Blue Care Network of Michigan

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

Group Name / Group ID: DETROIT PUBLIC SCHOOLS COMMUNITY DISTRICT / 00103623
Sub Group Name / Sub Group ID: DFT HE CORE / 1007
Class ID: 0003
Plan Description: Medical Healthy Living - Enhanced
Effective Date: 2025-01-01

Disclaimer: 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 to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificate and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this benefit summary and any applicable plan documents, the plan document will control.

DEDUCTIBLE

$500 per individual; $1,000 per family deductible per calendar year

COINSURANCE MAXIMUM

$1,500 per individual; $3,000 per family annual coinsurance maximum. The following do not apply to the coinsurance max if they are includedin your coverage: deductible, infertility services, male mastectomy, reduction mammoplasty, male sterilization, elective abortion, TMJ, orthognathic surgery, weight reduction procedures, DME, P&O, diabetic supplies and services with a flat dollar copay.

OUT-OF-POCKET MAXIMUM

$6,600 per individual; $13,200 per family out-of-pocket maximum per calendar year.

ALLERGY OFFICE VISIT

$40 copay per allergy office visit

AMBULANCE EMERGENT

10% coinsurance after deductible for emergency ambulance transport when other transportation would endanger a member's life

AMBULANCE NON-EMERGENT

10% coinsurance after deductible for non-emergent ambulance transport. Requires prior authorization by BCN.

DETOX - SUB ABUSE

10% coinsurance after deductible for inpatient or residential detox services. $20 copay per visit for outpatient detox services. Requiresprior authorization by BCN.

DURABLE MEDICAL EQUIPMENT

10% coinsurance for durable medical equipment. Must be preauthorizedand obtained from a BCN supplier. Breast pump to support breast feeding is covered in full.

EMERGENCY ROOM

$100 copay for emergency room treatment. ER copay waived if admittedas an inpatient. Your inpatient hospital benefit applies. See Inpatient Hospital.

HOME CARE VISITS

$40 copay per day for home care visits

INFERTILITY CARE (CRITERIA REQUIRED)

10% coinsurance after deductible for infertility services. Requires prior authorization by BCN. In-vitro fertilization is not covered.

INPATIENT HOSPITAL

10% coinsurance after deductible per inpatient hospital admission; unlimited days. See certificate for specific surgical coinsurance.

LAB

Lab and pathology services are covered in full.

MENTAL HEALTH INPATIENT

10% coinsurance after deductible for inpatient mental health/partial hospitalization per hospital admission. Requires prior authorization by BCN.

MENTAL HEALTH INPATIENT DAYS

Unlimited visits when medically necessary. Requires prior authorization by BCN Behavioral Health management.

MENTAL HEALTH INPATIENT TIME PERIOD

Coordinated by BCN Behavioral Health management

MENTAL HEALTH OUTPATIENT

$20 copay per visit for outpatient/intensive outpatient mental health. $20 copay per online mental health visit with a designated online BCN participating provider. Prior authorization not required for routine psychotherapy visits.

MENTAL HEALTH OUTPATIENT VISITS

Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.

MENTAL HEALTH OUTPT ADDL VISITS

Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.

ORTHOGNATHIC SURGERY

10% coinsurance after deductible for orthognathic surgery

ORTHOTICS

10% coinsurance for orthotics. Must be preauthorized and obtained from a BCN supplier.

OUTPATIENT SURGERY FACILITY

10% coinsurance after deductible for outpatient surgery. Preventive services and screenings as mandated by the Affordable Care Act are covered in full. See certificate for specific surgical coinsurance.

OUTPT FAC VISITS/DIAGNOSTIC SRVCS

10% coinsurance after deductible for outpatient diagnostic or therapeutic services. Lab and pathology services, prenatal ultrasound, preventive services and screenings as mandated by the Affordable Care Act are covered in full.

PCP VISITS

$20 copay per primary care physician office visit. Preventive services and screenings as mandated by the Affordable Care Act are covered in full. See BCBSM.com for a complete list of preventive services. $20 copay for Medical online visits when performed by a BCN designated online vendor, PCP or participating referral physician.

PHYSICAL THERAPY/REHAB OUTPT

$40 copay per visit for outpatient physical therapy and rehabilitation

PHYSICAL THERAPY/REHAB OUTPT LIMITS

Limited to 60 visits per calendar year for any combination of therapies.

PRE-EXISTING CONDITION

Not applicable

PRE-EXISTING TIME PERIOD

Not applicable

PROSTHETICS

10% coinsurance for prosthetics. Must be preauthorized and obtained from a BCN supplier.

SKILLED NURSING FACILITY

10% coinsurance after deductible for services in a skilled nursing facility

SKILLED NURSING FACILITY DAYS

Limited to 120 days of skilled nursing care per calendar year in a skilled nursing facility. Requires prior authorization by BCN.

SPECIALIST VISITS

$40 copay per specialist office visit when referred. Preventive services and screenings as mandated by the Affordable Care Act are coveredin full. Spinal manipulations limited to 30 combined visits per calendar year when provided by a chiropractor or osteopathic physician.

STERILIZATIONS

10% coinsurance after deductible for male sterilization. Female sterilization is covered in full.

SUB ABUSE INTERMEDIATE

10% coinsurance after deductible for residential/intermediate/partialhospitalization substance use disorder. Requires prior authorizationby BCN Behavioral Health management.

SUB ABUSE INTERMEDIATE TIME PERIOD

Coordinated by BCN Behavioral Health management

SUB ABUSE OUTPATIENT

$20 copay per visit for outpatient/intensive outpatient substance usedisorder. Prior authorization not required for routine psychotherapy visits.

SUB ABUSE OUTPATIENT VISITS

Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.

TEMPOROMANDIBULAR JOINT

10% coinsurance after deductible for TMJ services. Requires prior authorization by BCN.

ELECTIVE ABORTIONS

First trimester elective abortion is not a covered benefit.

URGENT CARE CENTER

$40 copay per urgent care visit

WEIGHT REDUCTION (CRITERIA REQUIRED)

10% coinsurance after deductible for weight reduction procedures. Requires prior authorization by BCN. Limited to one procedure per lifetime.

X-RAY

10% coinsurance after deductible for radiology services. Prenatal ultrasound and other preventive screenings are covered in full.

ANESTHESIA

10% coinsurance after deductible for anesthesia

SURGICAL ASSISTANT

Services performed by a surgical assistant are covered in full after deductible.

SECOND SURGICAL OPINION

$40 copay for second surgical opinion when referred

HOSPICE

Inpatient and outpatient hospice are covered in full after deductible. Inpatient care requires prior authorization.

NEWBORN CARE

10% coinsurance after deductible for newborn care in an inpatient setting

IMMUNIZATIONS

Pediatric and adult immunizations as recommended by the Advisory Committee on Immunization Practices are covered in full.

MATERNITY

Routine prenatal and postnatal visits are covered in full.

DIALYSIS

10% coinsurance after deductible for dialysis treatment in an inpatient or outpatient facility setting

CHEMOTHERAPY

10% coinsurance after deductible for chemotherapy in an inpatient or outpatient facility setting. Chemotherapy drugs are covered in full.

RADIATION THERAPY

10% coinsurance after deductible for radiation therapy in an inpatient or outpatient facility setting

AUTISM

$20 copay per visit for applied behavioral analysis. Outpatient therapy cost sharing applies for autism related speech, physical and occupational therapy with unlimited visits.

DIABETIC SUPPLIES

10% coinsurance for diabetic supplies and equipment. Must be preauthorized and obtained from a BCN supplier.

ALLERGY EVAL/SERUM/TESTING

Allergy related services are covered in full after deductible.

ALLERGY INJECTIONS

Allergy injections are covered in full.