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): 030
Section Code(s): 1000, 1100, 1200
PPO - PPO 2 Plan, Rx3 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	In-Network	Out-of-Network
Deductibles - per calendar year	$100 per member $200 per family	$250 per member $500 per family Out-of-Network deductible contributes toward the In-Network deductible
Copays • Fixed Dollar Copays	$20 copay for: • Facility Urgent care services • Professional Urgent care services • Primary Care Physician (PCP) Physician Office Visits • Medical Online visits • Chiropractic spinal manipulations $100 copay for : • Facility medical emergency	$100 copay for: • Facility medical emergency
Coinsurance • Percent Coinsurance • Annual Coinsurance Maximums	10% for most services. 50% for PDN up to a maximum of: $500 per member $1,000 per family	30% for most services. 50% for PDN up to a maximum of: $1,500 per member $3,000 per family Out-of-Network coinsurance contributes towards the In-Network coinsurance maximum **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 Out-of-Network Out-of-Pocket Maximum dollars contribute towards the In-Network Out-of-Pocket Maximum
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 - 70% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 70% after deductible
Fecal occult blood screening – one per calendar year	Covered - 100%	Not Covered
Flexible sigmoidoscopy exam – one per calendar year	Covered - 100%	Not Covered
Colonoscopy – routine or medically necessary – one per calendar year Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance if applicable	Covered - 100%	Not Covered
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 - 70% after deductible
Telemedicine Visits	Covered - 100% after $20 copay	Covered - 70% after deductible
Virtual Care - Online Medical Visits Note: Online Medical visits by a non-BCBSM selected vendor are not covered	Covered - 100% after $20 copay	Not Covered
Office Consultations	Covered – 100% after $20 copay	Covered - 70% after deductible
Outpatient and home medical care visits – must be medically necessary	Covered - 90% after deductible	Covered - 70% after deductible
Pre-Surgical Consultations	Covered – 100% after $20 copay	Covered - 70% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $100 copay; copay waived if admitted and accidental injury	Covered - 100% after $100 copay; copay waived if admitted and accidental injury
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 - 100% after $20 copay
Physician Urgent Care Services	Covered - 100% after $20 copay	Covered - 70% after deductible
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 - 90% after deductible	Covered - 70% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 90% after deductible	Covered - 70% after deductible
Radiation Therapy and Chemotherapy	Covered - 90% after deductible	Covered - 70% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 70% after deductible
Delivery and Nursery Care	Covered - 90% after deductible	Covered - 70% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies – unlimited days	Covered - 90% after deductible	Covered - 70% after deductible
Inpatient Medical Care	Covered - 90% after deductible	Covered - 70% after deductible

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 - 100%
Infusion therapy: Must be medically necessary Must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) May use drugs that require preauthorization – consult with doctor	Covered - 90% after deductible	Covered - 90% after in-network deductible
Home Health Care	Covered - 90% after deductible	Covered - 90% after in-network deductible

Skilled Nursing Limited to 120 days per calendar year	Covered - 90% after deductible	Covered - 90% after in-network deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 90% after deductible	Covered - 70% after deductible
Bariatric Surgery	Covered - 90% after deductible	Covered - 70% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 90% after deductible	Covered - 70% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 70% after deductible
Elective Abortions	Covered - 90% after deductible	Covered - 70% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Covered – 100%
Specified Oncology Clinical Trial Note: BCBSM covers clinical trials in compliance with PPACA	Covered - 90% after deductible	Covered - 70% after deductible
Kidney, Cornea, Bone Marrow and Skin	Covered - 90% after deductible	Covered - 70% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Use Disorder Treatment - unlimited days	Covered - 90% after deductible	Covered - 70% after deductible
Residential psychiatric treatment facility: Covered mental health services must be performed in a residential psychiatric treatment facility Treatment must be preauthorized Subject to medical criteria	Covered - 90% after deductible	Covered - 70% after deductible
Outpatient Mental Health Care	Covered - 90% after deductible	Covered - 90% after in-network deductible
Telemedicine Mental Health Care	Covered - 100% after $20 copay	Covered - 70% after deductible
Virtual Online Mental Health Care	Covered - 100% after $20 copay	Not Covered
Outpatient Substance Use Disorder Treatment	Covered - 90% after deductible	Covered - 90% after in-network deductible

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 - 90% after deductible	Covered - 90% after in-network deductible

Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 90% after deductible	Covered - 70% after deductible
Nutritional Counseling	Covered - 90% after deductible	Covered - 70% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 90% after deductible	Covered - 70% after deductible
Chiropractic Spinal Manipulation Services Limited to a maximum of 24 visits per member per calendar year	Covered – 100% after $20 copay	Covered - 70% after deductible
Durable Medical Equipment	Covered - 90% after deductible	Covered - 90% after in-network deductible
Prosthetic and Orthotic Devices	Covered - 90% after deductible	Covered - 90% after in-Network deductible
Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 90% after deductible	Covered - 90% after in-Network deductible
Private Duty Nursing Care	Covered - 50% after deductible	Covered - 50% after in-network deductible
Allergy Testing and Therapy	Covered - 100%	Covered - 70% after deductible
Outpatient Diabetes Management Program (ODMP) Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	Covered - 90% after deductible for diabetes medical supplies Covered -100% for diabetes self-management training	Covered - 70% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 180 visits per member per calendar year	Covered - 90% after deductible	Covered - 70% after deductible

County of Oakland
Group Number: 71852   Package Code(s): 030
Section Code(s): 1000, 1100, 1200
Prescription Drugs
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.

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 70% 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
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**.