Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

# County of Oakland
# Group Number: 71852  Package Code(s): 010
# Section Code(s): 3000, 3100, 3200
# CMM – Traditional Plan, Rx Plan
# Effective Date: 01/01/2024
# Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

**Note:** A list of services that require approval **before** they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services**.

## Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

| Benefits | Participating Provider |
|---|---|
| **Deductibles** - per calendar year | $200 per member<br>$400 per family<br>Not applicable for all services |
| **Copays**<br>• Fixed Dollar Copays | $100 copay for:<br>• Facility medical emergency |
| **Coinsurance**<br><br>• Annual Coinsurance maximums | 10% for most services, 25% for select service (PDN) up to a maximum of:<br>$1,000 per member<br>$1,000 per family |
| **Annual out-of-pocket maximums – per calendar year** | $4,125 per member<br>$10,250 per family<br>Includes Deductible, Coinsurance and Copays |
| **Lifetime dollar maximum** | Unlimited |

## Preventive Care Services

| Benefits | Participating Provider |
|---|---|
| Health Maintenance Exam - beginning age 4; one per calendar year | Covered - 100% |
| Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam | Covered - 100% |
| Annual Gynecological Exam - two per benefit period, in addition to health maintenance exam | Covered - 100% |
| Pap Smear Screening - one per calendar year | Covered - 100% |
| Mammography Screening - one per calendar year<br>includes 3D Mammography | Covered - 100% |
| Contraceptive Methods and Counseling | Covered - 100% |
| Prostate Specific Antigen (PSA) screening - one per benefit period | Covered - 100% |

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|---|---|
| Endoscopic Exams - one per benefit period | Covered - 100% |
| Fecal occult blood screening – one per calendar year | Covered - 100% |
| Flexible sigmoidoscopy exam – one per calendar year | Covered - 100% |
| Colonoscopy – routine or medically necessary – one per calendar year<br><br>Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable | Covered - 100% |
| Well Child Care<br>• 8 visits, birth through 12 months<br>• 6 visits, 13 months through 23 months<br>• 6 visits, 24 months through 35 months<br>• 2 visits, 36 months through 47 months<br><br>Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit | Covered - 100% |
| Immunizations - pediatric and adult | Covered - 100% |

## Physician Office Services

| Benefits | Participating Provider |
|---|---|
| Office Visits | Covered - 90% after deductible |
| Telemedicine Visits | Covered - 90% after deductible |
| Blue Cross Online Visits<br>Note: Services are payable when rendered through Blue Cross Online Visits℠ | Covered - 90% after deductible |
| Office Consultations | Covered - 90% after deductible |
| Outpatient and home medical care visits | Covered - 90% after deductible |
| Pre-Surgical Consultations | Covered - 90% after deductible |

## Emergency Medical Care

| Benefits | Participating Provider |
|---|---|
| Hospital Emergency Room<br>Qualified medical emergency | Covered - 100% after $100 copay; copay waived if admitted (includes accidental injuries) |
| Non-Emergency use of the Emergency Room | Covered - 100% after $100 copay; copay waived if admitted (includes accidental injuries) |
| Facility Urgent Care Services | Not Covered |
| Physician Urgent Care Services | Not Covered |
| Ambulance Services - Medically Necessary Transport | Covered - 90% after deductible |

## Diagnostic Services

| Benefits | Participating Provider |
|---|---|
| MRI, MRA, PET and CAT Scans and Nuclear Medicine | Covered - 90% |
| Diagnostic Tests, X-rays, Laboratory & Pathology | Covered - 90% |
| Radiation Therapy and Chemotherapy | Covered - 100% |

## Maternity Services Provided by a Physician

| Benefits | Participating Provider |
|---|---|
| Prenatal and Postnatal Care Visits | Covered - 100% |

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| Delivery and Nursery Care | Covered - 100% |

## Hospital Care

| Benefits | Participating Provider |
|---|---|
| Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies | Covered - 100% |
| Inpatient Medical Care | Covered - 100% |

## Alternatives to Hospital Care

| Benefits | Participating Provider |
|---|---|
| Hospice Care<br><br>Up to 28-pre hospice counseling visits before electing hospice services; when elected, four 90-day periods-provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management) | Covered - 100% |
| Infusion therapy:<br>Must be medically necessary<br>Must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC)<br>May use drugs that require preauthorization – consult with doctor | Covered - 100% |
| Home Health Care | Covered - 100% |
| Skilled Nursing | Covered - 100% |

## Surgical Services

| Benefits | Participating Provider |
|---|---|
| Surgery (includes related surgical services) | Covered - 100% |
| Bariatric Surgery | Covered - 90% |
| Sterilization - males only (Medical Necessary Only)<br>excludes reversal sterilization | Not Covered |
| Sterilization - females only<br>excludes reversal sterilization | Covered - 100% |
| Elective Abortions | Covered - 100% |

## Human Organ Transplants

| Benefits | Participating Provider |
|---|---|
| Specified Organ Transplants<br>In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504) | Covered - 100% |
| Specified Oncology Clinical Trial<br><br>Note: BCBSM covers clinical trials in compliance with PPACA | Covered - 100% |
| Kidney, Cornea, Bone Marrow and Skin | Covered - 100% |

## Behavioral Health Services (Mental Health and Substance Use Disorder)

| Benefits | Participating Provider |
|---|---|
| Inpatient Mental Health Care and Substance Use Disorder Treatment | Covered - 100% |
| Outpatient Mental Health Care and Substance Use Disorder Treatment | Covered - 100% |
| Telemedicine Mental Health Care | Covered - 100% |

## Autism Spectrum Disorders, Diagnoses and Treatment

| Benefits | Participating Provider |
|---|---|
| Applied Behavior Analysis (ABA)<br>Pre-authorization required<br><br>**Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment. | Covered - 100% |
| Physical, Occupational and Speech Therapy<br>Physical, Occupational and Speech therapy with an autism diagnosis is unlimited | Covered - 100% |
| Nutritional Counseling | Covered - 100% |

## Other Covered Services

| Benefits | Participating Provider |
|---|---|
| Cardiac Rehabilitation | Covered - 100% |
| Chiropractic Spinal Manipulation Services<br><br>Limited to a maximum of 38 visits per member per calendar year | Covered - 90% after deductible |
| Durable Medical Equipment | Covered - 90% after deductible |
| Prosthetic and Orthotic Devices | Covered - 90% after deductible |
| Diabetic Supplies<br>Test Strips, Lancets, Needles and Syringes | Covered - 90% after deductible |
| Private Duty Nursing Care | Covered - 75% after deductible |
| Allergy Testing and Therapy | Covered - 90% after deductible |

## Therapy Services

| Benefits | Participating Provider |
|---|---|
| Physical, Occupational and Speech Therapy combined therapy visits 1-60<br>Combined therapy visits 61 and after | Covered - 100%<br>Covered – 90% after deductible |

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# County of Oakland- DRAFT
# Group Number: 71852  Package Code(s): 010
# Section Code(s): 3000, 3100, 3200
# Prescription Drugs
# Effective Date: 01/01/2024
# Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

## Member's responsibility (copays and coinsurance amounts)

| Benefits | Coverage |
|---|---|
| Out of Pocket Maximum | $3,775 per member<br>$5,550 per family |
| Retail - 34-day or 90-day supply | $5 copay - Generic drugs<br>$20 copay - Preferred brand drugs<br>$40 copay - Non-Preferred brand drugs<br><br>Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 70% of the approved amount, less the member's copay. |
| Retail and Mail Order - 90-day supply | $5 copay - Generic drugs<br>$20 copay - Preferred brand drugs<br>$40 copay - Non-Preferred brand drugs |
| High-Cost Drug Discount Optimization Program | Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum. Note - Adjustments may be required to accurately reflect your annual out-of-pocket maximum with your true out-of-pocket costs. |
| Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA | Covered - 100% |
| **Oral and Injectable Contraceptives**<br>Retail and Mail Order | Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance |
| **Additional Services** | |
| Smoking Cessation Drugs | Covered |
| Weight Loss Drugs | Covered |

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| Impotency Drugs | Covered |
| Infertility Drugs | Not Covered |
| **Diabetic Supplies** | Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs.<br><br>• Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement.<br>• “Preferred” devices will be covered at 100% of our approved amount. “Nonpreferred” devices will be subject to your nonpreferred brand-name drugs cost-share requirement.<br>• If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies. |

## Features of your prescription drug plan

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| Prior authorization/step therapy | A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**. |