Benefits-at-a-Glance
Classic
00115485 COUNTY OF OAKLAND
0001/0001,0002/0001,0003/0001,0004/0001
Effective Date: 01/01/2025

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 to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

Preauthorization for Select Services - Services listed in this summary are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCN except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **https://bcbsm.com/priorauth**.

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

Benefits	
Deductible (Coinsurance and select fixed dollar copays as defined by your plan documents, apply once the deductible has been met.)	None
Fixed Dollar Copays	$20 for office visits $20 for urgent care visits $100 for emergency room visits $20 for referral physician visits
Coinsurance	None
Coinsurance Maximum	None
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$6,600 per member/$13,200 per family per calendar year

Preventive services

Benefits	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening - laboratory services only	100%
Well-Baby and Well-Child Visits	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening - laboratory services only	100%
Routine Colonoscopy	100%

Preventive services (continued)

Benefits	
Mammography Screening	100%
Voluntary Sterilization of Female Reproductive Organs	100%
Breast Pumps (DME guidelines apply.)	100%
Routine Maternity Prenatal and Postnatal Care	100%

Physician office services

Benefits	
PCP Office Visits **Note:** Applicable cost sharing applies when other services are received in the office	$20 Copay
Medical Online Visits - when performed by a BCN participating provider or BCN designated online vendor **Note:** Not all services delivered virtually are considered an online visit but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	$20 Copay
Referral Physician Visits - when referred for other than preventive services **Note:** Applicable cost sharing applies when other services are received in the office	$20 Copay

Emergency medical care

Benefits	
Hospital Emergency Room - copay waived if admitted as inpatient	$100 Copay
Urgent Care Center	$20 Copay
Retail Health Clinic	$20 Copay
Ambulance Services - medically necessary	100%

Diagnostic services

Benefits	
Laboratory and Pathology Tests	100%
Diagnostic Tests and X-rays	100%
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	100%
Radiation Therapy	100%

Maternity services provided by a physician

Benefits	
Routine Prenatal and Postnatal Care Visits	100%
Delivery and Nursery Care - professional services (see "Hospital Care" for facility charges)	100%

Hospital care

Benefits	
General Nursing Care, Hospital Services and Supplies	100%
Outpatient Surgery	100%

Alternatives to hospital care

Benefits	
Skilled Nursing Care	100% Up to 730 days per lifetime
Hospice Care	100%
Home Health Care	100%

Surgical services

Benefits	
Surgery - includes all related surgical services and anesthesia.	100%
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	100%
Expanded Abortion Services	Not covered
Human Organ Transplants (subject to medical criteria)	100%
Reduction Mammoplasty (subject to medical criteria)	100%
Male Mastectomy (subject to medical criteria)	100%
Temporomandibular Joint Syndrome (subject to medical criteria)	100%
Orthognathic Surgery (subject to medical criteria)	100%
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	100%

Behavioral health services (mental health and substance use disorder treatment)

Benefits	
Inpatient Mental Health Care	100%
Residential Substance Use Disorder	100%
Outpatient Mental Health Care includes online and telemedicine visits **Note:** For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	$20 Copay
Outpatient Substance Use Disorder	$20 Copay

Autism spectrum disorders, diagnoses and treatment

Benefits	
Applied behavioral analysis (ABA) treatment **Note:** 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)	$20 Copay
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	100%
Other covered services, including mental health services, for autism spectrum disorder	See your outpatient mental health, medical office visit and preventive benefit.

Other services

Benefits	
Allergy Testing and Therapy	100%
Allergy Office Visits	$20 Copay
Allergy Injections	100%
Chiropractic Spinal Manipulation - when referred	$20 Copay Limited to 30 visits per calendar year
Outpatient Physical, Speech and Occupational Therapy - Subject to meaningful improvement within 60 days	100% Limited to 60 visits per calendar year for any combination of outpatient rehabilitation therapies
Infertility Counseling and Treatment	100%
Assisted Reproductive Technology Services such as IVF, GIFT, TUFT and ZIFT	100%
Durable Medical Equipment	100%
Prosthetic and Orthotic Appliances	100%
Diabetic Supplies **Note:** Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable prescription drug cost-sharing will apply.	100%
Hearing Aid	Monaural benefit maximum - $3,000 every 36 months; Binaural benefit maximum - $6,000 every 36 months

Prescription drugs

Benefits	
Generic Tier	$10 copay
Preferred Brand Tier	$30 copay
Nonpreferred Brand Tier	$50 copay
Contraceptives	Women's Contraceptives - Generic - 100%, Preferred Brand - $30 copayment applies, Nonpreferred Tier - $50 Copayment applies
Drugs for the Treatment of Sexual Dysfunction	50% coinsurance
Mail Order Prescription Drugs	One time the applicable copay up to a 90 day supply. Specialty drugs are not covered through mail order pharmacies.

Prescription drugs (continued)

Benefits	
Diabetic Supplies	Select diabetic supplies and equipment are covered, applicable cost sharing will apply. Cost sharing may not apply to certain preferred glucometers as defined on the drug list.
Specialty Drug Pharmacy	Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs
Variable Cost Share Coupon Program	Your plan includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum.
Prescription Drug Deductible	None
Custom Drug List	The list of prescription drugs that have been approved by the U.S. Food and Drug Administration and approved by the BCBSM/BCN Pharmacy and Therapeutics Committee. The list represents the clinical judgment of Michigan physicians, pharmacists and other experts in the diagnosis and treatment of disease and promotion of health. Medications are selected based on clinical effectiveness, safety and opportunity for cost savings. Some drugs included in the Custom Drug List require prior authorization and/or step therapy by BCN before they are covered. The drug list may be modified by BCN as needed to remove or add a covered drug or to modify the requirements for authorization of a covered drug. The list may be found at https://www.bcbsm.com/druglists

For Internal Purposes Only
Benefits Selected - CLSSLG : 10305C,50CWR,6600PM,ART,CO20,DCCRM,ER100,HA3K36,MOPD1X,OPRH,SN730,UR20