



**Blue Cross  
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of Michigan

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## PPO Plan, Hearing, VSP Vision

### Benefits-at-a-Glance

## UAW Retirees of Daimler Trucks North America-Welfare Benefits Trust

#### In-Network

#### Out-of-Network

#### Deductible, Copays, Coinsurance and Dollar Maximum

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

#### Preventive Services

Health Maintenance Exam - beginning age 3; 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 - 70% 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
Office Consultation	Covered - 100% after \$30 copay	Covered - 70% after deductible
Pre-Surgical Consultation	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%



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##### 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	Covered - 100%	Covered - 70% after deductible
Chemotherapy	Covered - 100%	Covered - 70% after deductible

##### Maternity Services Provided by a Physician

Prenatal 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 a maximum of 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
Bariatric Surgery	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 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 - 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	Covered - 100% after \$30 copay	Covered - 70% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 60 visits combined with Occupational therapy, Speech therapy, Cardiac Rehab, Pulmonary Rehab and Congestive therapy per calendar year	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 Testing and Therapy	Covered - 100% after \$30 copay	Covered - 70% after deductible



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#### Therapy Services

Physical, Occupational and Speech Therapy Physical, Occupational, Speech therapy, Cardiac Rehab, Pulmonary Rehab, Congestive Therapy and Chiropractic Services is limited to a combined maximum of 60 visits per calendar year	Covered - 100% after \$30 copay	Covered - 70% after deductible
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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.**

<b>Frequency Limitation</b>	Once every 36 months
<b>Benefit Maximum</b>	\$1,000
<b>Audiometric Exam</b>	Covered - 80%
<b>Hearing Aid Evaluation</b>	Covered - 80%
<b>Hearing Aid</b>	Covered - 80% Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.
<b>Hearing Aid Conformity Test</b>	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. BCBSM provides administrative claims services only. Your employer is financially responsible for claims.



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## Blue Vision - VSP

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Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. There are more than 3,000 VSP provider locations in Michigan and 53,000 locations nationwide. To find a VSP provider, call 1-800-877-7195 or visit VSP's Web site at [www.vsp.com](http://www.vsp.com).

VSP Provider			Out-of-Network Provider		
<b>Eye exams</b>					
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 copayment	Covered - no copay - reimbursement up to \$46			
	once every 12 consecutive months				
<b>Eyeglass Frames</b>					
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				
<b>Eyeglass Lenses</b>					
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(one copay applies to both lenses and frames)	Covered - no copay - reimbursement up to a predetermined amount based on lense type			
	once every 12 consecutive months				
<b>Contact Lenses:</b> 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	Covered - no copay - reimbursement up to \$250			
	once every 12 consecutive months				
<b>Copays/Coinsurance</b>					
• Eye exam	Covered - \$25 copayment	no copay - reimbursement up to \$46			
• Frames and/or lenses or medically necessary contact lenses	Covered - no copay - reimbursement up to \$75	Member responsible for difference between approved amount and provider's charge, less a no copay - reimbursement up to \$75			

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