Blue Cross Blue Shield of Michigan

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

PPO –PPO, VSP, Hearing Benefits-at-a-Glance
UAW Retirees of Daimler Trucks North America - Welfare Benefits Trust

Deductible, Copays, Coinsurance and Dollar Maximums	In-Network	Out-of-Network
Deductible - per calendar year	$400 per member $800 per family	$800 per member $1,600 per family
Copays • Fixed Dollar Copays	$30 copay for: • Office visits • Chiropractic spinal manipulations • Allergy testing • Allergy therapy $50 copay for: • Urgent care services $100 copay for: • Facility medical emergency	$50 copay for: • Urgent care services $100 copay for: • Facility medical emergency
Coinsurance • Percent Coinsurance	20%	30% **Note: Services without a network are covered at the in-network level.**
Out-of-Pocket Maximum	$1,500 per member $3,000 per family *Includes Deductible, Coinsurance and Copays*	$2,000 per member $4,000 per family *Includes Deductible and Coinsurance*
Lifetime Maximum	Unlimited	

Preventive Services		
Health Maintenance Exam - one 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 - two per calendar year, in addition to health maintenance exam	Covered - 100%	Covered - 75% after deductible
Pap Smear Screening - one per calendar year	Covered - 100%	Covered - 75% after deductible
Mammography Screening - one per calendar year	Covered - 100%	Covered - 75% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Covered - 75% after deductible
Prostate Specific Antigen (PSA) Screening - one per calendar year	Covered - 100%	Covered - 75% after deductible
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 75% after deductible
Well Child Care – Unlimited maximum frequency up to and including age 2	Covered - 100%	Not Covered
Immunizations -pediatric and adult	Covered - 100%	Covered - 75% after deductible

Physician Office Services		
Office Visits	Covered - 100% after $30 copay	Covered - 70% after deductible

Emergency Medical Care

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	Covered - 80%	Covered - 70% after deductible
Urgent Care Services	Covered - 100% after $50 copay	Covered - 100% after $50 copay
Ambulance Services - Medically Necessary Transport	Covered - 80%	Covered - 80%

Diagnostic Services

MRI,MRA, PET and CAT Scans and Nuclear Medicine	Covered - 100%	Covered - 70% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 100%	Covered - 70% after deductible
Radiation Therapy and Chemotherapy	Covered - 100%	Covered - 70% after deductible

Maternity Services Provided by a Physician

Pre and Postnatal Care Visits	Covered - 100%	Covered - 70% after deductible
Delivery and Nursery Care	Covered - 80% after deductible	Covered - 70% after deductible

Hospital Care

Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible	Covered - 70% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 70% after deductible

Alternatives to Hospital Care

Hospice Care	Covered - 80% after deductible	Covered - 75% after deductible
Home Health Care	Covered - 100%	Covered - 70% after deductible
Skilled Nursing Limited to 60 days per calendar year	Covered - 80% after deductible	Covered - 70% after deductible

Surgical Services

Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 70% after deductible
Sterilization - males only; excludes reversal sterilization	Covered - 80% after deductible	Covered - 70% after deductible
Sterilization - females only; excludes reversal sterilization	Covered - 100%	Covered - 70% after deductible

Human Organ Transplants

Specified Organ Transplants	Covered - 100%	Covered - 75% after deductible
Kidney, Cornea, Bone Marrow and Skin	Covered - 100%	Covered - 70% after deductible

Behavioral Health Care and Substance Abuse Treatment Services

Inpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 80% after deductible	Covered - 70% after deductible
Outpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 100% after $30 copay	Covered - 70% after deductible

Other Services

Cardiac Rehabilitation Limited to 60 visits per calendar year; combined with outpatient physical, speech, occupational therapy and chiropractic services.	Covered - 100% after $30 copay	Covered - 70% after deductible
Chiropractic Services Limited to 60 visits per calendar year; combined with outpatient physical, speech, occupational therapy and cardiac rehabilitation.	Covered - 100% after $30 copay	Covered - 70% after deductible
Durable Medical Equipment	Covered - 100%	Covered - 70% after deductible
Prosthetic and Orthotic Devices	Covered - 100%	Covered - 70% after deductible
Private Duty Nursing	Covered - 80% after deductible	Covered - 70% after deductible
Allergy Therapy and Testing	Covered - 100% after $30 copay	Covered - 70% after deductible

Therapy Services

Physical, Occupational and Speech Therapy Limited to 60 visits combined per calendar year; combined with cardiac rehabilitation and chiropractic services.	Covered - 100% after $30 copay	Covered - 70% after deductible

Note: The following services require preapproval: Inpatient Care, select Radiology and Diagnostic Services, Inpatient Behavioral Health Care and Substance Abuse Treatment, and Skilled Nursing.

Hearing

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

Frequency Limitation	Once every 36 months
Benefit Maximum	$1,000
Audiometric Exam	Covered - 80%
Hearing Aid Evaluation	Covered - 80%
Hearing Aid	Covered - 80%
Hearing Aid Conformity Test	Covered - 80%

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.

Blue Cross Blue Shield of Michigan

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

Blue Vision - VSP

Benefits-at-a-Glance

UAW Retirees of Daimler Trucks North America - Welfare Benefits Trust

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. There are more than 1,100 VSP provider locations in Michigan and 24,000 locations nationwide. To find a VSP provider, call 1-800-877-7195 or visit VSP's Web site at www.vsp.com.

	VSP Provider	Out-of-Network Provider
Eye exams		
Covers a complete eye exam by an ophthalmologist or optometrists. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	Covered - $25 copay	Covered - No copay reimbursement up to $46
	once every 12 consecutive months	
Eyeglass Frames		
Covers standard eyeglass frames. A wide selection of quality frames is fully covered by VSP up to the frame allowance. Members should ask their doctor which frames are covered in full. Members may select a more expensive frame and pay a cost controlled price difference.	Covered - No copay reimbursement up to $75	Covered - No copay reimbursement up to $75
	once every 24 consecutive months	
Eyeglass Lenses		
Single vision, bifocal, trifocal or lenticular lenses in glass or plastic. Note: Additional pairs of prescription glasses and non-covered lens options are discounted when purchased from a VSP provider.	Covered - No copay reimbursement up to a predetermined amount based on lense type	Covered - No copay reimbursement up to a predetermined amount based on lense type
	once every 12 consecutive months	
Contact Lenses: Members may obtain either eyeglasses or contact lenses, but not both.		
Elective contact lenses (prescribed, but **not** medically necessary) may be chosen instead of spectacle lenses and a frame.	Covered - No copay reimbursement up to $215 that is applied toward contact lens exam (fitting and materials) and the contact lenses	Covered - No copay reimbursement up to $215 that is applied toward contact lens exam (fitting and materials) and the contact lenses
	once every 12 consecutive months	
Therapeutic contact lenses (medically necessary)	Covered - No copay reimbursement up to $250	Covered - No copay reimbursement up to $250
	once every 12 consecutive months	
Copays/Coinsurance		
• Eye exam	$25 copay	No copay
• Frames and/or lenses **or** medically necessary contact lenses	No copay	Member responsible for difference between approved amount and provider's charge

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.