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): 020
Section Code(s): 1000, 1100, 1200
PPO - PPO 1 Plan, Rx2 Plan
Effective Date: 01/01/2024
Benefits-at-a-glance

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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	In-Network	Out-of-Network
Deductibles - per calendar year	$0/individual or $0/family (for most covered services) $200 per member $400 per family (for limited number of services)	$200 per member $400 per family (for limited services)
Copays • Fixed Dollar Copays	$20 copay for: • Facility Urgent care services • Professional Urgent care services • Primary Care Physician (PCP) office visits • Specialist office visits • Chiropractic spinal manipulations $100 copay for: • Facility medical emergency	$20 copay for: • Primary Care Physician (PCP) office visits • Specialist office visits • Chiropractic spinal manipulations $100 copay for: • Facility medical emergency
Coinsurance • Percent Coinsurance • Annual coinsurance maximums	0% for most services. 10% for select services (e.g. Ambulance, PDN,) up to a maximum of: $1,000 per member $1,000 per family	15% for most services, 25% for select services (e.g. Prosthetics/Orthotics, DME, PDN, Diabetic Supplies) up to a maximum of: $1,000 per member $1,000 per family **Note:** Services without a network are covered at the in-network level.

Annual out-of-pocket maximums per calendar year	$4,125 per member $10,250 per family Includes Deductible, Coinsurance and Copays	$4,125 per member $10,250 per family Includes Deductible, Coinsurance and Copays
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 85%
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per benefit period	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered – 85%
Fecal occult blood screening – one per calendar year	Covered - 100%	Not Covered
Breastfeeding Equipment	Covered - 100%	Covered – 85%
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $20 copay	Covered - 85% after $20 copay
Telemedicine Visits	Covered - 100%	Covered - 85% after $20 copay
Virtual Care - Online Medical Visits Note: Online Medical visits by a non-BCBSM selected vendor are not covered	Covered - 100%	Not Covered
Office Consultations	Covered - 100% after $20 copay	Covered - 85% after $20 copay
Pre-Surgical Consultations	Covered - 100%	Covered - 85%

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $100 copay; copay waived if admitted (includes observation stays)	Covered - 100% after $100 copay; copay waived if admitted (includes observation stays)
Non-Emergency use of the Emergency Room	Covered - 100% after $100 copay; copay waived if admitted and accidental injury	Covered - 100% after $100 copay; copay waived if admitted and accidental injury

Facility Urgent Care Services	Covered - 100% after $20 copay	Covered - 85% after $20 copay
Physician Urgent Care Services	Covered - 100% after $20 copay	Covered - 85% after $20 copay
Ambulance Services - Medically Necessary Transport	Covered - 90% after deductible	Covered - 90% after in-network deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine -precertification may be required	Covered - 100%	Covered - 85%
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 100%	Covered - 85%
Radiation Therapy and Chemotherapy	Covered - 100%	Covered - 85%

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 85%
Delivery and Nursery Care	Covered - 100%	Covered - 85%

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 100%	Covered - 85%
Inpatient Medical Care	Covered - 100%	Covered - 85%

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care 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%	Covered - 85%
Home Health Care	Covered - 100%	Covered - 85%
Skilled Nursing	Covered - 100%	Covered - 85%

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 100%	Covered - 85%
Bariatric Surgery	Covered - 100%	Covered - 85%
Sterilization - males only excludes reversal sterilization	Covered - 100%	Covered - 85%
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 85%
Elective Abortions	Covered - 100%	Covered - 85%

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants	Covered - 100%	Covered – 85%
Kidney, Cornea, Bone Marrow and Skin	Covered - 100%	Covered - 85%

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 100%	Covered - 85%
Outpatient Mental Health Care	Covered - 100% after $20 copay	Covered - 85% after $20 copay
Telemedicine Mental Health Care	Covered - 100%	Covered - 85% after $20 copay
Virtual Online Mental Health Care	Covered - 100%	Not Covered
Outpatient Substance Use Disorder Treatment	Covered - 100% after $20 copay	Covered - 85% after $20 copay

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out-of-Network
Applied Behavior Analysis (ABA) Pre-authorization required **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%	Covered - 100%
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 100%	Covered - 85%
Nutritional Counseling	Covered - 100%	Covered - 85%

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 100%	Covered - 85%
Chiropractic Spinal Manipulation Services Limited to a maximum of 38 visits per member per calendar year	Covered - 100% after $20 copay	Covered - 85% after $20 copay
Durable Medical Equipment	Covered - 100%	Covered - 75% after deductible
Prosthetic and Orthotic Devices	Covered - 100%	Covered - 75% after deductible
Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 100%	Covered - 75% after deductible
Private Duty Nursing Care	Covered - 90% after deductible	Covered - 75% after deductible
Allergy Testing and Therapy	Covered - 100%	Covered - 85%

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Unlimited	Covered - 100%	Covered - 85%

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County of Oakland
Group Number: 71852 Package Code(s): 020
Section Code(s): 1000, 1100, 1200
Prescription Drugs
Effective Date: 01/01/2024
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BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

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 $5,550 per family
Retail - 34-day or 90-day supply	$5 copay - Generic drugs $20 copay - Preferred brand drugs $40 copay - Non-Preferred brand drugs Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 85% of the approved amount, less the member's copay.
Retail and Mail Order - 90-day supply	$5 copay - Generic drugs $20 copay - Preferred brand drugs $40 copay - Non-Preferred brand drugs
Specialty Retail - 90-day supply	$5 copay - Generic drugs $20 copay - Preferred brand drugs $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 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
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. • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement. • “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. • 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

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**.