

*PPO*

**Represented HBL Incentives Enhanced  
Benefits-at-a-Glance  
DTE Energy Company**

**In-Network**

**Out-of-Network**

**Deductible, Copays/Coinsurance and Dollar Maximums**

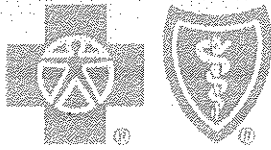
<b>Deductible - per calendar year</b>	\$300 per member \$600 per family	\$300 per member \$600 per family
<b>Copays/Coinsurance</b> • Fixed Dollar Copays	\$25 copay for: • Urgent Care Services • Office Visits • Outpatient mental health and substance abuse • Chiropractic Spinal Manipulations \$100 copay for: • Emergency Room	\$100 copay for: • Emergency Room
• Percent Coinsurance	10%	30% <b>Note:</b> Services without a network are covered at the in-network level.
<b>Out-of-Pocket Maximum</b> • Percent Coinsurance	\$1,200 per member \$2,400 per family	\$2,000 per member \$4,000 per family
<b>Lifetime Maximum</b>	Unlimited	

**Preventive Services**

Health Maintenance Exam - one per calendar year	Covered - 100%	Covered - 70% after deductible
Routine Physical Related Test - X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Covered - 70% after deductible
Annual Gynecological Exam - one per calendar year, in addition to health maintenance exam	Covered - 100%	Covered - 70% after deductible
Pap Smear Screening - one per calendar year	Covered - 100%	Covered - 70% after deductible
Mammography Screening - one per calendar year, no age restrictions	Covered - 100%	Covered - 70% after deductible
Prostate Specific Antigen (PSA) Screening - one per calendar year	Covered - 100%	Covered - 70% after deductible
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 70% after deductible
Well Child Care - 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 member per calendar year under the health maintenance exam benefit.	Covered - 100%	Covered - 70% after deductible
Immunizations -Pediatric & Adult	Covered - 100%	Covered - 70% after deductible

**Physician Office Services**

Office Visits	Covered - 100% after \$25 copay	Covered - 70% after deductible
---------------	---------------------------------	--------------------------------



**In-Network**

**Out-of-Network**

**Emergency Medical Care**

Hospital Emergency Room Qualified medical emergency	Covered - 100% after \$100 copay; copay waived if admitted	Covered - 100% after \$100 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Urgent Care Services	Covered - 100% after \$25 copay	Covered - 70% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 100%	Covered - 100%

**Diagnostic and Therapeutic Services**

MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 90% after deductible	Covered - 70% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 90% after deductible	Covered - 70% after deductible
Radiation Therapy and Chemotherapy	Covered - 90% after deductible	Covered - 70% after deductible

**Maternity Services Provided by a Physician**

Prenatal and Postnatal Care	Covered - 100%	Covered - 70% after deductible
Delivery and Nursery Care	Covered - 90% after deductible	Covered - 70% after deductible

**Hospital Care**

Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 90% after deductible	Covered - 70% after deductible
Inpatient Medical Care	Covered - 90% after deductible	Covered - 70% after deductible

**Alternatives to Hospital Care**

Hospice Care	Covered - 90% after deductible	Covered - 90% after deductible
Home Health Care	Covered - 90% after deductible	Covered - 90% after deductible
Skilled Nursing	Covered - 90% after deductible	Covered - 90% after deductible

**Surgical Services**

Surgery (includes related surgical services)	Covered - 90% after deductible	Covered - 70% after deductible
Sterilization - excludes reversal sterilization	Covered - 90% after deductible	Covered - 70% after deductible

**Human Organ Transplants**

Specified Organ Transplants in designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 90% after deductible	Covered - 70% after deductible

**Mental Health and Substance Abuse Services**

Inpatient Mental Health and Substance Abuse Care	Covered - 90% after deductible	Covered - 70% after deductible
Outpatient Mental Health and Substance Abuse Care	Covered - 100% after \$25 copay	Covered - 70% after deductible

**Other Services**

Cardiac Rehabilitation	Covered - 90% after deductible	Covered - 70% after deductible
Chiropractic Services 20 visit maximum per benefit period	Covered - 100% after \$25 copay	Covered - 70% after deductible
Durable Medical Equipment	Covered - 90% after deductible	Covered - 70% after deductible
Prosthetic and Orthotic Devices	Covered - 90% after deductible	Covered - 70% after deductible
Private Duty Nursing	Covered - 50% after deductible	Covered - 50% after deductible
Allergy Therapy and Testing	Covered - 90% after deductible	Covered - 70% after deductible

**Therapy Services**

Physical, Occupational and Speech Therapy Limited 60 visits combined per calendar year for Physical and Occupational Therapy. Speech Therapy is limited to a separate 120 visits.	Covered - 90% after deductible	Covered - 70% after deductible
--	--------------------------------	--------------------------------



The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This document is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

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. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-At-A-Glance and any applicable plan document, the plan document will control.