Blue Cross Blue Shield of Michigan

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Michigan Technological University
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Benefits-at-a-glance

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. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Note: A list of services that require approval **before** they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services**.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract.	$1,750 per member $3,500 per family	$3,500 per member $7,000 per family
Copays • Fixed Dollar Copays	No Copay	No Copay
Coinsurance • Percent Coinsurance	10% 35% on some services	30% 35% on some services **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums The full family out of pocket maximum must be met before it is considered satisfied.	$3,000 per member $6,000 per member in family plan $6,000 per family Includes Deductible, Coinsurance and Copays	$6,000 per member $12,000 per family Includes Deductible and Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered

Benefits	In-Network	Out-of-Network
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Not Covered
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - beginning 40 years of age; one per benefit period	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Not Covered
Well Child Care • 8 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%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 65% after deductible	Covered - 65% after deductible
Online Visits Note: Services are payable when rendered by American Well providers through Blue Cross Online Visits℠ or BCBS providers	Covered - 65% after deductible	Not Covered
Office Consultations	Covered - 65% after deductible	Covered - 65% after deductible
Pre-Surgical Consultations	Covered - 65% after deductible	Covered - 65% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 90% after deductible	Covered - 90% after deductible
Non-Emergency use of the Emergency Room	Covered - 65% after deductible	Covered - 65% after deductible
Urgent Care Services	Covered - 90% after deductible	Covered - 70% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 90% after deductible	Covered - 90% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
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

Benefits	In-Network	Out-of-Network
Prenatal Care Visits	Covered - 100%	Covered - 65% after deductible
Postnatal Care Visits	Covered - 65% after deductible	Covered - 65% after deductible
Delivery and Nursery Care	Covered - 90% after deductible	Covered - 70% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
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

Benefits	In-Network	Out-of-Network
Hospice Care Limited to lifetime maximum of 30 days	Covered - 90% after deductible	Covered - 70% after deductible
Home Health Care	Covered - 90% after deductible	Covered - 70% after deductible
Skilled Nursing Limited to a maximum of 120 days per calendar year	Covered - 90% after deductible	Covered - 70% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 90% after deductible	Covered - 70% after deductible
Bariatric Surgery	Covered - 90% after deductible	Covered - 70% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 90% after deductible	Covered - 70% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 70% after deductible

Human Organ Transplants

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

Services from a provider for which there is no Michigan PPO network and services from an out-of-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. Cost-sharing may differ when you obtain covered services outside of Michigan. 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.

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 90% after deductible	Covered - 70% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 65% after deductible	Covered - 65% after deductible
• Online Mental Health Visits	Covered - 65% after deductible	Covered - 65% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 90% after deductible	Covered - 70% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 24 visits per calendar year	Covered - 65% after deductible	Covered - 60% after deductible
Durable Medical Equipment	Covered - 65% after deductible	Covered - 65% after deductible
Prosthetic and Orthotic Devices	Covered - 65% after deductible	Covered - 65% after deductible
Private Duty Nursing Care	Covered - 90% after deductible	Covered - 70% after deductible
Allergy Testing and Therapy	Covered - 65% after deductible	Covered - 65% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 65% after deductible	Covered - 65% after deductible
Massage Therapy	Covered - 65% after deductible	Covered - 65% after deductible