Blue Cross Blue Shield

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GM UAW Hourly Traditional & In-Progression Plan Benefits at a glance August 1, 2017 Group #83200

Benefit	In-network	Out-of-network
Deductible, copays/coinsurance and dollar maximums		
Deductible – per calendar year	N/A	N/A
Coinsurance	N/A	10%
Out-of-pocket maximum – per calendar year (combination of deductible and coinsurance)*	N/A	$250 Single $500 Family
*Combined out-of-network Medical cost share with Mental Health/Substance Abuse (Beacon Health Options)		
Physician services		
Office visits	$25 Copayment – Not applied to out of pocket maximum	Not Covered without a referral
Online visits	Covered when rendered by American Well or Blue Cross PPO providers – $12.50 Copay	Not covered
Retail health care	$12.50 copayment	Not covered
Urgent care	Covered – $50 copayment Waived if patient is transferred to hospital emergency room.	$50 Copayment – Member liable for balance billed. Does not apply to out of pocket maximum
Emergency medical care (Qualified medical emergency and first aid services)		
Hospital emergency room	Covered – $100 Copay Waived if admitted, or placed into observation to receive covered services. Does not apply to out-of-pocket maximum.	Covered – $100 Copay Waived if admitted, or placed into observation to receive covered services. Does not apply to out-of-pocket maximum.
Physician	Covered	Covered
Ambulance services – medically necessary transport	Covered	Covered
Diagnostic services		
MRI, MRA, PET and CAT scans and nuclear medicine	Covered – 100%	Covered – Subject to coinsurance
Other diagnostic tests, X-rays, laboratory & pathology		
Maternity services		
Pre-natal and post-natal care	Covered – 100%	Covered – Subject to coinsurance
Delivery and nursery care		
Hospital care		
Semi-private room, inpatient physician care, general Maximum 365 days for each continuous period of hospital confinement or for successive periods of confinement separated by less than 60 days.	Covered – 100%	Covered – Subject to coinsurance
Nursing care, hospital services and supplies		
Inpatient medical care		
Chemotherapy/radiation therapy		

Benefits at a glance *For Represented Active Employees with Traditional Care Network:*

Benefit	In-network	Out-of-network
Alternatives to hospital care		
Skilled nursing facility – Limited to 2 days for each unused inpatient day available up to a maximum of 730 days for each continuous period of confinement or for successive periods of confinement separated by less than 60 days.	Covered – 100%	Not covered
Pre-hospice care – 28 lifetime pre-hospice visits for evaluation, consult education and support services		
Hospice care – Lifetime maximum of 365 days		
Home health care		
Outpatient surgical services		
Surgery – includes related surgical services	Covered – 100%	Covered – Subject to coinsurance
Voluntary sterilization – excludes reversal sterilization		
Human organ transplants		
Specified organ transplants	Covered – 100%	Covered – Subject to coinsurance
Other services		
Allergy Testing and Therapy	Not covered	Not covered
Chiropractic Care – Emergency first aid and x-ray of the spine only – excludes adjustment manipulation	$25 co-pay on first aid visit. Not applied to out of pocket maximum	$25 co-pay for first aid visit. Not applied to out of pocket maximum. X-ray subject to coinsurance.
Outpatient Speech and Occupational Therapy – Combined with Physical Therapy to include 60 visits per condition per calendar year	Covered – 100%	Covered – Subject to coinsurance
Outpatient physical therapy *Coverage administered by TheraMatrix 1-888-638-8786*	Covered – 100%	Not covered
Durable medical equipment (DME), medical supplies and prosthetic and orthotic appliances	Covered – 100%	Covered – Subject to coinsurance
Mental health care and substance abuse treatment – Coverage administered by Beacon Health Options: 1-800-235-2302		
Hearing Care – Coverage administered by SVS Claims Management: 1-866-614-7874		
Prescription Drugs – Coverage administered by CVS Caremark: 1-844-379-1671		
Vision Care – Coverage administered by Davis Vision, 1-888-672-8393		

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 to covered services. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or coinsurance/copayment amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

Preventive Health Services

All Preventive Services are covered 100% In-Network.

Services received Out of Network are covered applicable to out of network cost share.

Benefit	
Health maintenance exam	
Well baby	8 visits, Birth through 12 rolling months; 6 visits, 13 through 23 months
Well child	6 visits per year, 24 months through 35 rollling months, 1 visit per year, 36 months through 17 years
Well adult (Preventive/routine exam)	1 visit per year, Men and women age 18 and over
Colorectal cancer screening	
Fecal occult blood test	Men and women, 1 per year - 50 years and over
Colonoscopy OR Barium enema OR Sigmoidoscopy	Men and women, 1 every 10 years – 50 years and over Men and women, 1 every 5 years – 50 years and over Men and women, 1 every 5 years – 50 years and over
Proctosigmoidoscopy without biopsy	Men and women, 1 every 3 years – 40 years and over
Laboratory screening	
Total cholesterol screening	Men and women, 1 per year – Any age
Newborn screening – Congenital Hypothyroid, Phenylketonuria, Sickle Cell, Metabolic/Hemoglobin, Heritable Diseases	Once at birth
Child screening – Hematocrit or Hemoglobin, lead screening, Tuberculin Test and Dyslipidemia	1 per year, 24 months through 21 years
Type 2 Diabetes Mellitus Screening	Men and women, 2 per year
Men's health	
Prostate cancer screening	Men, 1 per year – 40 years and over
AAA by ultrasound screening	Men, 1 per lifetime – 65-75 years, who have ever smoked
Women's health	
GYN exam	Women, 2 per year – Any age
Cervical cancer screening – Papanicolaou (PAP smear)	Women, 1 per year – Any age
Breast cancer screening (mammography)	Women, 1 per year – 40 years and over
BRCA screening	Women, 1 per lifetime
Women's contraceptive methods – IUD, diaphragm, cervical cap (other methods may be covered, limitations may apply)	Benefit quantities based on method of contraception.
Osteoporosis screening –bone density	Women, 1 every 2 years – 65 years and over (age 60 if risk factors present)
Breastfeeding, support, supplies, and counseling	Women, any age-benefit based on service.
Prenatal visits	Pregnant women – any age
Pediatric screening	
Hearing loss	Newborn through age 21, 1 per year
Vision acuity	Newborn through age 5, 1 per year
Developmental	Newborn through age 2, 2 per year

Preventive health services continued

Benefit	
Prenatal screening	
Hepatitis B	Pregnant women, 1 per pregnancy - any age
Asymptomatic Bacteriuria	Pregnant women, 1 per pregnancy - any age
Iron Deficiency Anemia	Pregnant women, 1 per pregnancy - any age
Rh(d) Incompatibility	Pregnant women, 2 per pregnancy - any age
Infectious disease screening	
Chlamydia	Men and women, 1 per year - Up through 21 years; women over 21 if risk factors present
Gonorrhea	Men and women, 1 per year – Up through age 21; women over 21 if risk factors present
Syphilis	Men and women, 1 per year – any age
HIV	Men and women, 1 per year – any age
Hepatitis C	Men and women, 1 per year – any age who are at risk or have signs or symptoms which may indicate a Hepatitis C infection
Gestational screening - 2 per pregnancy	2 per pregnancy (Not to exceed two -Type 2 Diabetes Mellitus Screening in a calendar year.)
Counseling services	
Alcohol misuse screening and behavioral interventions	Men and women, unlimited – any age
Breastfeeding	Women, 2 per year – any age
Diet/obesity behaviorial	Men and women, 6 per year – any age
Tobacco use and tobacco caused disease	Men and women, unlimited – any age
Screening and counseling for interpersonal and domestic violence	Women, one per year – any age
Immunizations	
Baby/child/adult	Routine immunizations and administration of vaccines

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Here's why you need to immunize

Immunizations help protect you or your child from disease. They also help reduce the spread of disease to others and prevent epidemics.

In many cases when you get a vaccine, you get a tiny amount of the organism that causes the disease. This amount is not enough to give you the actual disease. But it is enough to cause your immune system to make antibodies that can recognize and attack the organism if you are ever exposed to it.

Immunizations and vaccinations are covered to prevent the following diseases and conditions:

- Diphtheria
- Tetanus
- Pertussis
- Poliomyelitis (polio)
- Haemophilus influenza type B
- Pneumococcus bacterium
- Measles
- Mumps
- Rubella
- Varicella
- Hepatitis A
- Hepatitis B
- Human papilloma virus
- Rotavirus
- Meningococcal disease
- Influenza
- Zoster shingles

Blue Cross Blue Shield

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