



**Blue Cross
Blue Shield
of Michigan**

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

FCA US

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CMM - CMM International Salary Active - High

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	Participating Provider
Deductibles - per calendar year	\$700 per member \$1,400 per family
Copays • Fixed Dollar Copays	\$12.50 copay for: •Retail Health visit \$25 copay for: •PCP Office visit \$35 copay for: •Specialist Office visit \$35 copay for: • Chiropractic spinal manipulations \$50 copay for: • Professional Urgent care services \$150 copay for: • Facility medical emergency
Plan Out of Pocket Maximum • Percent Coinsurance	20% up to a maximum of: \$2,300 per member \$4,600 per family Includes Deductible and Coinsurance
Annual out-of-pocket maximums	\$9,200 per member \$18,400 per family Includes Deductible, Coinsurance and Copays
Lifetime dollar maximum	Unlimited

Preventive Care Services

Benefits	Participating Provider
Health Maintenance Exam - beginning age 4	Covered - 100%

Routine Physical Related Tests and lab procedures performed as part of the health maintenance exam	Covered - 100%
Annual Gynecological Exam - 2 per calendar year, in addition to health maintenance exam	Covered - 100%
Pap Smear Screening – 1 per calendar year	Covered - 100%
Mammography Screening - 1 per calendar year includes 3D Mammography	Covered - 100%
Contraceptive Methods and Counseling	Covered - 100%
Prostate Specific Antigen (PSA) screening - beginning 40 years of age; 1 per calendar year	Covered - 100%
Endoscopic Exams -beginning at age 45: <ul style="list-style-type: none"> • 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%
Well Child Care <ul style="list-style-type: none"> • 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 <p>Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit</p>	Covered - 100%
Immunizations - pediatric and adult <ul style="list-style-type: none"> • Shingrix starting at age 50 • Zoster starting at age 50 	Covered - 100%

Physician Office Services

Benefits	Participating Provider
Office Visits	Covered - 100% after \$25 PCP copay; \$35 specialist copay
Retail Health Visit	Covered – 100% after \$12.50 copay
Telemedicine Visits	Covered - 100%
Virtual Care - Online Medical Visits Note: Online Medical visits by a non-BCBSM selected vendor are not covered.	Covered - 100%
Office Consultations	Covered - 100% after \$25 PCP copay; \$35 specialist copay
Pre-Surgical Consultations	Covered - 100% after \$25 PCP copay; \$35 specialist copay

Emergency Medical Care

Benefits	Participating Provider
Hospital Emergency Room Qualified medical emergency	Covered - 100% after \$150 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Not Covered
Facility Urgent Care Services	Covered - 100% after \$50 copay
Physician Urgent Care Services	Covered - 100% after \$50 copay
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible

Diagnostic Services

Benefits	Participating Provider
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible

Maternity Services Provided by a Physician

Benefits	Participating Provider
Prenatal and Postnatal Care Visits	Covered - 100%
Delivery and Nursery Care	Covered - 80% after deductible

Hospital Care

Benefits	Participating Provider
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible
Inpatient Medical Care	Covered - 80% after deductible

Alternatives to Hospital Care

Benefits	Participating Provider
Hospice Care	Covered - 80% after deductible
Home Health Care Limited to 3 days for each unused inpatient day per calendar year	Covered - 80% after deductible
Skilled Nursing	Covered - 80% after deductible

Surgical Services

Benefits	Participating Provider
Surgery (includes related surgical services)	Covered - \$50 copay then 80% after deductible
Sterilization - male reproductive organs excludes reversal sterilization	Covered - 80% after deductible
Sterilization - female reproductive organs excludes reversal sterilization	Covered - 100%
Expanded Abortion Services	Covered - 80% after deductible
Note: Abortions are not covered if rendered in a location where abortions are not legal.	

Human Organ Transplants

Benefits	Participating Provider
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	Participating Provider
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Outpatient Therapy Visit - \$25 copay; other Outpatient MH/SUD services subject to deductible and coinsurance
Telemedicine Mental Health/Substance Use Disorder	Covered - 100% for visits up to and including 5 th visit per member per calendar year; \$10 copay for 6 th visit and beyond NOTE: MH and SUD visits combined with respect to number of visits
Virtual Care - Online Mental Health/Substance Use Disorder Visits Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered.	Covered - 100% for visits up to and including 5 th visit per member per calendar year; \$10 copay for 6 th visit and beyond NOTE: MH and SUD visits combined with respect to number of visits

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	Participating Provider
Applied Behavior Analysis (ABA) 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
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 80% after deductible
Nutritional Counseling	Covered - 80% after deductible

Other Covered Services

Benefits	Participating Provider
Cardiac Rehabilitation	Covered - 80% after deductible
Chiropractic Spinal Manipulation Services Limited to a maximum of 24 visits per member per calendar year combined with Osteopathic Manipulations	Covered - 100% after \$35 copay
Durable Medical Equipment	Covered - 100%
Prosthetic and Orthotic Devices	Covered - 100%
Private Duty Nursing Care	Not Covered
Allergy Testing and Therapy	Covered - 80% after deductible
Facility Clinic Visit Cancer related diagnosis only	Covered - 80% after deductible

Therapy Services

Benefits	Participating Provider
Physical, Occupational and Speech Therapy	Covered - 80% after deductible