



Laborers' Detroit Metropolitan Health Care Fund

Comprehensive Major Medical (CMM) Health Care Coverage

Blue Preferred PPO

Effective April 1, 2013

Active, Self-Pay, Early Retirees

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. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or 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.

In-network

Out-of-network

Member's responsibility (deductible, copayments and dollar maximums as applicable)

Note: Services from a provider for which there is no PPO network are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between the BCBSM approved amount and the provider's charge.

Deductible		None	None
Copayments	Fixed dollar copayments	None	None
	Percent copayments	20% of approved amount	30% of approved amount
Copayment dollar maximums – excludes fixed dollar copayments and mental health care, substance abuse treatment and private duty nursing percent copayments		\$1,000 per contract per calendar year	Additional \$1,000 per contract per calendar year – Maximum \$2,000
Lifetime dollar maximum		None	

Preventive care services

Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures – one per calendar year	100% of approved amount	70% of approved amount
Routine gynecological exam – one per calendar year	100% of approved amount	70% of approved amount
Pap smear screening (laboratory and pathology services) – one per calendar year	100% of approved amount	70% of approved amount
Voluntary sterilizations for females	100% of approved amount	70% of approved amount
Prescription contraceptive devices – includes insertion and removal of an intrauterine device by a licensed physician	100% of approved amount	70% of approved amount
Contraceptive injections	100% of approved amount	70% of approved amount
Well-baby and child care visits <ul style="list-style-type: none"> • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per calendar year under the health maintenance exam benefit 	100% of approved amount	70% of approved amount

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

bcbsm.com



In-network

Out-of-network

Preventive care services, *continued*

Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	70% of approved amount
Fecal occult blood screening	100% of approved amount	70% of approved amount
Flexible sigmoidoscopy exam	100% of approved amount	70% of approved amount
Prostate specific antigen (PSA) screening	100% of approved amount	70% of approved amount
Prostate specific antigen (PSA) screening – one per calendar year (no age restriction)	100% of approved amount	70% of approved amount
Routine mammogram and related reading – one per calendar year	100% of approved amount Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copayment.	70% of approved amount
Colonoscopy – routine or medically necessary – one per calendar year	100% of approved amount for the first billed colonoscopy Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent copayment.	70% of approved amount

Physician office services

Office visits and office consultations	80% of approved amount	70% of approved amount
Outpatient and home medical care visits	80% of approved amount	70% of approved amount
Urgent care visits	80% of approved amount	70% of approved amount

Emergency medical care

Hospital emergency room	80% of approved amount	80% of approved amount
Ambulance services	80% of approved amount	80% of approved amount

Diagnostic services

Laboratory and pathology services	80% of approved amount	70% of approved amount
Diagnostic tests and x-rays	80% of approved amount	70% of approved amount
Therapeutic radiology	80% of approved amount	70% of approved amount

Maternity services provided by a physician or certified nurse midwife

Prenatal and postnatal care	80% of approved amount	70% of approved amount
Delivery and nursery care	80% of approved amount	70% of approved amount



In-network *

Out-of-network **

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies – unlimited days Note: Nonemergency services must be rendered in a participating hospital.	80% of approved amount	70% of approved amount
Inpatient consultations	80% of approved amount	70% of approved amount
Chemotherapy	80% of approved amount	70% of approved amount

Alternatives to hospital care

Skilled nursing care	80% of approved amount	80% of approved amount
Hospice care – up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only ; limited to dollar maximum that is reviewed and adjusted periodically	100% of approved amount	100% of approved amount
Home health care	80% of approved amount	80% of approved amount
Home infusion therapy	80% of approved amount	80% of approved amount

Surgical services

Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% of approved amount	70% of approved amount
Presurgical consultations	80% of approved amount	70% of approved amount
Voluntary sterilization for males Note: See “Preventive care service” section for voluntary sterilizations for females	80% of approved amount	70% of approved amount

Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (1-800-242-3504)	100% of approved amount, in designated facilities only	
Bone marrow transplants – when coordinated through BCBSM Human Organ Transplant Program (1-800-242-3504)	80% of approved amount	70% of approved amount
Specified oncology clinical trials	80% of approved amount	70% of approved amount
Kidney, cornea and skin transplants	80% of approved amount	70% of approved amount

Mental health care and substance abuse treatment

Inpatient mental health care and substance abuse treatment	80% of approved amount	70% of approved amount
Outpatient mental health care	80% of approved amount	70% of approved amount
Outpatient substance abuse care	80% of approved amount	70% of approved amount



In-network *

Out-of-network **

Other covered services

Outpatient Diabetes Management Program (ODMP) Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by a network provider.	80% of approved amount	70% of approved amount
Allergy testing and therapy	80% of approved amount	70% of approved amount
Chiropractic spinal manipulation – Limited to 12 visits calendar year per individual	80% of approved amount	70% of approved amount
Outpatient physical, speech and occupational therapy	80% of approved amount	70% of approved amount
Durable medical equipment Note: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by a network provider.	80% of approved amount	80% of approved amount
Orthotic shoe inserts – one pair per calendar year when rendered by any provider	80% of approved amount	70% of approved amount
Prosthetic and orthotic appliances	80% of approved amount	80% of approved amount
Orthotic shoe inserts – limited to one pair per lifetime	80% of approved amount	80% of approved amount
Voluntary Abortions - limited to one lifetime for dependents	80% of approved amount	70% of approved amount
Private duty nursing	80% of approved amount	80% of approved amount
Hearing care – Bi-aural	100% up to \$1,000 Lifetime Maximum	100% up to \$1,000 Lifetime Maximum

- * **PPO In-Network** – Providers who have contracted with BCBSM's PPO program are termed "participating" or "in-network" providers. In other words, these providers are part of the PPO network. If you use the services of a PPO network provider, you will be responsible only for applicable deductibles and copayments for approved services.
- ** **PPO Out-of-Network** – Providers who have not contracted with BCBSM's PPO program are considered "out-of-network" providers. If you choose an "out-of-network" provider for services, additional copayments will be required, **plus any amount charged by the provider greater than BCBSM's payment if the provider is also not part of BCBSM's Traditional Network. Please note that these balances could be substantial.** If a PPO provider "refers" you out-of-network to a BCBSM Traditional participating provider, you will not be liable for additional copayments or cost above BCBSM's approved payment. **However, if you are referred to a provider who does not participate in BCBSM's Traditional or PPO Network, you will be responsible for additional copayments plus costs greater than BCBSM's payment.**

Note: Coverage is excluded for any service related to an injury which is a direct or indirect result of an automobile accident, including but not limited to trucks, buses, motorcycles, etc. This exclusion applies whether or not the individual has no-fault insurance.