



**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
Division Code(s): 1000, 1100, 1200
PPO - PPO 2 Plan, Rx3, Hearing 1
Effective Date: 01/01/2025
Benefits-at-a-glance

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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.

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Annual out-of-pocket maximums	\$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	Covered - 100%	Not Covered
Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance if applicable		
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	Covered - 100%	Not Covered
Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit		
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	Covered - 100% after \$20 copay	Not Covered
Note: Online Medical visits by a non-BCBSM selected vendor are not covered.		
Office Consultations	Covered - 100% after \$20 copay	Covered - 70% after deductible

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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	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	Covered - 100% after \$100 copay; copay waived if admitted
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	Covered - 100%	Covered - 100%
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)		

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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 - male reproductive organs excludes reversal sterilization	Covered - 90% after deductible	Covered - 70% after deductible
Sterilization - female reproductive organs excludes reversal sterilization	Covered - 100%	Covered - 70% after deductible
Expanded Abortion Services	Covered - 90% after deductible	Covered - 70% after deductible
Note: Abortions are not covered if rendered in a location where abortions are not legal.		

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% -In designated facilities only
Specified Oncology Clinical Trial	Covered - 90% after deductible	Covered - 70% after deductible
Note: BCBSM covers clinical trials in compliance with PPACA		
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 and Substance Use Disorder Treatment	Covered - 90% after deductible	Covered - 90% after in-network deductible
Telemedicine Mental Health Care	Covered - 100% after \$20 copay	Covered - 70% after deductible

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Virtual Care - Online Mental Health Visits	Covered - 100% after \$20 copay	Not Covered
Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered.		
Office Equivalent Mental Health and Substance Use Disorder Treatment	Covered - 100% after \$20 copay	Covered - 70% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out-of-Network
Applied Behavior Analysis (ABA) Prior authorization required 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).	Covered - 100%	Covered - 100%
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 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

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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

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Group Number: 71852 Package Code(s): 030
Division Code(s): 1000, 1100, 1200
Hearing Care Coverage
Effective Date: 01/01/2025
Benefits-at-a-glance

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Member's responsibility (coinsurance)

Benefits	Participating Provider	Non-Participating Provider
Coinsurance	No Coinsurance	No Coinsurance

Covered services

To be payable, hearing care benefits may be received from a participating or non-participating provider and in the order listed.

Benefits	Participating Provider	Non-Participating Provider
Frequency Limitation	Once every 36 months	
Audiometric Exam	Covered - 100%	Covered - 100%
Hearing Aid Evaluation	Covered - 100%	Covered - 100%
Hearing Aid	Covered - 100%	Covered - 100%
Benefit Maximum - \$3000 1Hearing Aid \$2,000 2 Hearing Aids \$3000		
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%	Covered - 100%

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County of Oakland
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Division Code(s): 1000, 1100, 1200
Prescription Drugs
Effective Date: 01/01/2025
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 \$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 70% 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 Generic Specialty, \$30 Preferred Specialty, \$50 Non-Preferred Specialty Members are restricted to a 30 or 90-day supply and certain specialty drugs are limited to only a 15-day supply for each fill.

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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.

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.