



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 DIST
Group No:	28668003
Group Section No:	
Effective Date:	999**
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Eligibility Information	
Member	Eligibility Criteria
Dependents	Your spouse, and unmarried children until the end of the year in which they turn age 19.
Dependents Continuation	Dependents between the ages of 19 and 25 provided they meet all of the requirements of this rider.

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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	In-Network	Out-of-Network
<u>Deductible</u>	\$100 per member or \$200 for the family per calendar year ⌘ Note: Deductible may be waived if service is performed in a PPO physician's office.	\$250 per member or \$500 for the family per calendar year
<u>Copays</u>		
⌘ <u>Fixed dollar copays</u>	\$30 copay per visit for specific office services	Not applicable
⌘ <u>Emergency services copay</u>	\$100 copay for emergency services, waived if admitted or for an accidental injury	\$100 copay for emergency services, waived if admitted or for an accidental injury
⌘ <u>Percent copays</u>	⌘ 50 percent of approved amount for private duty nursing ⌘ 10 percent of approved amount for most other covered services (copay waived if service is performed in a PPO physician's office)	⌘ 50 percent of approved amount for private duty nursing ⌘ 30 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.	
<u>Copay dollar maximums</u> - 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 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.	\$500 per member or \$1,000 for the family per calendar year	\$1,500 per member or \$3,000 for the family per calendar year ⌘ Note: Out-of-network copays also apply toward the in-network maximum.
<u>Dollar maximums</u>	\$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	

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

Benefits	In-Network	Out-of-Network
<u>Health maintenance exam - includes chest x-ray, EKG and select lab procedures, one per calendar year</u>	Covered - 100 percent of the approved amount	Not covered
<u>Gynecological exam - one per calendar year</u>	Covered - 100 percent of the approved amount	Not covered
<u>Pap smear screening (laboratory and pathology services) - one per calendar year</u>	Covered - 100 percent of the approved amount	Not covered
<u>Well-baby and child care</u> ⌘ 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	Covered - 100 percent of the approved amount	Not covered
<u>Childhood immunizations as recommended by the Advisory</u>	Covered - 100 percent of the	Not covered

<u>Committee on Immunization Practices or other sources as recognized by BCBSM</u>	approved amount	
<u>Fecal occult blood screening - one per calendar year</u>	Covered - 100 percent of the approved amount	Not covered
<u>Flexible sigmoidoscopy exam - one per calendar year</u>	Covered - 100 percent of the approved amount	Not covered
<u>Prostate specific antigen (PSA) screening - one per calendar year</u>	Covered - 100 percent of the approved amount	Not covered

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Mammography

Benefits	In-Network	Out-of-Network
<u>Routine mammogram - One per calendar year, no age restrictions</u>	Covered - 90 percent of the approved amount after deductible	Covered - 70 percent of the approved amount after deductible

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Physician office services

Benefits	In-Network	Out-of-Network
<u>Office visits</u> ⋮ Note: Must be medically necessary for out-of-network services.	\$30 copay per visit for specific office services	Covered - 70 percent of the approved amount after deductible
<u>Outpatient and home medical care visits</u> ⋮ Note: Must be medically necessary for out-of-network services.	Covered - 90 percent of the approved amount after deductible	Covered - 70 percent of the approved amount after deductible
<u>Office consultations</u> ⋮ Note: Must be medically necessary for out-of-network services.	\$30 copay per visit for specific office services	Covered - 70 percent of the approved amount after deductible
<u>Urgent care visits</u> ⋮ Note: Must be medically necessary for out-of-network services.	\$30 copay per visit for specific office services	Covered - 70 percent of the approved amount after deductible

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Emergency medical care

Benefits	In-Network	Out-of-Network
<u>Hospital emergency room</u>	\$100 copay for emergency services, waived if admitted or for an accidental injury	\$100 copay for emergency services, waived if admitted or for an accidental injury
<u>Ambulance services - must be medically necessary</u>	Covered - 90 percent of the approved amount after deductible	Covered - 90 percent of the approved amount after deductible

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Diagnostic services

Benefits	In-Network	Out-of-Network
<u>Laboratory and pathology services</u>	Covered - 90 percent of the approved amount after deductible	Covered - 70 percent of the approved amount after deductible
<u>Diagnostic tests and x-rays</u>	Covered - 90 percent of the	Covered - 70 percent of the

	approved amount after deductible	approved amount after deductible
<u>Therapeutic radiology</u>	Covered - 90 percent of the approved amount after deductible	Covered - 70 percent of the approved amount after deductible

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Maternity services provided by a physician or certified nurse midwife

Benefits	In-Network	Out-of-Network
<u>Prenatal and postnatal care - includes covered services provided by a certified nurse midwife</u>	Covered - 100 percent of the approved amount	Covered - 70 percent of the approved amount after deductible
<u>Delivery and nursery care - includes covered services provided by a certified nurse midwife</u>	Covered - 90 percent of the approved amount after deductible	Covered - 70 percent of the approved amount after deductible

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Hospital care

Benefits	In-Network	Out-of-Network
<u>Semiprivate room - inpatient physician care, general nursing care, hospital services and supplies - unlimited days</u> ■ 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.	Covered - 90 percent of the approved amount after deductible	Covered - 70 percent of the approved amount after deductible
<u>Inpatient consultations</u>	Covered - 90 percent of the approved amount after deductible	Covered - 70 percent of the approved amount after deductible
<u>Chemotherapy</u>	Covered - 90 percent of the approved amount after deductible	Covered - 70 percent of the approved amount after deductible

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Alternatives to hospital care

Benefits	In-Network	Out-of-Network
<u>Skilled nursing care - up to 120 days per calendar year</u>	Covered - 90 percent of the approved amount after deductible	Covered - 90 percent of the approved amount after deductible
<u>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</u>	Covered - 100 percent of the approved amount	Covered - 100 percent of the approved amount
<u>Home health care - must be medically necessary</u>	Covered - 90 percent of the approved amount after deductible	Covered - 90 percent of the approved amount after deductible
<u>Home infusion therapy - must be medically necessary</u>	Covered - 90 percent of the approved amount after deductible	Covered - 90 percent of the approved amount after deductible

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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

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Surgical services		
Benefits	In-Network	Out-of-Network
<u>Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility.</u> ■ Note: Benefit also includes related surgical services such as colonoscopy services.	Covered - 90 percent of the approved amount after deductible	Covered - 70 percent of the approved amount after deductible
<u>Presurgical consultations</u>	Covered - 100 percent of the approved amount	Covered - 70 percent of the approved amount after deductible
<u>Voluntary sterilization</u>	Covered - 90 percent of the approved amount after deductible	Covered - 70 percent of the approved amount after deductible

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Human organ transplants		
Benefits	In-Network	Out-of-Network
<u>Specified human organ transplants - in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)</u> ■ 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
<u>Bone marrow transplants - when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)</u>	Covered - 90 percent of the approved amount after deductible	Covered - 70 percent of the approved amount after deductible
<u>Kidney, cornea and skin transplants</u>	Covered - 90 percent of the approved amount after deductible	Covered - 70 percent of the approved amount after deductible
<u>Specified oncology clinical trials</u>	Covered - 90 percent of the approved amount after deductible	Covered - 70 percent of the approved amount after deductible

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Mental health care and substance abuse treatment		
Benefits	In-Network	Out-of-Network
<u>Inpatient mental health care</u>	Covered - 50 percent of the approved amount after deductible	Covered - 50 percent of the approved amount after deductible
<u>Inpatient substance abuse treatment - limited to \$15,000 each calendar year with a lifetime maximum of \$30,000</u>	Covered - 50 percent of the approved amount after deductible	Covered - 50 percent of the approved amount after deductible
<u>Outpatient mental health care</u>		
■ Facility and clinic	Covered - 50 percent of the approved amount after deductible	Covered - 50 percent of the approved amount after deductible
■ Physician's office	Covered - 50 percent of the approved amount after deductible	Covered - 50 percent of the approved amount after deductible
<u>Outpatient substance abuse treatment (in approved facilities) - up to</u>	Covered - 50 percent of the	Covered - 50 percent of the

<u>the state, dollar amount that is adjusted annually</u>	approved amount after deductible	approved amount after deductible
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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

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Other covered services

Benefits	In-Network	Out-of-Network
<u>Outpatient diabetes management program (ODMP)</u>	Covered - 90 percent of the approved amount after deductible	Covered - 70 percent of the approved amount after deductible
<u>Allergy testing and therapy</u>	Covered - 100 percent of the approved amount	Covered - 70 percent of the approved amount after deductible
<u>Chiropractic spinal manipulation - limited to a combined maximum of 24 visits per member per calendar year</u>	Covered - 100 percent of the approved amount	Covered - 70 percent of the approved amount after deductible
<u>Outpatient physical, speech and occupational therapy - limited to a combined maximum of 60 visits per member per calendar year</u>	Covered - 90 percent of the approved amount after deductible	Covered - 70 percent of the approved amount after deductible
<u>Contraceptive injections</u>	Covered - 90 percent of the approved amount after deductible	Covered - 70 percent of the approved amount after deductible
<u>Prescription contraceptive devices</u>	Covered - 100 percent of the approved amount after deductible	Covered - 70 percent of the approved amount after deductible
<u>Durable medical equipment</u>	Covered - 90 percent of the approved amount after deductible	Covered - 90 percent of the approved amount after deductible
<u>Prosthetic and orthotic appliances</u>	Covered - 90 percent of the approved amount after deductible	Covered - 90 percent of the approved amount after deductible
<u>Private duty nursing</u>	Covered - 50 percent of the approved amount after deductible	Covered - 50 percent of the approved amount after deductible

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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

<ul style="list-style-type: none"> ⌘ Dental care (except to treat accidental injuries or multiple extractions requiring hospitalization), unless otherwise noted as an included benefit
<ul style="list-style-type: none"> ⌘ Artificial and endodontic dental implants and related services, including repair and maintenance of implants and surrounding tissue, unless otherwise noted as an included benefit
<ul style="list-style-type: none"> ⌘ Weight loss programs
<ul style="list-style-type: none"> ⌘ Contraceptive devices and medications used for the express purpose of preventing pregnancy, unless otherwise noted as an included benefit
<ul style="list-style-type: none"> ⌘ 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
<ul style="list-style-type: none"> ⌘ Services, care, supplies or devices not prescribed by a physician
<ul style="list-style-type: none"> ⌘ Services provided during nonemergency medical transport
<ul style="list-style-type: none"> ⌘ Experimental treatment
<ul style="list-style-type: none"> ⌘ Hearing aids or services to examine, prepare, fit or obtain hearing aids, unless otherwise noted as an included benefit
<ul style="list-style-type: none"> ⌘ Services to examine, prepare, fit or obtain eyeglasses or other corrective eye appliances, unless you lack a natural lens
<ul style="list-style-type: none"> ⌘ Hospital services, including services provided by hospital employees
<ul style="list-style-type: none"> ⌘ Drugs, medical appliances, materials or supplies or blood transfusions
<ul style="list-style-type: none"> ⌘ Any reversible or irreversible medical and/or dental services performed for diagnosis and/or treatment of temporomandibular joint (jaw joint) dysfunction, except for: <ul style="list-style-type: none"> ⌘ Surgery directly to the temporomandibular joint (jaw joint) ⌘ Diagnostic X-rays ⌘ Arthrocentesis ⌘ Physical therapy <p>Note: The above restriction applies to any condition causing the temporomandibular joint (jaw joint) dysfunction.</p>
<ul style="list-style-type: none"> ⌘ Alternative medicines or therapies (such as acupuncture, herbal medicines and massage therapy)
<ul style="list-style-type: none"> ⌘ 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
<ul style="list-style-type: none"> ⌘ Infertility services that do not treat a medical condition other than infertility This can include services such as: <ul style="list-style-type: none"> ⌘ 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

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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	<ul style="list-style-type: none"> \$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 	<ul style="list-style-type: none"> \$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, 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.

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Prescription covered services		
Benefits	Network Pharmacy	Non-network Pharmacy
FDA-approved drugs	Covered - 100 percent less plan copay	Covered - 75 percent less plan copay
State - controlled drugs	Covered - 100 percent less plan copay	Covered - 75 percent less plan copay
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs ⓘ Note: Needles and syringes have no copay.	Covered - 100 percent less plan copay for the insulin or other covered injectable legend drug	Covered - 75 percent less plan copay for the insulin or other covered injectable legend drug
Contraceptive medications	Covered - 100 percent less plan copay	Covered - 75 percent less plan copay
Mail order (home delivery) prescription drugs - up to a 90 - day supply of medication by mail from Medco (BCBSM network mail order provider)	Covered - 100 percent less plan copay	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.

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Prescription Drug other benefit information	
Benefits	Network Pharmacy Non - network Pharmacy
Preferred Therapy Program	Note: The Preferred Therapy Program is a process of deciding if a less costly drug is available for initial prescriptions. With preferred therapy, claims for prescription drugs that do not meet the preferred therapy criteria require demonstrated use of one of the generic products on the Preferred List.
Drug interchange and generic copay waiver	Certain drugs may not be covered for future prescriptions if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at bcbsm.com. ⓘ If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at bcbsm.com.
Prescription drug preferred therapy	A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications before prescribing a more expensive brand-name drug. It applies only to prescriptions being filed for the first time of a targeted medication. Before filling your initial prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name

drugs targeted for the preferred therapy program is available at bcbsm.com, along with the preferred medications. If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect all targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.

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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

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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).

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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	Covered at Medicare approved amount	Covered in full by Medicare
⌘ Flu shots and pneumonia vaccines		
⌘ 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

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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

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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

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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

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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

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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	Covers Medicare deductible and coinsurance; pays chemotherapy drugs which Medicare does not cover; must meet BCBSM criteria

	Medicare criteria	for payment
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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

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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

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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 ☰ Note: Pancreas transplants are covered under certain conditions. Please call Medicare for more information.	Not Covered ☰ 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

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Mental Health Care		
Benefits	Medicare	Blue Traditional Supplemental Coverage
Inpatient mental health care in psychiatric facility		
<ul style="list-style-type: none"> ☰ Days 1-190 lifetime 	Covered at Medicare approved amount less deductible and coinsurance <ul style="list-style-type: none"> ☰ 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
<ul style="list-style-type: none"> ☰ 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

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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 <ul style="list-style-type: none"> ☰ 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

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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

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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