

Enhanced Care PPO

For non-Medicare eligible UAW Trust members



2027 Frequently used benefits and out-of-pocket costs

	You pay	
	In network	Out of network
Monthly contributions and out-of-pocket expenses		
Monthly contribution – The monthly amount you must pay in order to have coverage for yourself and your dependents	General and Protected member member Individual: \$0 Family: \$0	
Deductible – per calendar year	Individual: \$175 Family: \$350 Protected member: \$0	Individual: \$1,000 Family: \$1,700 Protected member: \$0
Coinsurance	None	30% Protected member: 10%
Out-of-pocket maximum – per calendar year Combination of deductible and coinsurance	Individual: \$175 Family: \$350 Protected member: \$0	General and Protected member member Individual: \$3,000 Family: \$5,550
Physician office services		
Primary care office visits including virtual visits with your own doctor	Plan pays 100%	Not covered
Specialist office visits including virtual visits with your own doctor	\$10 copay	Not covered
Chiropractic spinal manipulations	\$20 copay per visit	Not covered
	Protected member – plan pays 100% Limited to 48 visits per year.	
Acupuncture (for chronic low back pain only) Acupuncture is not covered when billed by an Acupuncturist	Plan pays 100% after deductible Protected member – plan pays 100%	Not covered
Allergy testing Office visit copay may apply.	Plan pays 100% after deductible Protected member – plan pays 100%	Not covered
Allergy injections	Plan pays 100% after deductible Protected member – plan pays 100%	30% coinsurance after deductible Protected member – 10% coinsurance
Preventive services		
Routine physical	\$0 copay — Primary care \$10 copay — Specialist	Not covered
Cholesterol screening — one per calendar year starting at age 20	Plan pays 100%	Plan pays 100%
Pap smear screening — one per calendar year	Plan pays 100%	30% coinsurance after deductible Protected member – 10% coinsurance
Mammography screening — one routine exam per calendar year beginning at age 40. Under age 40, one per calendar year, if high-risk.	Plan pays 100%	30% coinsurance after deductible Protected member – 10% coinsurance
Prostate specific antigen (PSA) screening Screening test for asymptomatic males age 40 and older when performed in accordance with established guidelines — one per calendar year.	Plan pays 100%	30% coinsurance after deductible Protected member – 10% coinsurance
Colonoscopy preventive or diagnostic – once per calendar year.	Plan pays 100%	Plan pays 100%
Colorectal screening — barium enema x-ray and sigmoidoscopy – once every 5 years at age 45 and over or at any age if risk factors present Colorectal screening — fecal occult blood test and fecal immunochemical test (FIT) – once per calendar year at age 45 and over or at any age if risk factors present Lung cancer screening — one per calendar year, age 50 and over who have a 20 pack per year smoking history.	Plan pays 100%	Not covered
Hepatitis C (HCV) screening Those at risk or when signs or symptoms are present.	Plan pays 100%	30% coinsurance after deductible Protected member – 10% coinsurance
Immunizations/Vaccinations — regardless of place of service	Plan pays 100% Office visit copay may apply	Not covered (some exceptions may apply) ²
Diagnostic services		
Outpatient laboratory & pathology, X-rays, CAT scans, PET, MRI, MRA and nuclear medicine ¹	Plan pays 100% after deductible Protected member – plan pays 100%	30% coinsurance after deductible Protected member – 10% coinsurance
Sleep studies — in an office or outpatient location only ¹	Plan pays 100% after deductible Protected member – plan pays 100%	30% coinsurance after deductible Protected member – 10% coinsurance
Therapeutic treatment		
Radiation therapy ¹	Plan pays 100% after deductible Protected member – plan pays 100%	30% coinsurance after deductible Protected member – 10% coinsurance
Chemotherapy ¹	Plan pays 100% after deductible Protected member – plan pays 100%	30% coinsurance after deductible Protected member – 10% coinsurance

Protected member applies to retirees who retired before October 1, 1990 and surviving spouses of retirees who retired before October 1, 1999.

¹Preauthorization may be required.

²Contact Customer Service at the number on the back of your Blue Cross member ID card for a complete list.

Retiree Health Care Connect
1-866-637-7555 | TTY: 711
8:30 a.m. to 4:30 p.m. Monday - Friday

Customer Service
1-888-800-6403 | TTY: 711
8 a.m. to 8 p.m. Monday - Friday

	You pay	
	In network	Out of network
Emergency medical care		
Hospital emergency room	\$125 copayment (waived if admitted) Protected member: plan pays 100%	\$125 copayment (waived if admitted) Protected member: plan pays 100%
Urgent care/retail health clinics	\$40 copayment Protected member – plan pays 100%	Not covered
Ground ambulance Medically necessary transport	Plan pays 100% after deductible Protected member – plan pays 100%	Par Plan pays 100% after deductible Non Par Plan pays 100% up to charge Not subject to deductible Protected member – plan pays 100%
Air/water ambulance One-way transport to the nearest available facility.	Plan pays 100% up to the allowed amount	Plan pays 100% up to the allowed amount
Hospital services		
Semi-private room, general nursing services, meals, special diets and inpatient medical care ¹	Plan pays 100% after deductible Protected member – plan pays 100%	30% coinsurance after deductible Protected member – 10% coinsurance
Outpatient surgery — includes materials, supplies, preoperative and postoperative care, and suture removal.	Plan pays 100% after deductible Protected member – plan pays 100%	30% coinsurance after deductible Protected member – 10% coinsurance
Ambulatory surgical centers Must be an approved facility ¹	Plan pays 100% after deductible Protected member – plan pays 100%	Not covered
Human organ transplant — Specified organ and bone marrow transplants, in a participating facility only when coordinated through BCBSM Human Organ Transplant program (1-800-242-3504).	Blue Distinction designated facility Plan pays 100% Non-designated facility Plan pays 100% after deductible Protected member – plan pays 100%	Non-designated facility (Par) 30% coinsurance after deductible Protected member – 10% coinsurance Non-designated facility (Non-Par) Not covered
Reimbursement of travel and lodging expenses for specified organ and bone marrow transplants — Travel must be 100+ miles one way from residence. Includes member and one caregiver.	Plan pays 100% ²	Plan pays 100% ²
Kidney, cornea and skin transplant	Plan pays 100% after deductible Protected member – plan pays 100%	30% coinsurance after deductible Protected member – 10% coinsurance
Skilled nursing and hospice care		
Skilled nursing facility Must be an approved facility ¹	Plan pays 100% after deductible Protected member – plan pays 100%	30% coinsurance after deductible Protected member – 10% coinsurance
Hospice care Levels 1-5 ¹	Plan pays 100% after deductible Protected member – plan pays 100%	30% coinsurance after deductible Protected member – 10% coinsurance
Home health care ¹	Plan pays 100% after deductible Protected member – plan pays 100%	30% coinsurance after deductible Protected member – 10% coinsurance
Behavioral health care and substance use disorder treatment		
Inpatient behavioral health and substance use disorder treatment Preauthorization Required – 1-877-228-3912	Plan pays 100% up to 45 days treatment each for psychiatric and substance abuse	Plan pays 100% up to 45 days treatment each for psychiatric and substance abuse medical emergency admission only. Not covered if not a medical emergency admission.
Outpatient behavioral health treatment, including virtual visits with your own doctor	Plan pays 100%	Plan pays 100%
Outpatient substance use disorder treatment, including virtual visits with your own doctor	Plan pays 100%	Plan pays 100%
Outpatient therapy		
Cardiac Rehabilitation Only Phases I and II are covered. Must begin within 3 months of a cardiac event and be completed within 9 months.	Plan pays 100% Up to 36 sessions	Not covered
Outpatient physical and speech therapy Services covered in outpatient facility or in-home. Limited to 60 combined visits per calendar year, per condition.	Plan pays 100%	Not covered
Outpatient occupational therapy Services covered in outpatient facility only. Limited to 60 combined visits per calendar year, per condition.	Plan pays 100%	Not covered
Medical equipment and supplies		
Durable medical equipment, including prosthetics, compression stockings, diabetic shoes Subject to deductible when processed as part of inpatient services.	Plan pays 100%	Not covered
Diabetic monitoring supplies, including continuous glucose monitors (CGM)	Plan pays 100%	Not covered
Diabetes education Covers comprehensive American Diabetes Association-approved education classes for newly-diagnosed or uncontrolled diabetics	Plan pays 100%	Not covered
Wigs Up to \$250 per year, following cancer treatment	Plan pays 100%	Plan pays 100%

¹Preauthorization may be required.

²Maximum of \$10,000 over course of treatment for organ transplant event. Maximum of \$5,000 for bone marrow transplant