Michigan Technological University - 55248
Standard Plan – effective 2/1/04
Benefits-at-a-Glance

	STANDARD PLAN	
	In-Network	Out-of-Network
Preventative Services		
Health Maintenance Exam Annual Gynecological Exam	Covered – 100%, one of EACH per calendar year	Not Covered
Pap Smear Screening – Laboratory services only	Covered – 100%, one per calendar year	Not Covered
Well-Baby and Child Care	Covered – 100% • 6 visits per year through age 1 • 2 visits per year, age 2 through age 3 • 1 visit per year, age 4 through age 15	Not Covered
Immunizations	Covered – 100%, up through age 16	Not Covered
Fecal Occult Blood Screening	Covered – 100%, one per calendar year	Not Covered
Flexible Sigmoidoscopy Exam	Covered – 100%, one per calendar year	Not Covered
Prostate Specific Antigen (PSA) Screening	Covered – 100%, one per calendar year	Not Covered
Chemical Profile	Covered – 100%, one per calendar year	Not Covered
Urinalysis	Covered – 100%, one per calendar year	Not Covered
Chemistry	Covered – 100%, one per calendar year	Not Covered
Complete Blood Count	Covered – 100%, one per calendar year	Not Covered
Chest X-Ray	Covered – 100%, one per calendar year	Not Covered
EKG	Covered – 100%, one per calendar year	Not Covered
Digital Rectal Exam	Covered – 100%, one per calendar year	Not Covered
Air Contrast Barium Enema	Covered – 100%, one per calendar year	Not Covered
Proctoscopic Exam	Covered – 100%, one per calendar year	Not Covered
Mammography		
Mammography Screening	Covered – 100%	Covered - 70% after deductible
	One per calendar year for members any age	
Physician Office Services		
Office Visits	Covered – 65%	Covered – 65% after deductible
Outpatient and Home Visits	Covered – 65%	Covered – 65% after deductible
Office Consultations	Covered – 65%	Covered – 65% after deductible

	STANDARD PLAN (continued)	
	In-Network	Out-of-Network
Emergency Medical Care		
Hospital Emergency Room – Approved diagnosis	Covered – Subject to $50 copay, per occurrence.	Covered – Subject to $50 copay, per occurrence
	Copay waived if admitted or for an accidental injury	
Physician's Office – Approved diagnosis	Covered – 100%	Covered – 100%
Urgent Care Center	Covered – Subject to $50 copay, per occurrence	Covered – Subject to $50 copay, per occurrence
Ambulance Services – Medically necessary	Covered – 100%	Covered – 100%
Diagnostic Services		
Laboratory and Pathology Tests	Covered – 100%	Covered – 70% after deductible
Diagnostic Tests and X-rays	Covered – 100%	Covered – 70% after deductible
Radiation Therapy	Covered – 100%	Covered – 70% after deductible
Maternity Services Provided by a Physician		
Pre-Natal and Post-Natal Care	Covered – 100%	Covered – 70% after deductible
Delivery and Nursery Care	Covered – 100%	Covered – 70% after deductible
Hospital Care		
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 100%	Covered – 70% after deductible
	Unlimited days	
Inpatient Consultations	Covered – 100%	Covered – 65% after deductible
Chemotherapy	Covered – 100%	Covered – 70% after deductible
Alternatives to Hospital Care		
Skilled Nursing Care	Covered – 100%	Covered – 100%
	Up to 60 days per confinement	
Hospice Care	Covered – 100%	Covered – 100%
	Limited to the lifetime dollar maximum which is adjusted annually by the state	
Home Health Care	Covered – 100%	Covered – 100%
	Unlimited visits	
Individual Case Management	Covered – 100%	Covered – 100%
Surgical Services		
Surgery, including all related surgical services, anesthesia and surgical assistance	Covered – 100%	Covered – 70% after deductible
Voluntary Sterilization	Covered – 100%	Covered – 70% after deductible

	STANDARD PLAN (continued)	
	In-Network	Out-of-Network
Human Organ Transplants		
Liver, Heart, Lung, Pancreas and Heart-Lung	Covered – 100%	Covered – 70% after deductible
	Up to $1 million maximum per transplant type $5,000 maximum for travel, meals, and lodging (combined) and $30 maximum per day for meals	
Bone Marrow	Covered – 100%	Covered – 70% after deductible
Kidney, Cornea and Skin	Covered – 100%	Covered – 70% after deductible
Mental Health Care and Substance Abuse Treatment		
Inpatient Mental Health Care and Substance Abuse Care	Covered – 100% (approved facility)	Covered – 70% after deductible (approved facility)
	120 days lifetime maximum per member	
Outpatient Mental Health Care	Covered – 65%	Covered – 65% after deductible
Outpatient Substance Abuse Treatment	Covered – 65%	Covered – 65%
	Combined 40 visits per members, per calendar year Mental Health Services can be rendered by an M.D., D.O., Ph.D, Outpatient Psychiatric Center (OPC) or If rendered by an independent MSW, CSW, ACSW, MSSW, LLP, or MMH, or Catholic Social Services (located at 616 Shelden Ave., Suite 211, Houghton MI) covered 65% and reimbursed directly to the subscriber Substance Abuse services must be rendered by an approved Substance Abuse Facility	
Other Services		
Allergy Testing and Therapy	Covered – 65%	Covered – 60% after deductible
Chiropractic Spinal Manipulation	Covered – 65%	Covered – 60% after deductible
	Up to 24 visits per calendar year	
Outpatient Physical, Speech and Occupational Therapy	Covered – 65%	Covered – 60% after deductible
	Up to 60 visits per calendar year	
Durable Medical Equipment and Medical Supplies	Covered – 65%	Covered – 65%
Prosthetic and Orthotic Appliances	Covered – 65%	Covered – 65%
Private Duty Nursing	Covered – 100%	Covered – 100%
Acupuncture	Covered – 65%	Covered – 60% after deductible
	20 visits total, per member, per calendar year Services must been rendered by an M.D. or D.O. Must be an approved diagnosis	

	STANDARD PLAN (continued)	
	In-Network	Out-of-Network

Other Services

	In-Network	Out-of-Network
Shoe inserts when shoe is not attached to a brace	Covered - 65%	Covered - 65%
	One pair of either shoe inserts or lifts per calendar year	
Lab procedures performed in a physician's office that are not normally payable in a physician's office setting	Covered - 100%	Covered - 70% after deductible
Professional visits for a newborn in nursery	Covered - 100%	Covered - 70% after deductible
Outpatient Diabetes Education and Training	Covered - 100% Subject to lifetime maximum of $1,000 per member	
Phototherapy Light Equipment with Photometer (50v bulbs)	Covered - 65% of charges Subject to lifetime maximum of $400 Replacement bulbs not covered	
Cardiac Rehabilitation Phases II & III of Treatment	Covered - 100%	Covered - 70% after deductible
Massage Therapy • M.D., D.O. • Massage Therapist, Massage Clinic, or Independent Physical Therapist	Covered – 65% Covered – 65%	Covered – 60% after deductible Covered – 65%
	20 visits total, per member, per calendar year Doctors prescription required Approved amount capped at $40 less copay with reimbursement made to subscriber when services rendered by a Massage Therapist or Massage Clinic Must be performed in the office setting	
Prescription Contraceptive Devices	Covered – 65%	Covered – 65% after deductible

Deductible, Copays and Dollar Maximums

	In-Network	Out-of-Network
Deductible	None	$300 per member, $500 per family
Copays • Fixed (does not contribute to out-of-pocket maximum)	• **$50 per Emergency Room visit**	• **$50 per Emergency Room visit**
• Percent	• **No copay on most benefits** • **35% on select benefits** - Acupuncture - Allergy Testing and Treatment - Chiropractic Services - Durable Medical Equipment & Medical Supplies - Massage Therapy - Outpatient Mental Health & Outpatient Substance Abuse - Outpatient Physical Therapy, Occupational Therapy, Speech Therapy	• **30% for most benefits** • **35% on select benefits** - Durable Medical Equipment & Medical Supplies - Physician Office Visits, Consultations and Home Visits - Mental Health Outpatient and Substance Abuse Outpatient - Massage Therapy by a Massage Therapist, Clinic, or Independent Physical Therapist

	STANDARD PLAN (continued)	
	In-Network	Out-of-Network
• Percent (continued)	**35% on select benefits (cont.)** - Photo Light Equipment - Physician Office Visits, Consultations and Home Visits - Prosthetic and Orthotic Appliances - Shoe Inserts & Lifts	**35% on select benefits (cont.)** - Photo Light Equipment - Prosthetic and Orthotic Appliances - Shoe Inserts & Lifts • **40% on select benefits** - Acupuncture - Allergy Testing & Therapy - Chiropractic Services - Physical Therapy, Occupational Therapy, Speech Therapy - Massage Therapy by and M.D. , D.O.
Copay Dollar Maximums • Fixed copays • Percent copays	• None • $750 per member / $1,500 per family	• None • $1,000 per member / $2,000 per family •
Dollar Maximums	$3 million lifetime per member for all covered services and as noted above for individual services	

This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificate and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.

Prescription Coverage

Prescription Drug Coverage

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Covered Services:
• Federal-legend drugs
• State-controlled drugs
• Prescription drug contraceptive medicines
• 34 day supply or 100 units of medication
▪ Needles and syringes covered 100% only when provided at the time an Insulin prescription is filled.
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Retail Prescription Drug Program
Preferred Rx Pharmacy (in Michigan):
• Generic Drugs:
25% copay per prescription
Subject to a minimum copay of $10 and a maximum of $30

• Brand Drugs:
30% copay per prescription
Subject to a minimum copay of $20 and a maximum of $60

(Outside Michigan) Merck-Medco Managed Care PAID Prescriptions Pharmacy Network.

Non-Preferred or Non-PAID Pharmacy: 75% of approved amount less the appropriate 25% or 30% copay.
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• Up to a 90 day supply of almost any medication
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Mail Order Prescription Drug Program
MOPD is subject to the same copay percentages, minimum and maximum requirements as identified above under the Retail RX plan. However, the copay applies twice for a 90 day prescription.

• Generic Drugs:
25% copay per prescription
Subject to a minimum copay of $20 and a maximum of $60

• Brand Drugs:
30% copay per prescription
Subject to a minimum copay of $40 and a maximum of $120
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11/11/05