Blue Cross Blue Shield of Michigan

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

FCA US
Group Number: 82300
PPO - Hourly BU Active Blue PPO
Effective Date: 01/01/2024
Benefits-at-a-glance

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. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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**.

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

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	$150 per member $300 per family	$500 per member $1,000 per family
Copays • Fixed Dollar Copays	$15 copay for: • Retail Health care services $50 copay for : • Facility Urgent care services • Professional Urgent care services $100 copay for : • Facility medical emergency	$50 copay for : • Facility Urgent care services • Professional Urgent care services $100 copay for : • Facility medical emergency
Plan Out of Pocket Maximum • Percent Coinsurance	None	20% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$9,450 per member $18,900 per family Includes Deductible, Coinsurance and Copays	Unlimited Includes Deductible and Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4	Covered - 100%	Not Covered
Routine Physical Related Tests and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered

Annual Gynecological Exam - 2 per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening	Covered - 100%	Covered - 80% after deductible
Mammography Screening - 1 per calendar year includes 3D Mammography	Covered - 100%	Covered - 80% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - beginning 40 years of age; 1 per calendar year	Covered - 100%	Covered - 80% after deductible
Endoscopic Exams - beginning at age 45: • Colonoscopy: 1 every 10 years; or every 5 years when no sigmoidoscopy or Barium Enema or when no colonoscopy within 10 years • Sigmoidoscopy: 1 every 5 years when no sigmoidoscopy or Barium Enema or when no colonoscopy within 10 years • Barium Enema: 1 every 5 years when no sigmoidoscopy or Barium Enema or when no colonoscopy within 10 years • Cologuard: 1 every 3 years • Proctosigmoidoscopy: 1 per calendar year	Covered - 100%	Not Covered Proctosigmoidoscopy – Covered 80% 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 calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult • Shingrix starting at age 50 • Zoster starting at age 50	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits Retail Health Visits	Covered - 100% after 50% copay Covered - 100% after $15 copay	Not Covered Not covered
Telemedicine Visits	Covered - 100% after $10 copay	Not Covered
Virtual Care - Online Medical Visits Note: Online Medical visits by a non-BCBSM selected vendor are not covered.	Covered - 100% after $10 copay	Not Covered
Office Consultations	Covered - 100% after 50% copay	Not Covered
Pre-Surgical Consultations	Covered - 100% after 50% copay	Not Covered

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	Not Covered	Not Covered
Facility Urgent Care Services	Covered - 100% after $50 copay; copay waived if transferred to emergency room	Covered - 100% after $50 copay; copay waived if transferred to emergency room
Physician Urgent Care Services	Covered - 100% after $50 copay; copay waived if transferred to emergency room	Covered - 100% after $50 copay; copay waived if transferred to emergency room

Ambulance Services - Medically Necessary Transport	Covered - 100% after deductible	Covered - 80% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 100% after deductible	Covered - 80% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 100% after deductible	Covered - 80% after deductible
Radiation Therapy and Chemotherapy	Covered - 100% after deductible	Covered - 80% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal Care Visits	Covered - 100%	Not Covered
Postnatal Care Visits	Covered - 100%	Covered - 80% after deductible
Delivery and Nursery Care	Covered - 100% after deductible	Covered - 80% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies 365 days with 60-day renewal	Covered - 100% after deductible	Covered - 80% after deductible
Inpatient Medical Care	Covered - 100% after deductible	Covered - 80% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 100% after deductible	Not Covered
Home Health Care Limited to 3 days for each unused inpatient day with a 60-day renewal per calendar year	Covered - 100% after deductible	Covered - 80% after deductible
Skilled Nursing Limited to 2 days for each unused inpatient day with 60-day renewal	Covered - 100% after deductible	Covered - 80% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 100% after deductible	Covered - 80% after deductible
Bariatric Surgery	Covered - 100% after deductible	Covered - 80% after deductible
Sterilization - male reproductive organs excludes reversal sterilization	Covered - 100% after deductible	Covered - 80% after deductible
Sterilization - female reproductive organs excludes reversal sterilization	Covered - 100%	Covered - 80% after deductible
Elective Abortions	Covered - 100% after deductible	Covered - 80% 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 - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 100% after deductible	Covered - 80% 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	Services are administered by another vendor. Please see your ID card.	Services are administered by another vendor. Please see your ID card.
Outpatient Mental Health Care and Substance Use Disorder Treatment	Services are administered by another vendor. Please see your ID card.	Services are administered by another vendor. Please see your ID card.

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out-of-Network
Applied Behavior Analysis (ABA) Pre-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).	Services are administered by another vendor. Please see your ID card.	Services are administered by another vendor. Please see your ID card.
Physical, Occupational and Speech Therapy services with an autism diagnosis are unlimited. Note: Physical Therapy services are administered by another vendor. Please see your ID card.	Covered - 100% after deductible	Covered - 80% after deductible
Nutritional Counseling	Covered - 100% after deductible	Covered - 80% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 100% after deductible	Not Covered
Chiropractic Spinal Manipulation Services Limited to a maximum of 24 visits per calendar year combined with Osteopathic manipulations	Covered – 100% after 50% copay	Not Covered
Durable Medical Equipment	Covered - 100%	Covered - 80% up to $500 benefit maximum for DME/P&O
Prosthetic and Orthotic Devices	Covered - 100%	Covered - 80% up to $500 benefit maximum for DME/P&O
Private Duty Nursing Care	Not Covered	Not Covered
Allergy Testing and Therapy	Covered - 100% after deductible	Not Covered

Facility Clinic Visit Cancer related diagnoses only	Covered - 100% after deductible	Covered - 80% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical Therapy – Limited to 60 visits combined with OT and ST	Services are administered by another vendor. Please see your ID card.	Services are administered by another vendor. Please see your ID card.
Occupational Therapy - Limited to 60 visits combined with PT and ST	Covered - 100% after deductible	Covered - 80% after deductible
Speech Therapy – Limited to 60 visits combined with PT and OT	Covered - 100% after deductible	Covered - 80% after deductible