

**County of Oakland**  
PPO 2 Plan, Rx3, Hearing 1

Coverage for: Individual/Family | Plan Type: PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bcbsm.com](http://www.bcbsm.com) or call 1-877-752-1233. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-877-752-1233 to request a copy.

Important Questions	Answers		Why This Matters:
	In-Network	Out-of-Network	
What is the overall <u>deductible</u> ?	\$100 Individual/ \$200 Family	\$250 Individual/ \$500 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Preventive care, most outpatient physician services (e.g. primary care, urgent care, specialist visits, telemedicine e-visits), most chiropractic care, emergency room care and prescription drug coverage are covered before you meet your deductible.		This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.		You don't have to meet <u>deductibles</u> for specific services.
What is the <u>coinsurance limit</u> for this medical <u>plan</u> ?	\$500 Individual/ \$1,000 Family	\$1,500 Individual/ \$3,000 Family	
What is the <u>out-of-pocket limit</u> for this medical <u>plan</u> ? (These figures include the medical deductible, coinsurance and copays.)	\$4,125 Individual/ \$10,250 Family	\$4,125 Individual/ \$10,250 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. These figures include medical deductible, coinsurance and copays.
What is the <u>out-of-pocket limit</u> for this prescription <u>plan</u> ?	\$3,775 Individual/ \$5,550 Family	\$3,775 Individual/ \$5,550 Family	

Important Questions	Answers		Why This Matters:
	In-Network	Out-of-Network	
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<p>Premiums, <u>balance-billing</u> charges, any <u>pharmacy</u> penalty and health care this <u>plan</u> doesn't cover.</p> <p>Deductible and fixed dollar copayments are not included in the out-of-pocket limits applicable to <u>medical coinsurance</u>.</p> <p>Amounts attributed to the total out-of-pocket limits for <u>medical services</u> are not include in the out-of-pocket limits for <u>prescription costs</u>.</p>		Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. For a list of <u>network providers</u> see <a href="http://www.bcbsm.com">www.bcbsm.com</a> or call 1-877-752-1233		This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.		You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /office visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	Online visits	\$20 <u>copay</u> /office visit; <u>deductible</u> does not apply	Not Covered	Online Medical visits by a non-BCBSM selected vendor are not covered.
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> / immunization	No charge; <u>deductible</u> does not apply	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	May require <u>prior authorization</u> .
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.bcbsm.com/druglists">www.bcbsm.com/druglists</a>	Generic or prescribed over-the-counter drugs	\$10 <u>copay</u> /prescription for retail 30-day supply, \$10 <u>copay</u> /prescription for retail or mail order 90-day supply; <u>deductible</u> does not apply	\$10 <u>copay</u> /prescription for retail 30-day supply plus an additional 30% of BCBSM approved amount for the drug; <u>deductible</u> does not apply	<u>Prior authorization</u> , step therapy and quantity limits may apply to select drugs. <u>Preventive drugs</u> covered in full. Mail order drugs are not covered out-of-network. Effective 1/1/2021, select diabetic supplies and devices may be covered under the prescription drug program.  Covers up to a 90-day supply (retail or up to a 90-day supply mail order). Specific criteria may need to be met in order for some high-cost medications to be covered.
	Preferred brand-name drugs	\$30 <u>copay</u> /prescription for retail 30-day supply, \$30 <u>copay</u> /prescription for retail or mail order 90-day supply; <u>deductible</u> does not apply	\$30 <u>copay</u> /prescription for retail 30-day supply plus an additional 30% of BCBSM approved amount for the drug; <u>deductible</u> does not apply	
	Non-Preferred brand-name drugs	\$50 <u>copay</u> /prescription for retail 30-day supply, \$50 <u>copay</u> /prescription for retail or mail order 90-day supply; <u>deductible</u> does not apply	\$50 <u>copay</u> /prescription for retail 30-day supply plus an additional 30% of BCBSM approved amount for the drug; <u>deductible</u> does not apply	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$100 <u>copay</u> /visit; <u>deductible</u> does not apply	\$100 <u>copay</u> /visit; <u>deductible</u> does not apply	<u>Copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Mileage limits apply. Must be medically necessary.
	<u>Urgent care</u>	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior authorization</u> is required. Nonemergency services must be rendered in a participating hospital.
	Physician/surgeon fee	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need behavioral health services (mental health and substance use disorder)</b>	Outpatient services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Your cost share may be different for services performed in an office setting.
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior authorization</u> is required. Nonemergency services must be rendered in a participating hospital.
<b>If you are pregnant</b>	Office visits	No charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services <u>cost share</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Physician certification required. Unlimited visits.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Physical, Occupational, Speech therapy is limited to a combined maximum of 180 visits per member, per calendar year.
	<u>Habilitation services</u> Please see note in Limitations, Exceptions and & Other Important information for more details.	ABA- No Charge	ABA- No Charge	Habilitation services are limited to Applied Behavior Analysis (ABA) treatment for Autism – when rendered by Licensed Behavior Analyst (LBA), subject to <u>prior authorization</u> .  Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment. See Rehabilitation services for PT/OT/ST cost share.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Prior authorization</u> is required. Limited to a maximum of 120 days per member, per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	<u>Hospice services</u>	No charge; <u>deductible</u> and <u>coinsurance</u> do not apply	No charge; <u>deductible</u> and <u>coinsurance</u> do not apply	Physician certification required. 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.
<b>If your child needs dental or eye care</b>  No coverage for routine dental or eye care under the medical plan, except as required by PPACA.	Children's eye exam	Not Covered	Not Covered	For more information about vision coverage visit <a href="http://www.heritagevisionplans.com">www.heritagevisionplans.com</a> or <a href="http://www.oakgov.com/benefits">www.oakgov.com/benefits</a> .
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	For more information about dental coverage visit <a href="http://www.deltadentalmi.com">www.deltadentalmi.com</a> or <a href="http://www.oakgov.com/benefits">www.oakgov.com/benefits</a> .

**Excluded Services & Other Covered Services:**

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic surgery</li> <li>Dental care (Adult) (except to the extent required to be covered by PPACA)</li> <li>Glasses</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment (except the treatment of the underlying cause of infertility may be covered)</li> <li>Long-term care</li> <li>Routine eye care (Adult) (except to the extent required to be covered by PPACA)</li> </ul>	<ul style="list-style-type: none"> <li>Weight Loss programs (except to the extent required to be covered by PPACA)</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Chiropractic care</li> <li>Coverage provided outside the United States. See <a href="http://provider.bcbs.com">http://provider.bcbs.com</a></li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids</li> <li>Non-Emergency care when travelling outside the U.S.</li> <li>Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care</li> <li>Condition Management Solutions by Teladoc Health: Diabetes Management and Prevention, Hypertension Management, Weight Management</li> <li>Maven Clinic: Family Building, Maternity and Menopause Support</li> </ul>

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov) or by calling 1-877-752-1233. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross® and Blue Shield® of Michigan by calling 1-877-752-1233.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or <http://www.michigan.gov/difs> or [difs-HICAP@michigan.gov](mailto:difs-HICAP@michigan.gov)

**Does this plan provide Minimum Essential Coverage? Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet Minimum Value Standards? Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

**Language Access Services: See Addendum**

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$100
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This **EXAMPLE** event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$670</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$100
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This **EXAMPLE** event includes services like:

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$850</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$100
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This **EXAMPLE** event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic tests (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$150
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$450</b>

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or coinsurance, or benefits not otherwise covered.

