



**Blue Cross  
Blue Shield  
of Michigan**

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

## FCA US

**Group Number: 82100 Package Code(s): 010, 020, 030, 040**

**Division Code(s): 4000**

**PPO - Active NBU PPO HSA**

**Effective Date: 01/01/2025**

## 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
<b>Deductibles</b> - per calendar year The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract.	\$1,650 per member \$3,300 per two person \$3,300 per employee + children \$3,300 per family	\$1,650 per member \$3,300 per two person \$3,300 per employee + children \$3,300 per family
<b>Coinsurance</b> • Percent Coinsurance	20%	40% <b>Note:</b> Services without a network are covered at the in-network level.
<b>Annual out-of-pocket maximums</b> The full family out of pocket maximum must be met before it is considered satisfied.	\$3,300 per member \$6,400 per two person \$6,100 per employee + children \$6,600 per family Includes Deductible, Coinsurance and Copays	\$4,800 per member \$9,400 per two person \$9,200 per employee + children \$9,600 per family Includes Deductible and Coinsurance
<b>Lifetime dollar maximum</b>	Unlimited	

### Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; 1 per calendar year	Covered - 100%	Covered - 60% after deductible
Routine Physical Related Tests and lab procedures performed as part of the health maintenance exam	Covered - 100%	Covered - 60% after deductible
Annual Gynecological Exam - 2 per calendar year, in addition to health maintenance exam	Covered - 100%	Covered - 60% after deductible
Pap Smear Screening – 1 per calendar year	Covered - 100%	Covered - 60% after deductible

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Mammography Screening - 1 per calendar year includes 3D Mammography	Covered - 100%	Covered - 60% 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 - 60% after deductible
Endoscopic Exams - beginning at age 45: <ul style="list-style-type: none"> <li>• Colonoscopy: 1 every 10 years; or every 5 years when no sigmoidoscopy or Barium Enema or when no colonoscopy within 10 years</li> <li>• Sigmoidoscopy: 1 every 5 years when no sigmoidoscopy or Barium Enema or when no colonoscopy within 10 years</li> <li>• Barium Enema: 1 every 5 years when no sigmoidoscopy or Barium Enema or when no colonoscopy within 10 years</li> <li>• Cologuard: 1 every 3 years</li> <li>• Proctosigmoidoscopy: 1 per calendar year</li> </ul>	Covered - 100%	Covered - 60% after deductible
Well Child Care <ul style="list-style-type: none"> <li>• 8 visits, birth through 12 months</li> <li>• 6 visits, 13 months through 23 months</li> <li>• 6 visits, 24 months through 35 months</li> <li>• 2 visits, 36 months through 47 months</li> </ul> <p>Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</p>	Covered - 100%	Covered - 60% after deductible
Immunizations - pediatric and adult <ul style="list-style-type: none"> <li>• Shingrix starting at age 50</li> <li>• Zoster starting at age 50</li> </ul>	Covered - 100%	Covered - 60% after deductible

## Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 80% after deductible	Covered - 60% after deductible
Telemedicine Visits	Covered - 80% after deductible	Covered - 60% after deductible
Retail Health Visit	Covered - 80% after deductible	Covered - 60% after deductible
Virtual Care - Online Medical Visits Note: Online Medical visits by a non-BCBSM selected vendor are not covered.	Covered - 80% after deductible	Not Covered
Office Consultations	Covered - 80% after deductible	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 80% after deductible	Covered - 60% after deductible

## Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 80% after deductible	Covered - 80% after deductible
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Facility Urgent Care Services	Covered - 80% after deductible	Covered - 60% after deductible
Physician Urgent Care Services	Covered - 80% after deductible	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 60% after deductible

## Diagnostic Services

Benefits	In-Network	Out-of-Network
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MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 60% after deductible

## Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 60% after deductible
Delivery and Nursery Care	Covered - 80% after deductible	Covered - 60% 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 - 60% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 60% after deductible

## Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care Limited to lifetime maximum of 365 days	Covered - 80% after deductible	Not Covered
Home Health Care Limited to 3 days for each unused inpatient day per calendar year	Covered - 80% after deductible	Covered - 60% after deductible
Skilled Nursing	Covered - 80% after deductible	Covered - 60% after deductible

## Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Bariatric Surgery	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - male reproductive organs excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - female reproductive organs excludes reversal sterilization	Covered - 100%	Covered - 60% after deductible
Expanded Abortion Services	Covered - 80% after deductible	Covered - 60% after deductible
<b>Note:</b> Abortions are not covered if rendered in a location where abortions are not legal.		

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## 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 - 80% after deductible	Covered - 60% 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 - 60% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Telemedicine Mental Health/Substance Use Disorder Care	Covered - 80% after deductible	Covered - 60% after deductible
Virtual Care - Online Mental Health/Substance Use Disorder Visits Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered.	Covered - 80% after deductible	Not Covered

## Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out-of-Network
Applied Behavior Analysis (ABA) Prior authorization required  <b>Note:</b> 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 - 60% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 80% after deductible	Covered - 60% after deductible
Nutritional Counseling	Covered - 80% after deductible	Covered - 60% after deductible

## Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation Services Limited to a maximum of 24 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 60% after deductible
Private Duty Nursing Care	Covered - 80% after deductible	Covered - 60% after deductible
Allergy Testing and Therapy	Covered - 80% after deductible	Covered - 60% after deductible
Facility Clinic Visit Cancer related diagnosis only	Covered - 80% after deductible	Covered - 60% after deductible

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## Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy -Limitations apply	Covered - 80% after deductible	Covered - 60% after deductible

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