



**Blue Cross  
Blue Shield  
of Michigan**

A nonprofit corporation and independent licensee  
of the Blue Cross and Blue Shield Association

**Michigan Technological University**  
**Group Number: 71571 Package Code(s): 030**  
**Division Code(s): 1100, 1200**  
**PPO - Retiree HuskyCare 2**  
**Effective Date: 01/01/2025**  
**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
<b>Deductibles</b> - per calendar year	\$1,500 per member \$3,000 per family	\$3,000 per member \$6,000 per family
<b>Copays</b> • Fixed Dollar Copays	\$50 copay for : • Facility Urgent care services • Professional Urgent care services \$75 copay for : • Facility medical emergency	\$75 copay for : • Facility medical emergency
<b>Coinsurance</b> • Percent Coinsurance	10%	30% <b>Note:</b> Services without a network are covered at the in-network level.
<b>Annual out-of-pocket maximums</b>	\$3,000 per member \$6,000 per family Includes Deductible, Coinsurance and Copays	\$6,000 per member \$12,000 per family Includes Deductible and Coinsurance
<b>Lifetime dollar maximum</b>	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
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered

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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%	Covered - 65% after deductible
Telemedicine Visits	Covered - 65%	Covered - 65% after deductible
Virtual Care - Online Medical Visits Note: Online Medical visits by a non-BCBSM selected vendor are not covered.	Covered - 65%	Not Covered
Office Consultations	Covered - 65%	Covered - 65% after deductible
Pre-Surgical Consultations	Covered - 65%	Covered - 65% after deductible

## Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after \$75 copay; copay waived if admitted	Covered - 100% after \$75 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Covered - 65% after deductible	Covered - 65% after deductible
Facility Urgent Care Services	Covered - 100% after \$50 copay	Covered - 70% after deductible
Physician Urgent Care Services	Covered - 100% after \$50 copay	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%	Covered - 70% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 90%	Covered - 70% after deductible
Radiation Therapy and Chemotherapy	Covered - 90% after deductible	Covered - 70% after deductible

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## Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	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 120 days per benefit period	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 - male reproductive organs excludes reversal sterilization	Covered - 90% after deductible	Covered - 70% after deductible
Sterilization - female reproductive organs excludes reversal sterilization	Covered - 100%	Covered - 70% after deductible
Expanded Abortion Services	Covered - 90% after deductible	Covered - 70% after deductible
<b>Note:</b> Abortions are not covered if rendered in a location where abortions are not legal.		

## 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%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 90% after deductible	Covered - 70% after deductible

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## 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%	Covered - 65% after deductible
Telemedicine Mental Health Care	Covered - 65%	Covered - 65% after deductible
Virtual Care - Online Mental Health Visits Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered.	Covered - 65%	Not Covered

## Other Covered Services

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

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