

Your Benefit Chart

The information contained herein provides a general summary of your group's health care benefits. It is not a contract. This summary may not reflect additional limitations or exclusions that apply to covered services or the most recent updates to BCBSM certificates, riders, plan modifications and/or changes that your group may be making to your coverage. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. You can also contact your health care administrator or call the customer service phone number printed on the back of your ID card if you have additional questions regarding your health care benefits.

Group: WASHTENAW INTER SCHOOL D
Group No: 28668001
Group Section No:
Effective Date: 999**

Eligibility Information

Member

Dependents

Dependents Continuation

Sponsored Dependents

Eligibility Criteria

Your spouse, and unmarried children until the end of the year in which they turn age 19.

Dependents between the ages of 19 and 25 provided they meet all of the requirements of this rider.

Dependent coverage for those individuals who are financially dependent on the subscriber if they meet all of the requirements of this rider.

Please click here for your certificate. [Community Blue Certificate](#)

Note: Services from a provider for which there is no PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty 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 our approved amount and the provider's charge. There is a \$5 million lifetime maximum per member for all other covered services and as noted for individual services.

Member's Responsibility (Deductible, Copay and Maximums)

Benefits

Deductible

In-Network

None

Out-of-Network

\$250 per member or \$500 for the family per calendar year

Copays

Fixed dollar copays

\$10 copay per visit for specific office services

Not applicable

Emergency services copay

\$50 copay for emergency services, waived if admitted or for an accidental injury

\$50 copay for emergency services, waived if admitted or for an accidental injury

Percent copays

50 percent of approved amount for private duty nursing

50 percent of approved amount for private duty nursing
20 percent of approved amount for most other covered services

See "**Mental health care and substance abuse treatment**" section for mental health and substance abuse percent copay amounts.

Copay dollar maximums - applies to copays for all covered services - including mental health and substance abuse services - but does not apply to fixed dollar copays and private duty nursing percent copays

None

\$2,000 per member or \$4,000 for the family per calendar year

Note: For groups with 50 or fewer employees or groups that are not subject to the MHP law, mental health care and substance abuse treatment copays do not contribute to the copay dollar maximum.

Dollar maximums

\$1 million lifetime maximum per covered specified human organ transplant type and a separate \$5 million lifetime maximum per member for all other covered services and as noted for individual services

Preventive care services - \$500 annual maximum for covered preventive care services

Benefits

Health maintenance exam - includes chest x-ray, EKG and select lab procedures, one per calendar year

In-Network

Covered - 100 percent of the approved amount

Out-of-Network

Not covered

Gynecological exam - one per calendar year

Covered - 100 percent of the approved amount

Not covered

Pap smear screening (laboratory and pathology services) - one per calendar year

Covered - 100 percent of the approved amount

Not covered

Well-baby and child care

Covered - 100 percent of the approved amount

Not covered

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 examination benefit		
Childhood immunizations as recommended by the Advisory Committee on Immunization Practices or other sources as recognized by BCBSM	Covered - 100 percent of the approved amount	Not covered
Fecal occult blood screening - one per calendar year	Covered - 100 percent of the approved amount	Not covered
Flexible sigmoidoscopy exam - one per calendar year	Covered - 100 percent of the approved amount	Not covered
Prostate specific antigen (PSA) screening - one per calendar year	Covered - 100 percent of the approved amount	Not covered
Mammography		
Benefits	In-Network	Out-of-Network
Routine mammogram - One per calendar year, no age restrictions	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Physician office services		
Benefits	In-Network	Out-of-Network
Office visits	\$10 copay per visit for specific office services	Covered - 80 percent of the approved amount after deductible
Note: Must be medically necessary for out-of-network services.		
Outpatient and home medical care visits	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Note: Must be medically necessary for out-of-network services.		
Office consultations	\$10 copay per visit for specific office services	Covered - 80 percent of the approved amount after deductible
Note: Must be medically necessary for out-of-network services.		
Urgent care visits	\$10 copay per visit for specific office services	Covered - 80 percent of the approved amount after deductible
Note: Must be medically necessary for out-of-network services.		
Emergency medical care		
Benefits	In-Network	Out-of-Network
Hospital emergency room	\$50 copay for emergency services, waived if admitted or for an accidental injury	\$50 copay for emergency services, waived if admitted or for an accidental injury
Ambulance services - must be medically necessary	Covered - 100 percent of the approved amount	Covered - 100 percent of the approved amount after deductible
Diagnostic services		
Benefits	In-Network	Out-of-Network
Laboratory and pathology services	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Diagnostic tests and x-rays	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Therapeutic radiology	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Maternity services provided by a physician or certified nurse midwife		
Benefits	In-Network	Out-of-Network
Prenatal and postnatal care - includes covered services provided by a certified nurse midwife	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Delivery and nursery care - includes covered services provided by a certified nurse midwife	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Hospital care		
Benefits	In-Network	Out-of-Network
Semiprivate room - inpatient physician care, general nursing care, hospital services and supplies - unlimited days	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Note: Maternity care and routine newborn nursery care during a mother's eligible hospital stay. Under federal law, we generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than:		
48 hours following a vaginal delivery		
96 hours following a delivery by cesarean section		
Note: Non-emergency services must be rendered in a participating hospital.		
Inpatient consultations	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible

Chemotherapy	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
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Alternatives to hospital care

Benefits

Skilled nursing care - up to 120 days per calendar year

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

Home health care - must be medically necessary

Home infusion therapy - must be medically necessary

In-Network

Covered - 100 percent of the approved amount

Covered - 100 percent of the approved amount

Covered - 100 percent of the approved amount

Covered - 100 percent of the approved amount

Out-of-Network

Covered - 100 percent of the approved amount after deductible

Covered - 100 percent of the approved amount

Covered - 100 percent of the approved amount after deductible

Covered - 100 percent of the approved amount after deductible

Inpatient Hospital Benefits Not Covered

Services that may be medically necessary but can be provided safely in an outpatient or office location; except when noted by other benefit coverage

Services of physicians and surgeons not employed by the hospital

Custodial care or rest therapy

Psychological tests if used as part of, or in connection with, vocational guidance training or counseling

Dental services. However, certain procedures may be payable as medical services if performed in a hospital because the patient has a dental condition that is adversely affecting a medical condition such as:

- Bleeding or clotting abnormalities
- Unstable angina
- Severe respiratory disease
- Known reaction to analgesics, anesthetics, etc.

Those procedures include:

- Alveoplasty
- Diagnostic X-rays
- Multiple extractions or removal of unerupted teeth
- Gingivectomy

Note: Medical records must verify the patient's concurrent hazardous medical condition.

Services covered under any other Blue Cross Blue Shield contract or under any health care benefits plan

Screening services

Artificial and endodontic transplants and related services, including repair and maintenance of implants and surrounding tissue

Those for care that is not considered acute, such as:

- Observation
- Dental treatment, including extraction of teeth, except as otherwise noted in this Certificate
- Diagnostic evaluations
- Lab exams
- Electrocardiography
- Weight reduction
- X-ray, exams or therapy
- Cobalt or ultrasound studies
- Basal metabolism tests
- Convalescence or rest care
- Convenience items

Those mainly for physical therapy, speech and language pathology services or occupational therapy; except when noted by other benefit coverage

Surgical services

Benefits

Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility.

Note: Benefit also includes related surgical services such as colonoscopy services.

Presurgical consultations

Voluntary sterilization

In-Network

Covered - 100 percent of the approved amount

Covered - 100 percent of the approved amount

Covered - 100 percent of the approved amount

Out-of-Network

Covered - 80 percent of the approved amount after deductible

Covered - 80 percent of the approved amount after deductible

Covered - 80 percent of the approved amount after deductible

Human organ transplants

Benefits	In-Network	Out-of-Network
Specified human organ transplants - in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504) Limited to \$1 million lifetime maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	Covered - 100 percent of the approved amount	Covered - 100 percent of the approved amount
Bone marrow transplants - when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Kidney, cornea and skin transplants	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Specified oncology clinical trials	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible

Mental health care and substance abuse treatment

Benefits	In-Network	Out-of-Network
Inpatient mental health care - Unlimited days	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Inpatient substance abuse treatment - Unlimited days	Covered - 100 percent of the approved amount	Covered - 100 percent of the approved amount after deductible
Outpatient mental health care		
Facility and clinic	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Physician's office	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Outpatient substance abuse treatment (in approved facilities only)	Covered - 100 percent of the approved amount	Covered - 100 percent of the approved amount after deductible

Outpatient Hospital Benefits Not Covered

- Outpatient inhalation therapy
- Cardiac rehabilitation services that require less than intensive monitoring (EKGs) or supervision because the patient's endurance while exercising and management of risk factors are stable
- Sports medicine, pain management, patient education or home exercise programs

Other covered services

Benefits	In-Network	Out-of-Network
Outpatient diabetes management program (ODMP)	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Allergy testing and therapy	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Chiropractic spinal manipulation - limited to a combined maximum of 24 visits per member per calendar year	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Outpatient physical, speech and occupational therapy - limited to a combined maximum of 60 visits per member per calendar year	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Contraceptive injections	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Prescription contraceptive devices	Covered - 100 percent of the approved amount	Covered - 80 percent of the approved amount after deductible
Durable medical equipment	Covered - 100 percent of the approved amount	Covered - 100 percent of the approved amount after deductible
Prosthetic and orthotic appliances	Covered - 100 percent of the approved amount	Covered - 100 percent of the approved amount after deductible
Private duty nursing	Covered - 50 percent of the approved amount	Covered - 50 percent of the approved amount after deductible

Physician and Other Professional Benefits Not Covered

- Services covered under any other Blue Cross or Blue Shield contract or under any other health care benefits plan
- Self-treatment by a professional provider and services given by the provider to parents, siblings, spouse or children
- Services for cosmetic surgery when performed primarily to improve appearance
- Health care services provided by persons who are not legally qualified or licensed to provide them
- Dental care (except to treat accidental injuries or multiple extractions requiring hospitalization), unless otherwise noted as an included benefit
- Artificial and endodontic dental implants and related services, including repair and maintenance of implants and surrounding tissue, unless otherwise noted as an included benefit

Weight loss programs

Contraceptive devices and medications used for the express purpose of preventing pregnancy, unless otherwise noted as an included benefit

Rest therapy or services provided to you while you are in a convalescent home, long, term care facility, nursing home, rest home or similar nonhospital institution

Services, care, supplies or devices not prescribed by a physician

Services provided during nonemergency medical transport

Experimental treatment

Hearing aids or services to examine, prepare, fit or obtain hearing aids, unless otherwise noted as an included benefit

Services to examine, prepare, fit or obtain eyeglasses or other corrective eye appliances, unless you lack a natural lens

Hospital services, including services provided by hospital employees

Drugs, medical appliances, materials or supplies or blood transfusions

Any reversible or irreversible medical and/or dental services performed for diagnosis and/or treatment of temporomandibular joint (jaw joint) dysfunction, except for:

- Surgery directly to the temporomandibular joint (jaw joint)
- Diagnostic X-rays
- Arthrocentesis
- Physical therapy

Note: The above restriction applies to any condition causing the temporomandibular joint (jaw joint) dysfunction.

Alternative medicines or therapies (such as acupuncture, herbal medicines and massage therapy)

Cardiac rehabilitation services that do not require intensive monitoring (EKGs) or supervision because the patient's endurance while exercising and management of risk factors are stable

Infertility services that do not treat a medical condition other than infertility This can include services such as:

- Sperm washing
- Post coital test
- Monitoring of ovarian response to ovulatory stimulants
- In vitro fertilization
- Ovarian wedge resection or ovarian drilling
- Reconstructive surgery of one or both fallopian tubes to open the blockage that causes infertility
- Diagnostic studies done for the sole purpose of infertility assessment
- Any procedure done to enhance reproductive capacity or fertility

Note: You or your physician can call us to determine if other proposed services are a covered benefit under your Certificate

Sports medicine, pain management, patient education (except as otherwise specified) or home exercise programs

Screening services (except as otherwise stated)

Those for which you legally do not have to pay or for which you would not have been charged if you did not have coverage under your Certificate

Those available in a hospital maintained by the state or federal government, unless payment is required by law

Those payable by government, sponsored health care programs, such as Medicare, for which a member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs. However, care and services is payable if federal laws require the government, sponsored program to be secondary to this coverage.

Any services not listed in your Certificate as being payable

Blue Preferred Rx® Prescription Drug Coverage

Note: Effective February 1, 2010, the mail order pharmacy for specialty drugs changed to Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blue members.) A list of specialty drugs is available on our Web site at bcbsm.com. Log in under "I am a Member." If you have any questions, please call Walgreens Specialty Pharmacy customer service at 866 - 515 - 1355.

BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

Blue Preferred RX Prescription Drug Coverage

Benefits	Network Pharmacy	Non-network Pharmacy
Copay	\$10 for each generic drug	\$10 for each generic drug

	\$60 for each brand - name drug, even if the prescription is marked "DAW" or there is no generic equivalent drug available	\$60 for each brand - name drug, even if the prescription is marked "DAW" or there is no generic equivalent drug available, plus 25 percent of the BCBSM approved amount for the drug
Elective Drugs (Elective drugs are health habit and reproductive drugs)	Covered - 50 percent of the approved amount	Covered - 50 percent of the approved amount, plus 25 percent of the BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	Covered - Copay is a separate copay amount for covered drugs up to 30 day supply for prescription or refill. Copay is double for drugs between 31 and 90 day supply for prescription or refill.	Not covered

Note: If your prescription is filled by any type of network pharmacy, and you request the brand - name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber has not indicated "Dispensed as Written" (DAW) on the prescription, you must pay the difference in cost between the brand - name drug dispensed and the maximum allowable cost for the generic plus the applicable copay.

Prescription covered services

Benefits

FDA-approved drugs

State - controlled drugs

Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs

Note: Needles and syringes have no copay.

Contraceptive medications

Mail order (home delivery) prescription drugs - up to a 90 - day supply of medication by mail from Medco (BCBSM network mail order provider)

Network Pharmacy

Covered - 100 percent less plan copay

Covered - 100 percent less plan copay

Covered - 100 percent less plan copay for the insulin or other covered injectable legend drug

Covered - 100 percent less plan copay

Covered - 100 percent less plan copay

Non-network Pharmacy

Covered - 75 percent less plan copay

Covered - 75 percent less plan copay

Covered - 75 percent less plan copay for the insulin or other covered injectable legend drug

Covered - 75 percent less plan copay

Not covered

Prescription Drugs Not Covered

Any contraceptive medications and devices, whether over-the-counter or FDA-approved or not, regardless of the reason they were prescribed or their intended use, unless otherwise noted as an included benefit

Therapeutic devices or appliances including, but not limited to, hypodermic or disposable needles and syringes when not dispensed with a covered injectable drug, insulin or self - administered chemotherapeutic drugs

Drugs prescribed for cosmetic purposes

The charge for any prescription refill in excess of the number specified by the prescriber or any refill dispensed one year after the prescriber's prescription order

Any vaccine given solely to resist infectious diseases

Administration of covered drugs (e.g., injections)

Non-self-administered injectable drugs

More than a 30-day supply of a covered drug. We may make exceptions for certain maintenance drugs or for drugs whose minimal package size prevents a 30-day supply from being dispensed (e.g., inhalers)

More than 12 doses of an impotence drug in a 30-day period unless otherwise noted or excluded. If you have a BCBSM mail order drug program, no more than 36 doses in a 90-day period

More than the quantities and doses allowed per prescription of select drugs by BCBSM, unless the prescribing physician obtains preauthorization from BCBSM. A list of drugs that may have quantity and/or dose limits is available at the BCBSM Web site at bcbsm.com.

Any drug we determine to be experimental or investigational

Any covered drug entirely consumed at the time and place of the prescription

Anything other than covered drugs and services

Diagnostic agents

Any drug or device prescribed for uses or in dosages other than those specifically approved by the Federal Food and Drug Administration. This is often referred to as the off - label use of a drug or device. Some chemotherapeutic drugs may be subject to prior authorization review.

Drugs that are not labeled FDA-approved, except for state - controlled drugs and insulin, or such drugs the BCBSM designates as covered

Covered drugs or services dispensed to a member when such services are benefits under other Blue Cross and Blue Shield certificates

Drugs or services obtained before the effective date of this contract, or after the contract ends

Nonpreferred co - branded drugs, unless they are preauthorized

Claims for covered drugs or services submitted after the applicable time limit for filing claims

Support garments or other nonmedical items

Supplemental Coverage

For more detailed information on Medicare benefits, please call or visit your local Social Security office or consult the Medicare Handbook (available on the Medicare Web site at medicare.gov or at any Social Security office).

Preventive Care Services

Benefits	Medicare	Blue Traditional Supplemental Coverage
Health maintenance exam	Not covered	Not covered
Gynecological exam	Covered at Medicare approved amount less Part B coinsurance, once every 24 months at age 50 and older	Not covered
Pap smear screening - laboratory services only	Covered at Medicare approved amount, once every 24 months	Covered in full by Medicare
Well-baby and child care	Not covered	Not covered
Immunizations		
Flu shots and pneumonia vaccines	Covered at Medicare approved amount	Covered in full by Medicare
Hepatitis B vaccines - for those at risk of contracting the disease	Covered at Medicare approved amount less Part B deductible and coinsurance	Not covered
Prostate specific antigen (PSA) test	Covered at Medicare approved amount, once every 12 months over age 50	Covered in full by Medicare

Mammography Services

Benefits	Medicare	Blue Traditional Supplemental Coverage
Mammography screening	Covered at Medicare approved amount less Part B coinsurance, once every 12 months at age 40 and older	Covers Medicare coinsurance

Physician office services

Benefits	Medicare	Blue Traditional Supplemental Coverage
Office visits	Covered at Medicare approved amount less Part B deductible and coinsurance	Not covered
Outpatient and home visits	Covered at Medicare approved amount less Part B deductible and coinsurance	Not covered
Office consultations	Covered at Medicare approved amount less Part B deductible and coinsurance	Not covered

Emergency medical care

Benefits	Medicare	Blue Traditional Supplemental Coverage
Hospital emergency room (professional services) - must be medically necessary	Covered at Medicare approved amount less Part B deductible and coinsurance or set copayment	Covers Medicare deductible and coinsurance or set copayment
Ambulance services - must be medically necessary	Covered at Medicare approved amount less Part B deductible and coinsurance	Covers Medicare deductible and coinsurance

Clinical laboratory services

Benefits	Medicare	Blue Traditional Supplemental Coverage
Laboratory and pathology tests - used in the diagnosis and treatment of an illness or injury	Covered at Medicare approved amount	Covered in full by Medicare

Hospital Care

Benefits	Medicare	Blue Traditional Supplemental Coverage
Semi-private room, inpatient physician care, general nursing care, hospital services and supplies		
Days 1-60	Covered at Medicare approved amount less Part A deductible	Covers Medicare deductible
Days 61-90	Covered at Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
Lifetime reserve days (60 days)	Covered at Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
Additional days	Not covered	Covered at BCBSM approved amount, up to an additional 275 days
Chemotherapy	Covered for administration and drugs, at Medicare approved amount less deductible and coinsurance; must meet Medicare criteria	Covers Medicare deductible and coinsurance; pays chemotherapy drugs which Medicare does not cover; must meet BCBSM criteria for payment

Alternatives to hospital care

Benefits	Medicare	Blue Traditional Supplemental Coverage
Skilled nursing facility care - specific criteria applies		
Days 1-20	Covered at Medicare approved amount	Covered in full by Medicare
Days 21-100	Covered at Medicare approved amount less daily coinsurance	Covers Medicare coinsurance
Days 101 and after	Not covered	Not covered
Hospice care	Covered at Medicare approved amount less small copayment for outpatient drugs and less small coinsurance for inpatient respite care	Covers limited costs Not Covered by Medicare
Home health care - medically necessary	Covered at Medicare approved amount	Covered in full by Medicare

Surgical services provided by a physician

Benefits	Medicare	Blue Traditional Supplemental Coverage
Surgery - includes related surgical services	Covered at Medicare approved amount less Part B deductible and coinsurance	Covers Medicare deductible and coinsurance

Human organ transplants

Benefits	Medicare	Blue Traditional Supplemental Coverage
Heart and liver	Covered at Medicare approved amount less deductible and coinsurance	Covers Medicare deductible and coinsurance
Lung and heart-lung	Covered at Medicare approved amount less deductible and coinsurance	Covers Medicare deductible and coinsurance
Pancreas	Not Covered	Not Covered

	Note: Pancreas transplants are covered under certain conditions. Please call Medicare for more information.	Note: Covers Medicare deductible and coinsurance when covered by Medicare.
Cornea	Covered at Medicare approved amount less deductible and coinsurance	Covers Medicare deductible and coinsurance
Bone marrow and kidney	Covered at Medicare approved amount less deductible and coinsurance	Covers Medicare deductible and coinsurance

Mental Health Care

Benefits	Medicare	Blue Traditional Supplemental Coverage
Inpatient mental health care in psychiatric facility	Covered at Medicare approved amount less deductible and coinsurance	
Days 1-190 lifetime	Note: In most cases, psychiatric care in general (as opposed to psychiatric) hospitals is not subject to the 190-day limit.	Covers Medicare deductible and coinsurance
Additional days after 190 lifetime days are used	Not covered	Not covered
Outpatient mental health care	Covered at Medicare approved amount less Part B deductible and coinsurance or set copayment for therapeutic services. Diagnostic services are covered at the Medicare approved amount less Part B deductible and coinsurance.	Covers Medicare deductible and coinsurance or set copayment

Other Services

Benefits	Medicare	Blue Traditional Supplemental Coverage
Allergy testing and therapy - with approved diagnosis	Covered at Medicare approved amount less Part B deductible and coinsurance	Covers Medicare deductible and coinsurance for testing. Injections are not covered.
Chiropractic spinal manipulation - must be medically necessary	Covered when medically necessary, at Medicare approved amount less Part B deductible and coinsurance	Not covered
Outpatient physical, speech and occupational therapy	Covered at Medicare approved amount less Part B deductible and coinsurance or set copayment Note: Services of independent physical or occupational therapist subject to annual dollar limit.	Covers Medicare deductible and coinsurance or set copayment
Durable medical equipment	Covered at Medicare approved amount less Part B deductible and coinsurance	Covers Medicare deductible and coinsurance
Prosthetic appliances	Covered at Medicare approved amount less Part B deductible and coinsurance	Covers Medicare deductible and coinsurance
Private duty nursing	Not covered	Not covered
Prescription drugs	Not covered	Not covered
Oral cancer drugs	Approved drugs are covered	Covered in full by Medicare

Foreign Travel

Benefits	Medicare	Blue Traditional Supplemental Coverage
Hospital services	Not Covered, except for inpatient hospital services in Canada or Mexico in rare situations	Covered at BCBSM approved amount, up to 30 days for covered services
Physician services	Not Covered, except for services rendered in Canada or Mexico in connection with a covered inpatient stay	Covered up to BCBSM approved amount

Supplemental Benefits Not Covered

- Home and office medical visits
- Osteopathic or chiropractic manipulation therapy
- Whole blood and packed red blood cells
- Hospital services, including services provided by hospital employees
- Dental services such as care, treatment, or replacement of teeth
- Services that you could get free if you did not have health care coverage
- Services covered under any other Blue Cross or Blue Shield contract or under any other health care benefits plan
- A provider's charge in excess of Medicare's approved amount
- A provider's charge in excess of our approved amount for emergency care received outside the United States
- Care that is not reasonable and necessary under Medicare program standards. Medicare does not pay for services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury
- Drugs or devices not approved by the Food and Drug Administration (FDA)
- Experimental chemotherapy drugs
- Services performed by immediate relatives or members of your household
- Self-treatment by a professional provider and services given by the provider to parents, siblings, spouse or children
- Services provided by employer facilities
- Private duty nursing

Master Medical 65 Coverage

Master Medical 65 Benefits are in addition to your Medicare and Traditional plans. Services are payable after exhausting benefits in your basic Medicare and Traditional plans.

Copayment, Deductible and Maximum

Benefits	Requirements
Deductible	\$100 per person per calendar year
Percent Copay	20 percent copay requirement
Private Duty Nursing Copay	50 percent copay requirement
Copay Dollar Maximum	\$2,500 per calendar year up to a lifetime maximum of \$5,000

Note: Once the \$5,000 lifetime maximum has been reached, an additional \$1,000 allowance is restored for each calendar year of continuous coverage.

Hospital Coverage

Benefits	Requirements
Additional days for Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 100 percent of the approved amount, no copay or deductible requirement

Mental Health Care

Benefits	Requirements
Inpatient Mental Health Care in psychiatric facility	Covered - 80 percent of the approved amount after deductible and after Medicare and Traditional coverage has been exhausted

Other Services

Benefits	Requirements
Private duty nursing in the hospital or at home	Covered - 50 percent of the approved amount after deductible

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