Blue Cross Blue Shield of Michigan

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

PPO - Penske TCN Plan
Benefits-at-a-Glance
UAW Retirees of ACC Benefit Trust

Deductible, Copays, Coinsurance and Dollar Maximum

	In-Network	Out-of-Network
Deductible - per calendar year	$500 per member $1,000 per family	$1,000 per member $2,000 per family
Copays • Fixed Dollar Copays	$100 copay for : • Facility medical emergency	$100 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	20%	40% **Note:** Services without a network are covered at the in-network level.
Out-of-Pocket Maximum	$1,000 per member $2,000 per family *Includes Deductible*	$2,000 per member $4,000 per family *Includes Deductible*
Lifetime Maximum	No lifetime maximum	

Preventive Services

Health Maintenance Exam	Covered - 80% after deductible	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 80% after deductible	Not Covered
Annual Gynecological Exam	Not Covered	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Covered - 60% after deductible
Mammography Screening - beginning age 40; one per calendar year	Covered - 100%	Covered - 60% after deductible
Prostate Specific Antigen (PSA) Screening - one per calendar year	Covered - 100%	Covered - 60% after deductible
Endoscopic Exams	Covered - 100%	Covered - 60% after deductible
Well Child Care • 6 visits, per year through age 1 • 2 visits, per year, age 2 through 3 • 1 visit per year, age 4 through 15	Covered - 100%	Not Covered
Immunizations- pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Office Visits	Not Covered	Not Covered
Office Consultation	Not Covered	Not Covered
Pre-Surgical Consultation	Not Covered	Not Covered

Emergency Medical Care

Hospital Emergency Room Qualified medical emergency	Covered - $100 copay then 80% after deductible; copay waived if admitted	Covered - $100 copay then 80% after deductible; copay waived if admitted
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Urgent Care Services	Not Covered	Not Covered
Ambulance Services - Medically Necessary Transport	Covered - 100%	Covered - 100%

Diagnostic Services

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

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	In-Network	Out-of-Network
Maternity Services Provided by a Physician		
Prenatal and Postnatal Care Visits	Covered - 80% after deductible	Covered - 60% after deductible
Delivery and Nursery Care excludes dependent children	Covered - 80% after deductible	Covered - 60% after deductible
Hospital Care		
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies 365 day with 60 renewal	Covered - 80% after deductible	Covered - 60% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 60% after deductible
Alternatives to Hospital Care		
Hospice Care Limited to lifetime maximum of 210 days	Covered - 80% after deductible	Covered - 60% after deductible
Home Health Care Limited to a maximum of 365 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible
Skilled Nursing Limited to a maximum of 730 days per calendar year	Covered - 80% after deductible	Covered - 60% after deductible
Surgical Services		
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Bariatric Surgery	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Human Organ Transplants		
Specified Organ Transplants in designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 80% after deductible	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 60% after deductible
Behavioral Health Care and Substance Abuse Treatment Services		
Inpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Outpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Other Services		
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation	Covered - 80% after deductible	Covered - 60% after deductible
Durable Medical Equipment	Covered - 100%	Covered - 100%
Prosthetic and Orthotic Devices	Covered - 100%	Covered - 100%
Private Duty Nursing	Not Covered	Not Covered
Allergy Testing and Therapy	Not Covered	Not Covered
Therapy Services		
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 80% after deductible	Covered - 60% 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

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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Prescription Drugs

Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Retail - 30 day supply	$15 copay - Generic drugs $50 copay - Preferred brand name drugs $100 copay - Non-Preferred brand name drugs Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Mail Order - 90 day supply	$30 copay - Generic drugs $100 copay - Preferred brand name drugs $200 copay - Non-Preferred brand name drugs
Specialty Drugs – 30 day supply	Retail: $15 copay - Generic drugs $50 copay - Preferred brand name drugs $100 copay - Non-Preferred brand name drugs Mail Order: $30 copay - Generic drugs $100 copay - Preferred brand name drugs $200 copay - Non-Preferred brand name drugs Member are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.
Additional Services Oral and Injectable Contraceptive Smoking Cessation Drugs Weight Loss Drugs Impotency Drugs Infertility Drugs	 Covered Covered Covered Not Covered Not Covered
Diabetic Supplies	Not Covered

Features of your prescription drug plan

Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

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