Blue Cross Blue Shield of Michigan

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

FCA US
Group Number: 82400
PPO - Standard Care Network
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 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.	None	None
Copays • Fixed Dollar Copays	$25 copay for : • Office visits • Chiropractic spinal manipulations $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	0% up to a maximum of: Includes Deductible and Coinsurance	10% up to a maximum of: $250 per member $500 per family Includes Deductible and Coinsurance **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.	$10,600 per member $21,200 per family Includes Deductible, Coinsurance and Copays	None Includes Deductible and Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; 1 per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG 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 - 1 per calendar year	Covered - 100%	Covered - 90%
Mammography Screening - 1 per calendar year includes 3D Mammography	Covered - 100%	Covered - 90%
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 - 90%
Endoscopic Exams - beginning at age 45, colonoscopy: 1 every 10 calendar years; sigmoidoscopy: 1 every 5 calendar years; barium enema: 1 every 5-10 calendar years; protosigmoidoscopy: 1 per calendar year	Covered - 100%	Not Covered
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	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $25 copay	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 $25 copay	Not Covered
Pre-Surgical Consultations	Covered - 100% after $25 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	Covered - 100% after $50 copay
Physician Urgent Care Services	Covered - 100% after $50 copay	Covered - 100% after $50 copay
Ambulance Services - Medically Necessary Transport	Covered - 100%	Covered - 90%

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 100%	Covered - 90%

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 100%	Covered - 90%
Radiation Therapy and Chemotherapy	Covered - 100%	Covered - 90%

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 - 90%
Delivery and Nursery Care Note: For facility services See "Hospital Care"	Covered - 100%	Covered - 90%

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%	Covered - 90%
Inpatient Medical Care	Covered - 100%	Covered - 90%

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 100%	Not Covered
Home Health Care Limited to 3 days for each unused inpatient day with a 60 day renewal per calendar year	Covered - 100%	Covered - 90%
Skilled Nursing Limited to 2 days for each unused inpatient day with 60 day renewal	Covered - 100%	Covered - 90%

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 100%	Covered - 90%
Bariatric Surgery	Covered - 100%	Covered - 90%
Sterilization - male reproductive organs excludes reversal sterilization	Covered - 100%	Covered - 90%
Sterilization - female reproductive organs excludes reversal sterilization	Covered - 100%	Covered - 90%
Elective Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	Covered - 100%	Covered - 90%

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%	Covered - 90%

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 - 100%	Covered - 90%
Outpatient Mental Health Care	Covered - 100%	Covered - 50%
Telemedicine Mental Health Care	Covered - 100% after $10 copay	Not Covered
Virtual Care - Online Mental Health Visits Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered.	Covered - 100% after $10 copay	Not Covered
Outpatient Substance Use Disorder Treatment	Covered - 100%	Covered - 100% after 50% copay

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 - 100%	Covered - 90%
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	PT: Not Covered OT: Covered - 100% ST: Covered - 100%	Not Covered
Nutritional Counseling	Covered - 100%	Covered - 90%

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 100%	Not Covered
Chiropractic Spinal Manipulation Services Limited to a maximum of 24 visits per calendar year	Covered - 100% after $25 copay	Not Covered
Durable Medical Equipment	Covered - 100%	Covered - 80%
Prosthetic and Orthotic Devices	Covered - 100%	Covered - 80%
Private Duty Nursing Care	Not Covered	Not Covered
Allergy Testing	Covered - 100%	Not Covered
Allergy Therapy	Covered - 100%	Covered - 90%
Facility Clinic Visit	Covered - 100%	Covered - 90%

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Occupational therapy is limited to 60 visits, Speech therapy is limited to 60 visits	PT: Not Covered OT: Covered - 100% ST: Covered - 100%	Not Covered

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.