer you to specialists when necessary. *Care outside the network is not covered.*

VALUE (CATASTROPHIC) PLANS

Available to individuals and members: Under 30 years of age. Must not have attained the age of 30 prior to the first day of the plan or policy year. Available to anyone of any age who has received a certification of exemption from the inividual mandate due to affordability or hardship.

PRESCRIPTION DRUG PLANS PACKAGED WITH ALL MEDICAL PLANS*

5-TIER RX PLAN Packaged with all PPO Plans	
Tier 1	Preferred Generic
Tier 2	Preferred Brand
Tier 3	Nonpreferred Brand
Tier 4	Preferred Specialty
Tier 5	Nonpreferred Specialty

6-TIER RX PLAN Packaged with all HMO Plans	
Tier 1a	Preferred Generic
Tier 1b	Nonpreferred Generic
Tier 2	Preferred Brand
Tier 3	Nonpreferred Brand
Tier 4	Preferred Specialty
Tier 5	Nonpreferred Specialty

CUSTOM SELECT DRUG LIST - NOW EXCLUDED	
Brand-name drugs with a generic equivalent available	Prescription drugs with comparable products available over-the-counter, including, but not limited to, cough/cold products
Compound hormones	
Lifestyle drugs	Select high abuse drugs
Compound drugs that contain any ingredients that are not approved by BCBSM	Drugs newly approved by the FDA until review and coverage determined by BCBSM Pharmacy and Therapeutics (P & T) Committee
State-controlled drugs	Dietary supplements
Over-the-Counter (OTC) drugs unless deemed as an Essential Health Benefit	Certain drugs may not be covered based on recommendations from the P & T Committee

**Rx copays vary by plan.*
Please refer to the Benefits-at-a-Glance for plan specific details.

Detailed **Benefits-at-a-Glance** for each plan are available in the **Plans** section.