

# Community Blue<sup>SM</sup> PPO

## Benefits-at-a-Glance

### UP Plumbers & Pipefitters Health & Welfare Fund 42809

**In-Network**

**Out-of-Network**

**Preventive Services – Limited to \$500 per calendar year**

Health Maintenance Exam – includes chest X-ray, EKG and select lab procedures	Covered – 100%, one per calendar year	Not covered
Annual Gynecological Exam	Covered – 100%, one per calendar year	Not covered
Pap Smear Screening – laboratory services only	Covered – 100%, one per calendar year	Not covered
Well-Baby and Child Care	Covered – 100% <ul style="list-style-type: none"> <li>Up to 6 visits per year, through age 1</li> <li>Up to 2 visits per year, age 2 through 3</li> <li>1 visit per year, age 4 through 15</li> </ul>	Not covered
Immunizations	Covered – 100%, up through age 16	Not covered
Fecal Occult Blood Screening	Covered – 100%, one per calendar year	Not covered
Flexible Sigmoidoscopy Exam	Covered – 100%, one per calendar year	Not covered
Prostate Specific Antigen (PSA) Screening	Covered – 100%, one per calendar year	Not covered

**Mammography**

Mammography Screening	Covered – 80% after deductible	Covered – 60% after deductible
One per calendar year, no age restrictions		

**Physician Office Services**

Office Visits	Covered – \$15 copay	Covered – 60% after deductible, must be medically necessary
Outpatient and Home Visits	Covered – 80% after deductible	Covered – 60% after deductible, must be medically necessary
Office Consultations	Covered – \$15 copay	Covered – 60% after deductible, must be medically necessary
Urgent Care Visits	Covered – \$15 copay	Covered – 60% after deductible, must be medically necessary

**Emergency Medical Care**

Hospital Emergency Room	Covered – \$25 copay, waived if admitted or for an accidental injury	Covered – \$25 copay, waived if admitted or for an accidental injury
Ambulance Services – medically necessary	Covered – 80% after deductible	Covered – 80% after deductible

**Diagnostic Services**

Laboratory and Pathology Tests	Covered – 80% after deductible	Covered – 60% after deductible
Diagnostic Tests and X-rays	Covered – 80% after deductible	Covered – 60% after deductible
Radiation Therapy	Covered – 80% after deductible	Covered – 60% after deductible

**Maternity Services Provided by a Physician**

Pre-Natal and Post-Natal Care	Covered – 100%	Covered – 60% after deductible
	Includes care provided by a certified nurse midwife	
Delivery and Nursery Care	Covered – 80% after deductible	Covered – 60% after deductible
	Includes delivery provided by a certified nurse midwife	

**Hospital Care**

Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies <b>Note:</b> Nonemergency services must be rendered in a participating hospital	Covered – 80% after deductible	Covered – 60% after deductible
	Unlimited days	
Inpatient Consultations	Covered – 80% after deductible	Covered – 60% after deductible
Chemotherapy	Covered – 80% after deductible	Covered – 60% after deductible

**Alternatives to Hospital Care**

Skilled Nursing Care	Covered – 80% after deductible	Covered – 80% after deductible
	Up to 120 days per calendar year	
Hospice Care	Covered – 100%	Covered – 100%
	Limited to lifetime dollar maximum which is adjusted periodically	
Home Health Care	Covered – 80% after deductible	Covered – 80% after deductible
	Unlimited visits	

**Surgical Services**

Surgery – includes related surgical services	Covered – 80% after deductible	Covered – 60% after deductible
Voluntary Sterilization	Covered – 80% after deductible	Covered – 60% after deductible

**In-Network**

**Out-of-Network**

**Human Organ Transplants**

Specified Organ Transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered – 100%	Covered – in designated facilities <b>only</b>
	Up to \$1 million maximum per transplant type	
Bone Marrow – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504); specific criteria applies	Covered – 80% after deductible	Covered – 60% after deductible
Kidney, Cornea and Skin	Covered – 80% after deductible	Covered – 60% after deductible

**Mental Health Care and Substance Abuse Treatment**

Inpatient Mental Health Care	Covered – 80% after deductible	Covered – 80% after deductible
	Unlimited days	
Inpatient Substance Abuse Care	Covered – 80% after deductible	Covered – 80% after deductible
	Unlimited days, up to \$15,000 annual, \$30,000 lifetime maximum	
Outpatient Mental Health Care • Facility and Clinic • Physician’s Office	Covered – 80% after deductible	Covered – 80% after deductible
	Covered – 80%	Covered – 80% after deductible
Outpatient Substance Abuse Care – in approved facilities	Covered – 80% after deductible	Covered – 80% after deductible
	Up to the state-dollar amount which is adjusted annually	

**Other Services**

Outpatient Diabetes Management Program (ODMP)	Covered – 80% after deductible	Covered – 60% after deductible
Allergy Testing and Therapy	Covered – 100%	Covered – 60% after deductible
Chiropractic Spinal Manipulation	Covered – 100%	Covered – 60% after deductible
	Up to 24 visits per calendar year	
Outpatient Physical, Speech and Occupational Therapy • Facility and Clinic • Physician’s Office – <b>excludes speech and occupational therapy</b>	Covered – 80% after deductible	Covered – 80% after deductible
	Covered – 80% after deductible	Covered – 60% after deductible
	A combined 60-visit maximum per calendar year for physical therapy in the outpatient department of a hospital as well as in the physician’s office	
Durable Medical Equipment	Covered – 80% after deductible	Covered – 80% after deductible
Prosthetic and Orthotic Appliances	Covered – 80% after deductible	Covered – 80% after deductible
Private Duty Nursing	Covered – 50% after deductible	Covered – 50% after deductible

**Deductible, Copays and Dollar Maximums**

**Note:** 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.

<b>Deductible</b>	\$500 per member, \$1000 family per calendar year <b>Note: Deductible waived if service is performed in a PPO physician’s office.</b>	\$500 per member, \$1,000 family per calendar year <b>Note:</b> Out-of-network deductible amounts also apply toward the in-network deductible.
<b>Copays</b> • Fixed Dollar Copays  • Percent Copays	\$15 for office visits and \$25 for emergency room visits	\$25 for emergency room visits
	20% for general services, <b>waived if service is performed in a PPO physician’s office</b> , and 20% for mental health care, substance abuse care and 50% for private duty nursing	40% for general services and 20% for mental health care, substance abuse care and 50% for private duty nursing <b>Note:</b> Services without a network are covered at the in-network level
<b>Copay Dollar Maximums</b> • Fixed Dollar Copays • Percent Copays – excludes mental health care, substance abuse care and private duty nursing copays	None	None
	\$500 per member, \$1,000 family per calendar year	\$5,000 per member, \$10,000 family per calendar year <b>Note:</b> Out-of-network copays also apply toward the in-network maximum.
<b>Dollar Maximums</b>	\$5 million lifetime per member for all covered services and as noted above for individual services	

This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificate and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.