

Detroit Academy of Arts and Sciences

2018-2019 Summary Plan Description

BCN HMOSM \$500/10%

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

Member's Responsibility: Deductible, Copays, Coinsurance and Dollar Maximums

Note: The Deductible will apply to certain services as defined below.

Deductible Note: Coinsurance and select fixed dollar copays apply once the deductible has been met.	\$500 per individual/\$1,000 per family per calendar year
Fixed dollar copays	\$20 for office visits, \$40 for specialist visits, \$50 for urgent care visits, \$150 for emergency room visits, \$150 for high tech imaging and \$5 for allergy injections
Coinsurance	10% and 50% for select services as noted below
Annual Coinsurance Maximum – The following services DO NOT apply to the Annual Coinsurance Maximum if they are included in your coverage: <ul style="list-style-type: none"> • Deductible amounts • Services with a flat dollar copay • Infertility services • Male Mastectomy • Reduction Mammoplasty • Male Sterilization • Elective Abortion • TMJ • Orthognathic Surgery • Weight Reduction procedures • Durable Medical Equipment • Prescription Drugs • Prosthetics and Orthotics • Diabetic Supplies 	\$2,500 per member/\$5,000 per family per calendar year
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays	\$6,600 per member/\$13,200 per family per calendar year

Preventive Services – as defined by the Affordable Care Act and included in your Certificate of Coverage

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%
Routine Colonoscopy	Covered – 100%
Mammography Screening	Covered – 100%
Voluntary Female Sterilization	Covered – 100%
Breast Pumps	Covered – 100%
Maternity Pre-Natal Care	Covered – 100%

Physician Office Services

PCP Office Visits	Covered – \$20 copay
Online Visits	Covered – \$20 copay
Consulting Specialist Care – when referred for other than preventive services	Covered – \$40 copay



Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered – \$150 copay after deductible
Urgent Care Center	Covered – \$50 copay
Ambulance Services – medically necessary	Covered – 90% after deductible

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100%
Diagnostic Tests and X-rays	Covered – 90% after deductible
High Technology Imaging (MRI, CAT, PET)	Covered – \$150 copay after deductible
Radiation Therapy	Covered – 90% after deductible

Maternity Services Provided by a Physician

Post-Natal Care. See Preventive Services section for Pre-Natal Care	Covered – \$20 copay
Delivery and Nursery Care	Covered – 100% after deductible for professional services; see Hospital Care for facility charges

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 90% after deductible; unlimited days
Outpatient Surgery – See member certificate for select surgical coinsurance	Covered – 90% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 90% after deductible up to 45 days per calendar year
Hospice Care	Covered – 100% after deductible when authorized
Home Health Care	Covered – \$40 copay after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 90% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – 50% after deductible
Elective Abortion (One procedure per two year period of membership)	Covered – 50% after deductible
Human Organ Transplants (subject to medical criteria)	Covered – 90% after deductible
Reduction mammoplasty (subject to medical criteria)	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 50% after deductible

Mental Health Care and Substance Use Disorder Treatment

Inpatient Mental Health Care and Substance Use Disorder Care	Covered – 90% after deductible
Outpatient Mental Health Care	Covered – \$20 copay
Outpatient Substance Use Disorder Care	Covered – \$20 copay



**Blue Care
Network
of Michigan**

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

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	Covered - \$20 copay
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18	Covered - \$40 copay after deductible
Physical, speech and occupational therapy for autism spectrum disorder is unlimited.	
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit

Other Services

Allergy Testing and Serum	Covered - 50% after deductible
Allergy office visits	Covered - 50% after deductible
Allergy Injections	Covered - \$5 copay
Chiropractic Spinal Manipulation - when referred	Covered - \$40 copay; up to 30 visits per calendar year
Outpatient Physical, Speech and Occupational Therapy - subject to meaningful improvement within 60 days	Covered - \$40 copay after deductible; limited to 60 visits per calendar year for any combination of therapies
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered - 50% after deductible on all associated costs
Durable Medical Equipment	Covered - 50%
Prosthetic and Orthotic Appliances	Covered - 50%
Diabetic Supplies	Covered - 90%

CLSSLG, D500, CI10%, WDRPOV, 6600PM, CO20, 40RP, ER150, UR50, IMG150, DSR10%, 25ECM, OMRR, VACR50



Custom Drug List SM \$4/\$15/\$40/\$80/20%/20% Prescription Drug Coverage

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Prescription Drugs

Tier 1A – Value Generics	\$4 Copayment
Tier 1B - Generics	\$15 Copayment
Tier 2 – Preferred Brand Drugs	\$40 Copayment
Tier 3 – Non-Preferred Drugs	\$80 Copayment
Tier 4 – Preferred Specialty	20% Coinsurance of the BCN Approved Amount (Maximum Copayment \$200)
Tier 5 Non-Preferred Specialty	20% Coinsurance of the BCN Approved Amount (Maximum Copayment \$300)
Sexual Dysfunction Drugs	50% Coinsurance of the BCN Approved Amount
Contraceptives Note: Your cost sharing may be waived for Tier 1B, Tier 2 or Tier 3 contraceptive drugs if there are no appropriate generic products or preferred drugs available.	<ul style="list-style-type: none"> • Tier 1A – Covered in Full • Tier 1B – \$15 Copay • Tier 2 - \$40 Copay • Tier 3 - \$80 Copay
Preventive Medications	<ul style="list-style-type: none"> • Tier 1A – Covered in Full • Tier 1B Generic – Covered in Full • Tier 2 Preferred Brand – Covered in Full • Tier 3 Non-Preferred Drugs – Covered in Full
31-90 day supply for Mail-Order Pharmacy	Three times applicable copay minus \$10
84-90 day supply for Retail Pharmacy	Three times applicable copay minus \$10
Out-of-Pocket Maximum	Your medical out-of-pocket maximum is integrated with your BCN covered Prescription Drugs. The out-of-pocket maximum amount is listed with your medical benefits.

Definitions

Brand Name Drug	Manufactured and marketed under a registered trade name and trademark. <ul style="list-style-type: none"> • Multi-source Brand Name Drug: a drug that is available from a brand name manufacturer and also has a generic version. • Single Source Brand Name Drug: the drug can only be produced by the company holding the patent; no generics are available.
Generic Drugs	Prescription drugs that have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark.
Non-Preferred Drugs	Prescription drugs that may not have a proven record for safety or their clinical record may not be as high as the BCN preferred alternatives.
Non-Preferred Specialty Drugs	Specialty drugs that may not have a proven record for safety or their clinical value may not be as high as the Specialty Drugs.
Out-of-Pocket Maximum	The highest amount of money you have to pay for covered services during the Calendar Year.
Preferred Brand Drugs	Prescription drugs that are Single Source Brand drugs that have a proven record for safety and effectiveness.
Preferred Specialty Drugs	Generic or Single Source Brand Specialty drugs that have a proven record for safety and effectiveness and offer the best value to our members.
Value Generic Drugs	Prescription drugs that have a proven clinical value essential for treatment of chronic conditions.



BCN HMO SM \$1000/20%

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Member's Responsibility: Deductible, Copays, Coinsurance and Dollar Maximums

Note: The Deductible will apply to certain services as defined below.

Deductible Note: Coinsurance and select fixed dollar copays apply once the deductible has been met.	\$1,000 per individual/\$2,000 per family per calendar year
Fixed dollar copays	\$20 for office visits, \$40 for specialist visits, \$50 for urgent care visits, \$150 for emergency room visits, \$150 for high tech imaging and \$5 for allergy injections
Coinsurance	20% and 50% for select services as noted below
Annual Coinsurance Maximum - The following services DO NOT apply to the Annual Coinsurance Maximum if they are included in your coverage: <ul style="list-style-type: none"> • Deductible amounts • Services with a flat dollar copay • Infertility services • Male Mastectomy • Reduction Mammoplasty • Male Sterilization • Elective Abortion • TMJ • Orthognathic Surgery • Weight Reduction procedures • Durable Medical Equipment • Prosthetics and Orthotics • Prescription Drugs • Diabetic Supplies 	\$2,500 per member/\$5,000 per family per calendar year
Annual out-of-pocket maximums - applies to deductibles, copays and coinsurance amounts for all covered services - including prescription drug copays	\$6,600 per member/\$13,200 per family per calendar year

Preventive Services - as defined by the Affordable Care Act and included in your Certificate of Coverage

Health Maintenance Exam	Covered - 100%
Annual Gynecological Exam	Covered - 100%
Pap Smear Screening - laboratory services only	Covered - 100%
Well-Baby and Child Care	Covered - 100%
Immunizations - pediatric and adult	Covered - 100%
Prostate Specific Antigen (PSA) Screening - laboratory services only	Covered - 100%
Routine Colonoscopy	Covered - 100%
Mammography Screening	Covered - 100%
Voluntary Female Sterilization	Covered - 100%
Breast Pumps	Covered - 100%
Maternity Pre-Natal Care	Covered - 100%

Physician Office Services

PCP Office Visits	Covered - \$20 copay
Online Visits	Covered - \$20 copay
Consulting Specialist Care - when referred for other than preventive services	Covered - \$40 copay



Emergency Medical Care

Hospital Emergency Room - copay waived if admitted	Covered - \$150 copay after deductible
Urgent Care Center	Covered - \$50 copay
Ambulance Services - medically necessary	Covered - 80% after deductible

Diagnostic Services

Laboratory and Pathology Tests	Covered - 100%
Diagnostic Tests and X-rays	Covered - 80% after deductible
High Technology Imaging (MRI, CAT, PET)	Covered - \$150 copay after deductible
Radiation Therapy	Covered - 80% after deductible

Maternity Services Provided by a Physician

Post-Natal Care. See Preventive Services section for Pre-Natal Care	Covered - \$20 copay
Delivery and Nursery Care	Covered - 100% after deductible for professional services; see Hospital Care for facility charges

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible; unlimited days
Outpatient Surgery - See member certificate for select surgical coinsurance	Covered - 80% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered - 80% after deductible up to 45 days per calendar year
Hospice Care	Covered - 100% after deductible when authorized
Home Health Care	Covered - \$40 copay after deductible

Surgical Services

Surgery - includes all related surgical services and anesthesia.	Covered - 80% after deductible
Voluntary Male Sterilization - See Preventive Services section for voluntary female sterilization	Covered - 50% after deductible
Elective Abortion (One procedure per two year period of membership)	Covered - 50% after deductible
Human Organ Transplants (subject to medical criteria)	Covered - 80% after deductible
Reduction mammoplasty (subject to medical criteria)	Covered - 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered - 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered - 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered - 50% after deductible
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	Covered - 50% after deductible

Mental Health Care and Substance Use Disorder Treatment

Inpatient Mental Health Care and Substance Use Disorder Care	Covered - 80% after deductible
Outpatient Mental Health Care	Covered - \$20 copay
Outpatient Substance Use Disorder Care	Covered - \$20 copay



Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	Covered – \$20 copay
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18	Covered – \$40 copay after deductible
Physical, speech and occupational therapy for autism spectrum disorder is unlimited.	
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit

Other Services

Allergy Testing and serum	Covered – 50% after deductible
Allergy office visits	Covered – 50% after deductible
Allergy Injections	Covered – \$5 copay
Chiropractic Spinal Manipulation – when referred	Covered – \$40 copay; up to 30 visits per calendar year
Outpatient Physical, Speech and Occupational Therapy – subject to meaningful improvement within 60 days	Covered – \$40 copay after deductible; limited to 60 visits per calendar year for any combination of therapies
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%
Diabetic Supplies	Covered – 80%

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Tier 2 – Preferred Brand Drugs	\$40 Copayment
Tier 3 – Non-Preferred Drugs	\$80 Copayment
Tier 4 – Preferred Specialty	20% Coinsurance of the BCN Approved Amount (Maximum Copayment \$200)
Tier 5 Non-Preferred Specialty	20% Coinsurance of the BCN Approved Amount (Maximum Copayment \$300)
Sexual Dysfunction Drugs	50% Coinsurance of the BCN Approved Amount
Contraceptives Note: Your cost sharing may be waived for Tier 1B, Tier 2 or Tier 3 contraceptive drugs if there are no appropriate generic products or preferred drugs available.	<ul style="list-style-type: none"> • Tier 1A – Covered in Full • Tier 1B – \$15 Copay • Tier 2 - \$40 Copay • Tier 3 - \$80 Copay
Preventive Medications	<ul style="list-style-type: none"> • Tier 1A – Covered in Full • Tier 1B Generic – Covered in Full • Tier 2 Preferred Brand – Covered in Full • Tier 3 Non-Preferred Drugs – Covered in Full
31-90 day supply for Mail-Order Pharmacy	Three times applicable copay minus \$10
84-90 day supply for Retail Pharmacy	Three times applicable copay minus \$10
Out-of-Pocket Maximum	Your medical out-of-pocket maximum is integrated with your BCN covered Prescription Drugs. The out-of-pocket maximum amount is listed with your medical benefits.

Definitions

Brand Name Drug	Manufactured and marketed under a registered trade name and trademark. <ul style="list-style-type: none"> • Multi-source Brand Name Drug: a drug that is available from a brand name manufacturer and also has a generic version. • Single Source Brand Name Drug: the drug can only be produced by the company holding the patent; no generics are available.
Generic Drugs	Prescription drugs that have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark.
Non-Preferred Drugs	Prescription drugs that may not have a proven record for safety or their clinical record may not be as high as the BCN preferred alternatives.
Non-Preferred Specialty Drugs	Specialty drugs that may not have a proven record for safety or their clinical value may not be as high as the Specialty Drugs.
Out-of-Pocket Maximum	The highest amount of money you have to pay for covered services during the Calendar Year.
Preferred Brand Drugs	Prescription drugs that are Single Source Brand drugs that have a proven record for safety and effectiveness.
Preferred Specialty Drugs	Generic or Single Source Brand Specialty drugs that have a proven record for safety and effectiveness and offer the best value to our members.
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Client: Detroit Academy o Arts

BCN HMOSM 20%

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Note: The Deductible will apply to certain services as defined below.

Deductible Note: Coinsurance and select fixed dollar copays apply once the deductible has been met.	None
Fixed dollar copays	\$25 for office visits, \$35 for specialist visits, \$35 for urgent care visits, \$150 for emergency room visits, \$150 for high tech imaging and \$5 for allergy injections
Coinsurance	20% and 50% for select services as noted below
Annual Coinsurance Maximum – The following services DO NOT apply to the Annual Coinsurance Maximum if they are included in your coverage: <ul style="list-style-type: none"> • Deductible amounts • Services with a flat dollar copay • Infertility services • Male Mastectomy • Reduction Mammoplasty • Male Sterilization • Elective Abortion • TMJ • Orthognathic Surgery • Weight Reduction procedures • Durable Medical Equipment • Prescription Drugs • Prosthetics and Orthotics • Diabetic Supplies 	\$1,000 per member/\$2,000 per family per calendar year
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays	\$6,600 per member/\$13,200 per family per calendar year

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Pap Smear Screening – laboratory services only	Covered – 100%
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Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%
Routine colonoscopy	Covered – 100%
Mammography Screening	Covered – 100%
Voluntary Female Sterilization	Covered – 100%
Breast Pumps	Covered – 100%
Maternity Pre-Natal Care	Covered – 100%

Physician Office Services

PCP Office Visits	Covered – \$25 copay
Online Visits	Covered – \$25 copay
Consulting Specialist Care – when referred for other than preventive services	Covered – \$35 copay



Emergency Medical Care

Hospital Emergency Room - copay waived if admitted	Covered - \$150 copay
Urgent Care Center	Covered - \$35 copay
Ambulance Services - medically necessary	Covered - 80%

Diagnostic Services

Laboratory and Pathology Tests	Covered - 100%
Diagnostic Tests and X-rays	Covered - 80%
High Technology Imaging (MRI, CAT, PET)	Covered - \$150 copay
Radiation Therapy	Covered - 80%

Maternity Services Provided by a Physician

Post-Natal Care. See Preventive Services section for Pre-Natal Care	Covered - \$25 copay
Delivery and Nursery Care	Covered - 100% for professional services; see Hospital Care for facility charges

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered - 80%; unlimited days
Outpatient Surgery - See member certificate for select surgical coinsurance	Covered - 80%

Alternatives to Hospital Care

Skilled Nursing Care	Covered - 80% up to 45 days per calendar year
Hospice Care	Covered - 100% when authorized
Home Health Care	Covered - \$35 copay

Surgical Services

Surgery - includes all related surgical services and anesthesia.	Covered - 80%
Voluntary Male Sterilization - See Preventive Services section for voluntary female sterilization	Covered - 50%
Elective Abortion (One procedure per two year period of membership)	Covered - 50%
Human Organ Transplants (subject to medical criteria)	Covered - 80%
Reduction mammoplasty (subject to medical criteria)	Covered - 50%
Male Mastectomy (subject to medical criteria)	Covered - 50%
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered - 50%
Orthognathic Surgery (subject to medical criteria)	Covered - 50%
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	Covered - 50%

Mental Health Care and Substance Use Disorder Treatment

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Tier 5 Non-Preferred Specialty	20% Coinsurance of the BCN Approved Amount (Maximum Copayment \$300)
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84-90 day supply for Retail Pharmacy	Three times applicable copay minus \$10
Out-of-Pocket Maximum	Your medical out-of-pocket maximum is integrated with your BCN covered Prescription Drugs. The out-of-pocket maximum amount is listed with your medical benefits.

Definitions

Brand Name Drug	<p>Manufactured and marketed under a registered trade name and trademark.</p> <ul style="list-style-type: none"> • Multi-source Brand Name Drug: a drug that is available from a brand name manufacturer and also has a generic version. • Single Source Brand Name Drug: the drug can only be produced by the company holding the patent; no generics are available.
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Non-Preferred Drugs	Prescription drugs that may not have a proven record for safety or their clinical record may not be as high as the BCN preferred alternatives.
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Value Generic Drugs	Prescription drugs that have a proven clinical value essential for treatment of chronic conditions.

2018-2019
EFFECTIVE October 01, 2018
Employee Insurance Contributions
Blue Care Network
Medical & RX Only
Plan A \$1,000/\$2,000 Deductible

<i>PLAN</i>	<i>PER PAY CONTRIBUTION</i>
YOU ALONE	\$43.51
YOU + 1	\$104.02
YOU + 2 OR MORE	\$131.02
FAMILY CONTINUATION	\$0.00

BLUE CARE NETWORK
Plan B \$500/\$1,000 Deductible

<i>PLAN</i>	<i>PER PAY CONTRIBUTION</i>
YOU ALONE	\$54.86
YOU + 1	\$131.25
YOU + 2 OR MORE	\$174.29
FAMILY CONTINUATION	\$0.00

BLUE CARE NETWORK
Plan C \$0 Deductible

<i>PLAN</i>	<i>PER PAY CONTRIBUTION</i>
YOU ALONE	\$66.85
YOU + 1	\$160.04
YOU + 2 OR MORE	\$210.28
FAMILY CONTINUATION	\$0.00