Blue Cross Blue Shield of Michigan

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

Lineage OP, LP
Group Number: 71890 Package Code(s): 020
Division Code(s): 1000, 1010, 2000, 2010, 3000, 3010, 4000, 4010, 5000, 5010, 6000, 6010
PPO - Core Plan, Rx2, Hearing 2
Effective Date: 07/01/2026
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 benefit period Note: Two or more members must meet the family deductible. If the one-member deductible has been met, but not the family deductible, we will pay for covered services only for that member who has met the deductible. Covered services for the remaining family members will be paid when the full family deductible has been met.	$2,000 per member $6,000 per family	$4,000 per member $12,000 per family
Copays • Fixed Dollar Copays	$40 copay for : • Primary Care Physician (PCP) office visits • Chiropractic spinal manipulations $55 copay for : • Specialist office visits $90 copay for : • Facility Urgent care services • Professional Urgent care services $230 copay for : • Facility medical emergency	$230 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	20%	50% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums All members on the contract can contribute to the family out of pocket maximum; however, a single member will not exceed the individual out of pocket maximum.	$6,000 per member $12,000 per family Includes Deductible, Coinsurance and Copays	$12,000 per member $24,000 per family Includes Deductible and Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - 1 per benefit period	Covered - 100%	Covered - 50% after deductible
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Covered - 50% after deductible
Annual Gynecological Exam - 2 per benefit period, in addition to health maintenance exam	Covered - 100%	Covered - 50% after deductible
Pap Smear Screening - 1 per benefit period	Covered - 100%	Covered - 50% after deductible
Mammography Screening - 1 per benefit period includes 3D Mammography	Covered - 100%	Covered - 50% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - 1 per benefit period	Covered - 100%	Covered - 50% after deductible
Endoscopic Exams - 1 per benefit period	Covered - 100%	Covered - 50% after deductible
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 benefit period under the health maintenance exam benefit	Covered - 100%	Covered - 50% after deductible
Immunizations - pediatric and adult	Covered - 100%	Covered - 50% after deductible

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $40 pcp copay; $55 specialist copay	Covered - 50% after deductible
Telemedicine Visits	Covered - 100% after $40 pcp copay; $55 specialist copay	Covered - 50% after deductible
Virtual Care - Online Medical Visits Note: Online Medical visits by a non-BCBSM selected vendor are not covered.	Covered - 100%	Not Covered
Office Consultations	Covered - 100% after $40 pcp copay; $55 specialist copay	Covered - 50% after deductible
Pre-Surgical Consultations	Covered - 100% after $40 pcp copay; $55 specialist copay	Covered - 50% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered – Visits 1-3 $230 Copay then 80% after Deductible per visit Visits 4+ $275 Copay then 80% after Deductible per visit	Covered – Visits 1-3 $230 Copay then 80% after Deductible per visit Visits 4+ $275 Copay then 80% after Deductible per visit
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Facility Urgent Care Services	Covered - 100% after $90 copay	Covered - 50% after deductible

Physician Urgent Care Services	Covered - 100% after $90 copay	Covered - 50% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 50% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 50% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 50% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 50% after deductible
Delivery and Nursery Care Note: For facility services See "Hospital Care"	Covered - 80% after deductible	Covered - 50% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible	Covered - 50% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 50% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 80% after deductible	Covered - 50% after deductible
Home Health Care Limited to a maximum of 100 visits per benefit period	Covered - 80% after deductible	Covered - 50% after deductible
Skilled Nursing Limited to 100 days per benefit period	Covered - 80% after deductible	Covered - 50% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 50% after deductible
Bariatric Surgery Blue Distinction Centers only	Covered - 80% after deductible	Not Covered
Sterilization - male reproductive organs excludes reversal sterilization	Covered - 80% after deductible	Covered - 50% after deductible
Sterilization - female reproductive organs excludes reversal sterilization	Covered - 100%	Covered - 50% after deductible

Elective Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	Covered - 80% after deductible	Covered - 50% 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 - 80% after deductible	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 50% 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	Covered - 80% after deductible	Covered - 50% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 100% after $40 copay	Covered - 50% after deductible
Telemedicine Mental Health Care	Covered - $40 copay then 80% after deductible	Covered - 50% after deductible
Virtual Care - Online Mental Health Visits Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered.	Covered - 100%	Not Covered

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 - 80% after deductible	Covered - 50% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 100% after $40 copay	Covered - 50% after deductible
Nutritional Counseling	Covered - 80% after deductible	Covered - 50% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 50% after deductible
Chiropractic Spinal Manipulation Services Limited to a maximum of 20 visits per benefit period	Covered - 100% after $40 copay	Covered - 50% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 50% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 50% after deductible

Private Duty Nursing Care	Not Covered	Not Covered
Allergy Testing and Therapy	Covered - 80% after deductible	Covered - 50% after deductible
Facility Clinic Visit	Covered - 80% after deductible	Covered - 50% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical and Occupational Therapy - limited to a combined maximum of 40 visits per benefit period. Speech Therapy - limited to a separate maximum of 30 visits per benefit period.	Covered - 100% after $40 copay	Covered - 50% after deductible

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Hearing Care Coverage
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Member's responsibility (deductible and coinsurance)

Benefits	Participating Provider	Non-Participating Provider
Deductible	$2,000 per member $6,000 per family	$4,000 per member $12,000 per family
Coinsurance	20%	50%

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	Not Covered	Not Covered
Hearing Aid Evaluation	Covered - 80% after deductible	Covered - 50% after deductible
Hearing Aid Limited to a maximum of $5,000 Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.	Covered - 80% after deductible	Covered - 50% after deductible
Hearing Aid Conformity Test	Covered - 80% after deductible	Covered - 50% after deductible

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Prescription Drugs
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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
Retail - 30-day supply	$15 copay - Generic drugs $30 copay - Preferred brand drugs 50% coinsurance - Non-Preferred brand drugs $55 minimum 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	$30 copay - Generic drugs $60 copay - Preferred brand drugs 50% coinsurance - Non-Preferred brand drugs $110 minimum
Specialty Drugs **Exclusive Specialty Network**: We only cover specialty drugs when obtained from our exclusive specialty pharmacy network. Covered drugs will be subject to the member's cost-share requirements. If a member obtains specialty drugs from any other provider, they may be responsible for the total cost.	Retail 30-day: $15 copay - Generic drugs $30 copay - Preferred brand drugs 50% coinsurance - Non-Preferred brand drugs $55 minimum Members are restricted to a 30-day supply and certain specialty drugs are limited to only a 15-day supply for each fill.
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	Not 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

Preferred Therapy Program	A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications before prescribing a more expensive brand-name drug. It applies only to prescriptions being filled for the first time of a targeted medication. Before filling your initial prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at bcbsm.com/pharmacy, along with the preferred medications. If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect all targeted brand- name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.
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**.