Benefits-at-a-Glance

Healthy *Blue* Living SM

00103623_1307_0005 DETROIT PUBLIC SCHOOLS_HFPN DFT HE CORE PLUS

Effective Date: 1/1/2024

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 certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. 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 for fully insured plans.

Services must be provided or arranged by the member's primary care physician or health plan.

Preauthorization for Select Services – Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCN except in an emergency.

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

Healthy Blue Living subscribers must complete program requirements within the first 90 days of enrollment or re-enrollment. To qualify for or maintain enhanced benefits, the subscriber needs to complete a health assessment and qualification form during the first 90 days and follow their primary care physician's recommendations for a healthy lifestyle. If a tobacco user, must enroll in the BCN-sponsored tobacco cessation program within 120 days of the start of the plan year. If BMI is greater than or equal to 30, must select and begin participating in a weight management program within 120 days of the start of the plan year.

Enhanced Benefits : BCN1LG : SDCCR, ER100, 5254C, MOPD2O, SNU, UR50, OMRR, WR1000, 6600PM, SPRX0C, 6600PM, DCCRM, CO20, OPRH

Standard Benefits : BCN1LG : SDCCR, ER100, 5254C, MOPD2O, SNU, UR50, OMRR, WR1000, WDEDFC, 6600PM, SPRX0C, 6600PM, D500, DCCRM, CO20, OPRH

	Enhanced Benefits (BCN1LG)	Standard Benefits (BCN1LG)
Member's responsibility (deductibles, copays, coinsurance and dollar maximums)		
Deductible	None	$500 individual/$1,000 family per calendar year
Fixed Dollar Copays		
	$20 for office visits	$20 for office visits
	$50 for urgent care visits	$50 for urgent care visits
	$100 for emergency room visits	$100 for emergency room visits
	$20 for referral physician visits	$20 for referral physician visits
Coinsurance		
Medical Annual Coinsurance Maximum (ACM)	None	None
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$6,600 per individual/$13,200 per family	$6,600 per individual/$13,200 per family
Preventive services		
Health Maintenance Exam	100%	100%
Annual Gynecological Exam	100%	100%
Pap Smear Screening	100%	100%
Well-Baby and Child Care	100%	100%
Immunizations	100%	100%
Prostate Specific Antigen (PSA) Screening	100%	100%
Routine Colonoscopy	100%	100%
Mammography Screening	100%	100%
Voluntary Female Sterilization	100%	100%
Breast Pumps (DME guidelines apply.)	100%	100%
Maternity Pre-Natal care	100%	100%

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Physician office services		
PCP Office Visits - Note: Applicable cost sharing applies when other services are received in the office	$20 Copay	$20 Copay
Medical Online Visits	$20 Copay	$20 Copay
Consulting Specialist Care - When referred for other than preventive services. Note: Applicable cost sharing applies when other services are received in the office.	$20 Copay	$20 Copay
Emergency medical care		
Hospital Emergency Room - Copay waived if admitted	$100 Copay	$100 Copay
Urgent Care Center	$50 Copay	$50 Copay
Retail Health Clinic	$50 Copay	$50 Copay
Ambulance Services	100%	100% after deductible
Diagnostic services		
Laboratory and Pathology Services	100%	100%
Diagnostic Tests and X-rays	100%	100% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	100%	100% after deductible
Radiation Therapy	100%	100% after deductible
Maternity services provided by a physician		
Post-Natal and Non-routine Pre-Natal Care (See Preventive Services section for routine Pre-Natal Care) *Effective 1/1/23, routine postnatal visits are covered in full.	$20 Copay	$20 Copay
Delivery and Nursery Care	100% For professional services. (See Hospital Care for facility charges)	100% For professional services. (See Hospital Care for facility charges) after deductible

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Hospital care		
General Nursing Care, Hospital Services and Supplies	100%	100% after deductible
Outpatient Surgery - included all related surgical services and anesthesia - see member certificate for specific surgical copays.	100%	100% after deductible
Alternatives to hospital care		
Skilled Nursing Care	100%	100% after deductible
	Unlimited days	Unlimited days
Hospice Care	100%	100% after deductible
Home Health Care	100%	100% after deductible
Surgical services		
Surgery - included all related surgical services and anesthesia.	100%	100% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	100%	100% after deductible
Elective Abortion (One procedure per two year period of membership)	Not Covered	Not Covered
Human Organ Transplants	100%	100% after deductible
Reduction Mammoplasty	100%	100% after deductible
Male Mastectomy	100%	100% after deductible
Temporomandibular Joint Syndrome	100%	100% after deductible
Orthognathic Surgery	100%	100% after deductible
Weight Reduction Procedures (Limited to one procedure per lifetime)	$1,000 copay or 50% of the BCN approved amount, whichever is less, on all associated costs	$1,000 copay or 50% of the BCN approved amount, whichever is less, on all associated costs

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Behavioral health services (mental health and substance use disorder treatment)		
Inpatient Mental Health Care	100%	100% after deductible
Inpatient Substance Use Disorder	100%	100% after deductible
Outpatient Mental Health Care includes online visits Note: For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	$20 Copay	$20 Copay
Outpatient Substance Use Disorder	$20 Copay	$20 Copay
Autism spectrum disorders, diagnoses and treatment		
Applied behavioral analyses (ABA)	$20 Copay	$20 Copay
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	100%	100% after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visit and preventive benefit.	See your outpatient mental health, medical office visit and preventive benefit.
Other services		
Allergy Testing and Therapy	100%	100% after deductible
Allergy Injections	100%	100%
Chiropractic Spinal Manipulation - when referred	$20 Copay	$20 Copay
Outpatient Physical, Speech and Occupational Therapy	100%	100% after deductible
	60 visits per calendar year for any combination of therapies	60 visits per calendar year for any combination of therapies
Infertility Counseling and Treatment	100%	100% after deductible
Durable Medical Equipment	100%	100%
Prosthetic and Orthotic Appliances	100%	100%
Diabetic Supplies	100%	100%
Hearing Aid	Not Covered	Not Covered

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Prescription drugs		
Prescription Drugs - (Eff. 1/1/21 Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable pharmacy cost-sharing will apply.)	Tier 1 - $5 copay, Tier 2 - $25 copay, Tier 3 - $40 copay; 30 day supply	Tier 1 - $5 copay, Tier 2 - $25 copay, Tier 3 - $40 copay; 30 day supply
	Sexual Dysfunction drugs - 50% coinsurance	Sexual Dysfunction drugs - 50% coinsurance
	Women's Contraceptives - Tier 1 - 100%, Tier 2 - Tier 2 Copayment/Coinsurance above applies, Tier 3 - Tier 3 Copayment/Coinsurance above applies	Women's Contraceptives - Tier 1 - 100%, Tier 2 - Tier 2 Copayment/Coinsurance above applies, Tier 3 - Tier 3 Copayment/Coinsurance above applies
Mail Order Prescription Drugs	Two times the applicable copay up to a 90 day supply	Two times the applicable copay up to a 90 day supply
Prescription Drug Deductible	Not covered	Not covered
	Effective 1/1/20 -Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs	Effective 1/1/20 -Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs

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Pharmacy	0000F496	0050	

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