

# Blue Cross Blue Shield Supplemental Coverage Benefits-at-a-Glance for Oakland University – Faculty & Staff 1-1-07

## Blue Traditional Supplemental Exact Fill Coverage

### Medicare

#### Preventive Services

Health Maintenance Exam	Not Covered	Not Covered
Annual Gynecological Exam	Not Covered	Not Covered
Pap Smear Screening – laboratory services only	Covered at Medicare approved amount, once every 36 months	Covered in full by Medicare
Well-Baby and Child Care	Not Covered	Not Covered
Vaccinations • Flu Shots and Pneumonia Vaccines	Covered at Medicare approved amount	Covered in full by Medicare
Prostate Specific Antigen (PSA) Test	Covered at Medicare approved amount, once every 12 months at age 50 and older	Covered in full by Medicare

#### Mammography

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

Office Visits	Covered at Medicare approved amount less Part B deductible and coinsurance	Covers Medicare deductible and coinsurance; follows group's coverage (Master Medical)
Outpatient and Home Visits	Covered at Medicare approved amount less Part B deductible and coinsurance	Covers Medicare deductible and coinsurance; follows group's coverage (Master Medical)
Office Consultations	Covered at Medicare approved amount less Part B deductible and coinsurance	Covers Medicare deductible and coinsurance; follows group's coverage (Master Medical)

#### Emergency Medical Care

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
Ambulance Services – must be medically necessary	Covered at Medicare approved amount less Part B deductible and coinsurance	Covers Medicare deductible and coinsurance; follows group's coverage (Master Medical)

#### Clinical Laboratory Services

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

Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies • Days 1-60 • Days 61-90 • Lifetime Reserve Days (60 days) • Additional Days	Covered at Medicare approved amount less Part A deductible  Covered at Medicare approved amount less Part A daily coinsurance  Covered at Medicare approved amount less Part A daily coinsurance  Not Covered	Covers Medicare deductible  Covers Medicare daily coinsurance  Covers Medicare daily coinsurance  Covered at BCBSM approved amount, up to maximum number of days available under group's coverage (Master Medical) less Medicare days
Chemotherapy	Covered for administration and drugs, at Medicare approved amount less deductible and coinsurance; must meet Medicare criteria	Covers Medicare deductible and coinsurance

#### Alternatives to Hospital Care

Skilled Nursing Facility Care – specific criteria applies • Days 1-20 • Days 21-100 • Days 101 and after	Covered at Medicare approved amount  Covered at Medicare approved amount less daily coinsurance  Not Covered	Covered in full by Medicare  Covers Medicare coinsurance  Covered at BCBSM approved amount
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, up to level of group's coverage
Home Health Care – medically necessary	Covered at Medicare approved amount	Covered in full by Medicare

**Medicare**

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**Surgical Services Provided by a Physician**

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**

**Note:** Payment is based on medical necessity and must be rendered in an approved facility.

Heart and Liver	Covered at Medicare approved amount less deductible and coinsurance	Covers Medicare deductible and coinsurance up to level of group’s coverage
Lung and Heart-lung	Covered at Medicare approved amount less deductible and coinsurance	Covers Medicare deductible and coinsurance up to level of group’s coverage
Pancreas	Not Covered <b>Note:</b> Pancreas transplants are covered under certain conditions. Please call Medicare for more information.	Not Covered <b>Note:</b> Covers Medicare deductible and coinsurance when covered by Medicare up to level of group’s coverage.
Cornea	Covered at Medicare approved amount less deductible and coinsurance	Covers Medicare deductible and coinsurance up to level of group’s coverage
Bone Marrow and Kidney	Covered at Medicare approved amount less deductible and coinsurance	Covers Medicare deductible and coinsurance up to level of group’s coverage

**Mental Health Care**

<b>Inpatient</b> Mental Health Care in psychiatric facility • Days 1-190 <b>Lifetime</b>  • Additional Days after 190 lifetime days are used	Covered at Medicare approved amount less Medicare deductible and coinsurance <b>Note:</b> In most cases, psychiatric care in general (as opposed to psychiatric) hospitals is not subject to the 190-day limit.  Not Covered	Covers Medicare deductible and coinsurance up to level of group’s coverage (Basic & Master Medical)  Covered up to level of group’s coverage (Master Medical)
<b>Outpatient</b> 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 Medicare approved amount less Part B deductible and coinsurance.	Covers Medicare deductible and coinsurance or set copayment up to level of group’s coverage

**Other Services**

<b>Allergy Testing and Therapy – with approved diagnosis</b>	<b>Covered at Medicare approved amount less Part B deductible and coinsurance</b>	<b>Covers Medicare deductible and coinsurance up to level of group’s coverage (Master Medical)</b>
Chiropractic Spinal Manipulation – must be medically necessary	Covered when medically necessary, at Medicare approved amount less Part B deductible and coinsurance	Covers Medicare deductible and coinsurance up to level of group’s coverage (Master Medical)
Outpatient Physical, Speech and Occupational Therapy	Covered at Medicare approved amount less Part B deductible and coinsurance <b>Note:</b> Services of independent physical or occupational therapist subject to annual dollar limit.	Covers Medicare deductible and coinsurance up to level of group’s coverage ( Master Medical)
Durable Medical Equipment	Covered at Medicare approved amount less Part B deductible and coinsurance	Covers Medicare deductible and coinsurance up to level of group’s coverage (Master Medical)
Prosthetic Appliances	Covered at Medicare approved amount less Part B deductible and coinsurance	Covers Medicare deductible and coinsurance up to level of group’s coverage (Master Medical)
Private Duty Nursing	Not Covered	Covered up to level of group’s coverage (Master Medical)
Outpatient Prescription Drugs	Not Covered	\$10 copay for staff and \$15 copay for faculty
Oral Cancer Drugs	Approved drugs are covered	Covered in full by Medicare

**Foreign Travel**

Hospital Services	Not Covered, except for inpatient hospital services in Canada or Mexico in rare situations	Covered up to level of group’s coverage
Physician Services	Not Covered, except for services rendered in Canada or Mexico in connection with a covered inpatient stay	Covered up to level of group’s coverage

This is not a Medicare document. It is intended as an easy-to-read summary of many important features of Blue Cross Blue Shield Supplemental health care benefits. 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 certificate and riders.