



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

## County of Oakland

**Group Number: 71872    Package Code(s): 060**

**Division Code(s): 4000, 4100**

**CMM - Medicare Sup CMM Trad Plan, Rx 5, Hearing 1**

**Effective Date: 01/01/2025**

## 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**.

**Services not covered under the BCBSM plan may be covered by Medicare.**

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

Benefits	Participating Provider
<b>Deductibles</b> - per calendar year	None
<b>Copays</b> • Fixed Dollar Copays	\$100 copay for: • Facility medical emergency; copay waived if admitted
<b>Coinsurance</b> • Percent Coinsurance	0%
<b>Annual out-of-pocket maximums</b>	None Includes Deductible, Coinsurance and Copays
<b>Lifetime dollar maximum</b>	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 - one 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 includes 3D Mammography	Covered - 100%
Contraceptive Methods and Counseling	Covered - 100%
Prostate Specific Antigen (PSA) screening	Covered - 100%
Endoscopic Exams - one per benefit period	Covered - 100%

Well Child Care <ul style="list-style-type: none"> <li>• 8 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 6 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> </ul> Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered – 100%
Immunizations – adult <ul style="list-style-type: none"> <li>• Influenza</li> <li>• Pneumococcal</li> <li>• Hepatitis B</li> <li>• Zosters</li> <li>• Chickenpox</li> </ul>	Covered - 100%

## Physician Office Services

Benefits	Participating Provider
Office Visits	Not Covered by BCBSM
Virtual Care - Online Medical Visits Note: Online Medical visits by a non-BCBSM selected vendor are not covered.	Covered - 100%
Telemedicine Visits	Not Covered by BCBSM
Office Consultations	Not Covered by BCBSM
Pre-Surgical Consultations	Not Covered by BCBSM

## Emergency Medical Care

Benefits	Participating Provider
Hospital Emergency Room Qualified medical emergency	Covered - 100% after \$100 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Covered - 100% after \$100 copay; copay waived if admitted
Facility Urgent Care Services	Not Covered by BCBSM
Physician Urgent Care Services	Not Covered by BCBSM
Ambulance Services - Medically Necessary Transport	Covered - 100%

## Diagnostic Services

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

## Maternity Services Provided by a Physician

Benefits	Participating Provider
Prenatal and Postnatal Care Visits	Covered - 100%
Delivery and Nursery Care excludes dependent children	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	Covered - 100%
Home Health Care	Covered - 100%
Skilled Nursing Limited to 100 days per calendar year	Covered - 100%

Surgical Services	
Benefits	Participating Provider
Surgery (includes related surgical services)	Covered - 100%
Bariatric Surgery	Covered - 100%
Sterilization - male reproductive organs excludes reversal sterilization	Covered - 100%
Sterilization - female reproductive organs excludes reversal sterilization	Covered - 100%
Expanded Abortion Services	Covered - 100%
<b>Note:</b> Abortions are not covered if rendered in a location where abortions are not legal.	

Human Organ Transplants	
Benefits	Participating Provider
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	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 (excluding office visits)	Covered - 100%
Virtual Care - Online Mental Health Visits Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered.	Covered - 100%

## Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	Participating Provider
Applied Behavior Analysis (ABA) Pre-authorization required  <b>Note:</b> Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).	Covered - 100%
Physical, Occupational and Speech Therapy 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	Covered - 100%
Durable Medical Equipment	Covered - 100%
Prosthetic and Orthotic Devices	Covered - 100%
Private Duty Nursing Care	Covered - 100%
Allergy Testing and Therapy	Covered - 100%

## Therapy Services

Benefits	Participating Provider
Physical, Occupational and Speech Therapy	Covered - 100%



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**Group Number: 71872    Package Code(s): 060**  
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**Hearing Care Coverage**  
**Effective Date: 01/01/2025**  
**Benefits-at-a-glance**

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Benefits	Participating Provider
Frequency Limitation	Once every 36 months
Audiometric Exam	Covered - 100% by BCBSM
Hearing Aid Evaluation	Covered - 100% by BCBSM
Hearing Aid	Covered - 100% by BCBSM
Benefit Maximum	Hearing Aid Maximum \$2,000 per ear Total Hearing Aid Maximum \$3,000
Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.	
Hearing Aid Conformity Test	Covered - 100% by BCBSM

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### Prescription Drugs

### Effective Date: 01/01/2025

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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.

Prescription drug plan will cover drugs on the Custom PPO Drug List, which is available at [bcbsm.com/customdruglist](https://bcbsm.com/customdruglist)

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

Benefits	Coverage
Out of Pocket Maximum	\$3,775 per member \$5,550 per family
Retail - 30-day supply	\$10 copay - Generic drugs \$30 copay - Preferred brand drugs \$50 copay - Non-Preferred brand drugs  Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Retail and Mail Order - 90-day supply	\$10 copay - Generic drugs \$30 copay - Preferred brand drugs \$50 copay - Non-Preferred brand drugs
Specialty Drugs	Retail 30-day: \$10 copay - Generic drugs \$30 copay - Preferred brand drugs \$50 copay - Non-Preferred brand drugs  Retail 90-day: \$10 copay - Generic drugs \$30 copay - Preferred brand drugs \$50 copay - Non-Preferred brand drugs  Members are restricted to a 30-day supply and certain specialty drugs are limited to only a 15-day supply for each fill.
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%

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<b>Oral and Injectable Contraceptives</b> Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance
<b>Additional Services</b>	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Not Covered
<b>Diabetic Supplies</b>	<p>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.</p> <ul style="list-style-type: none"> <li>• Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement.</li> <li>• "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.</li> <li>• 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.</li> </ul>

Features of your prescription drug plan	
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM <b>before</b> select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. <b>Step Therapy</b> , 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 <a href="http://bcbsm.com/pharmacy">bcbsm.com/pharmacy</a> .
Maximum allowable cost drugs	When you receive a generic maximum allowable cost (MAC) drug from an in-network pharmacy, you pay your cost share as noted in your coverage. However, if you request a brand-name drug and the prescriber did not write "Dispense as Written" or "DAW" on the prescription, you must pay the difference between the maximum allowable cost and the Blue Cross Blue Shield of Michigan approved amount for the brand-name drug, plus your copayment. If the prescriber wrote "Dispense as Written" or "DAW" on the prescription, we will pay the pharmacy the approved amount for the brand-name drug, after deduction of your copayment.