This booklet is intended to describe the essential features of your health plans in general terms. It is not intended to be a full description of coverage. All efforts have been made to correctly summarize the level of benefits; however, if an error has been made in the summary description, the Benefits At A Glance issued by the plan will supersede this document.
## Blue Care Network

Health Maintenance Organization (HMO) Healthy Blue Living Plan
Summary of Benefits for Detroit Public Schools Community District
January 1st – December 31st, 2017

### Health Care Services

<table>
<thead>
<tr>
<th>Benefit Period / Annual Deductibles &amp; Maximums:</th>
<th>Enhanced</th>
<th>Standard</th>
<th>Limitations (Enhanced and Standard)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Period:</td>
<td>Calendar Year</td>
<td>Calendar Year</td>
<td></td>
</tr>
<tr>
<td>Annual Deductible (Individual / Family):</td>
<td>None</td>
<td>$600 / $1,000</td>
<td></td>
</tr>
<tr>
<td>Co-insurance (amount member pays):</td>
<td>N/A</td>
<td>N/A</td>
<td>*For selected services, some services have a 50% coinsurance level. Please see below.</td>
</tr>
<tr>
<td>Annual Co-insurance Maximum (Individual / Family):</td>
<td>None</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum (Individual / Family):</td>
<td>$6,800 / $13,200</td>
<td>$6,800 / $13,200</td>
<td>Medical Cost Sharing Only - applies to deductibles, copays, coinsurance amounts for all covered services:</td>
</tr>
</tbody>
</table>

### Preventive Services:
- Health Maintenance Exam: Plan Pays 100%
- Annual Gynecological Exam: Plan Pays 100%
- Pap Smears and Mammograms: Plan Pays 100%
- Well-Baby and Child Care: Plan Pays 100%
- Immunizations: Plan Pays 100%
- Prostate Specific Antigen (PSA) Screening: Plan Pays 100%
- Voluntary Female Sterilization: Plan Pays 100%
- Breast Pumps: Plan Pays 100%
- Mammography: Plan Pays 100%
- Routine Colonoscopy: Plan Pays 100%

### Physician Office Services:
- Primary Care Physician Office Visit: $20 Copay
- Consulting Specialist Care: $20 Copay
- Online Visits: $20 Copay

### Emergency / Urgent Care:
- Emergency Room Services: $100 Copay
- Urgent Care Facility Services: $50 Copay
- Emergency Ambulance Services: Plan Pays 100%

### Diagnostic Services:
- Laboratory and Pathology Tests: Plan Pays 100%
- Diagnostic Tests and X-Rays: Plan Pays 100%
- High Technology Radiology Imaging: Plan Pays 100%

### Maternity Services:
- Post-Natal and Non-Routine Pre-Natal Care: $20 Copay
- Hospital Care: Covered

### Hospital Care:
- General Nursing Care, Hospital Services and Supplies: Plan Pays 100%
- Outpatient Surgery: Plan Pays 100%

### Alternatives to Hospital Care:
- Skilled Nursing Care: Plan Pays 100%
- Hospice Care: Plan Pays 100%
- Home Health Care: Plan Pays 100%

### Surgical Services:
- Surgery: Plan Pays 100%
- Elective Abortion: Not Covered
- Human Organ Transplants: Plan Pays 100%
- Weight Reduction Procedures: $1,000 Copay or 50% of the BCN approved amount, whichever is less, on all associated costs

### Mental Health Care and Substance Abuse Treatment:
- Inpatient Mental Health Care: Plan Pays 100%
- Inpatient Substance Abuse Care: Plan Pays 100%
- Outpatient Mental Health Care: $20 Copay

### Autism Spectrum Disorders, Diagnoses, and Treatment:
- Applied behavioral analysis (ABA) treatment: $20 Copay
- Outpatient Therapy: $20 Copay

### Other Services:
- Allergy Testing and Therapy: Plan Pays 100%
- Allergy Injections: 100%
- Chronic Pain Management: Plan Pays 100%
- Outpatient Physical, Speech, Occupational Therapy: Plan Pays 100%
- Inpatient Counseling and Treatment: Plan Pays 50%
- Durable Medical Equipment (DME): Plan Pays 100%
- Prosthetic and Orthotic Appliances (Prosthetics): Plan Pays 100%
- Prescription Drugs (EHM Rx): $5 / $25 / $40
- Mail Order Prescription Drugs: 2x Rx Copay
- Prescription Drugs Deductible: None
- Hearing Aids: Not Covered

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### Health Care Services

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<th>Benefit Period / Annual Deductibles &amp; Maxima:</th>
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<th>Standard</th>
<th>Limitations (Enhanced and Standard)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible (Individual / Family)</td>
<td>$500 / $1,000</td>
<td>$2,000 / $4,000</td>
<td>For Select Services Below</td>
</tr>
<tr>
<td>Annual Co-insurance (amount member pays)</td>
<td>10%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum (Individual / Family)</td>
<td>$1,500 / $3,000</td>
<td>$2,000 / $4,000</td>
<td></td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum (Individual / Family)</td>
<td>$8,600 / $13,200</td>
<td>$8,600 / $13,200</td>
<td>Medical Cost Sharing Only - applies to deductibles, copays, coinsurance for all covered services</td>
</tr>
</tbody>
</table>

### Preventive Services:

- Preventive Services: Health Maintenance Exam, Annual Gynecological Exam, Pap Smears and Mammograms, Well Baby and Child Care, Breast Pumps, Maternity Pre-Natal Care, Routine Colonoscopy

### Physician Office Services:

- Primary Care Physician Office Visit: $20 Copay $20 Copay
- Consulting Specialist Care: $40 Copay $45 Copay
- Online Visits: $30 Copay $30 Copay

### Emergency / Urgent Care:

- Emergency Room Services: $100 Copay $150 Copay
- Urgent Care Facility Services: $40 Copay $45 Copay
- Emergency Ambulance Services: $150 Copay $150 Copay

### Diagnostic Services:

- Laboratory and Pathology Tests: Plan Pays 100% Plan Pays 100%
- Diagnostic Tests and X-Rays: Plan Pays 100% Plan Pays 100%
- High Technology Radiology Imaging: Plan Pays 100% Plan Pays 80%
- Radiation Therapy: Plan Pays 100% Plan Pays 80%

### Maternity Services:

- Post-Natal and Non-Routine Prenatal Care: $20 Copay $20 Copay
- Delivery and Nursing Care: Covered Covered

### Hospital Care:

- General Nursing Care, Hospital Services and Supplies: Plan Pays 100% Plan Pays 100%
- Outpatient Surgery: Plan Pays 100% Plan Pays 80%

### Alternatives to Hospital Care:

- Skilled Nursing Care: Plan Pays 100% Plan Pays 80%
- Hospice Care: Plan Pays 100% Plan Pays 100%
- Home Health Care: $45 Copay $45 Copay

### Surgical Services:

- Surgery: Plan Pays 100% Plan Pays 100%
- Elective Abortion: Not Covered Not Covered
- Human Organ Transplants: Plan Pays 100% Plan Pays 80%
- Weight Reduction Procedures: Plan Pays 100% Plan Pays 80%

### Mental Health Care and Substance Abuse Treatment:

- Inpatient Mental Health Care: Plan Pays 100% Plan Pays 80%
- Inpatient Substance Abuse Care: Plan Pays 100% Plan Pays 80%
- Psychotropic Drugs (Opioids): Plan Pays 100% Plan Pays 80%

### Autism Spectrum Disorders, Diagnoses, and Treatment:

- Applied behavioral analysis (ABA) treatment: $20 Copay $30 Copay
- Outpatient Therapy: $45 Copay

### Other Services:

- Allergy Testing and Therapy: 100% 100%
- Allergy Injections: 100% 100%
- Osteopathic Manipulative Medicine: Plan Pays 100% Plan Pays 80%
- Pain Management: Plan Pays 100% Plan Pays 80%
- Prosthetic and Orthotic Appliances (P&O): Plan Pays 100% Plan Pays 80%
- Proton Beam Therapy: Plan Pays 100% Plan Pays 80%
- Covered Services: Includes mental health services for autism spectrum - see outpatient mental health and medical office visit benefit

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