

Blue Care Network Benefits-at-a-Glance for Ann Arbor Public Schools

This is intended as an easy-to-read summary. It is not a contract. An official description of benefits is contained in applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible and/or copay amounts required by the plan. 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.**

Preventive Services

Health Maintenance Exam	Covered – \$5 copay
Annual Gynecological Exam	Covered – \$5 copay
Pap Smear Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit
Well-Baby and Child Care	Covered -- \$0 copay for well child visits through age 6; over age 6, \$5 copay per visit
Immunizations – pediatric and adult	Covered – Office visit copay may apply per member, per visit
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – Office visit copay may apply per member, per visit

Mammography

Mammography Screening	Covered – Office visit copay may apply per member, per visit
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Physician Office Services

Office Visits	Covered – \$5 copay
Consulting Specialist Care – when referred	Covered – \$5 copay

Emergency Medical Care

Hospital Emergency Room (copay waived if admitted)	Covered – \$25 copay
Physician's Office	Covered – \$5 copay
Urgent Care Center	Covered – \$10 copay
Ambulance Services – medically necessary	Covered – 100%, ground and air services

Diagnostic Services

Laboratory and Pathology Tests	Covered – Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered – Office visit copay may apply per member, per visit
Radiation Therapy	Covered – Office visit copay may apply per member, per visit

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered - \$5 copay initial visit only, thereafter, no copay
Delivery and Nursery Care	Covered – 100%

Hospital Care

Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 100%
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Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100%, up to 45 days per member per calendar year
Hospice Care	Covered – 100%
Home Health Care	Covered – 100%

Surgical Services

Surgery – includes all related surgical services and anesthesia – see member certificate for specific surgical copays	Covered – 100%
Voluntary Sterilization	Covered – 100% on all associated costs
Human Organ Transplants	Covered – 100%, subject to medical criteria

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	Mental Health Care: Covered – 100%, up to 30 days per calendar year Substance Abuse Care: Covered – 50%, one program per 12-month period
Outpatient Mental Health Care	Covered - \$15 copay– up to 20 visits per calendar year
Outpatient Substance Abuse Care	Covered – \$15 copay - up to 20 visits per calendar year

Other Services

Allergy Testing and Therapy	Covered – office visit copay may apply per member per visit
Chiropractic Spinal Manipulation (when referred)	Covered – \$5 copay
Outpatient Physical, Speech and Occupational Therapy	Covered – 100%, limited to 60 consecutive days per episode per year for a combination of therapies; subject to significant improvement within 60 days
Weight Reduction	Covered - \$1000 copay on all associated costs
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% for consultation, diagnostic testing and treatment when authorized by BCN
Hearing Aid	One hearing exam and one hearing aid prescription every 36 months. Office visit copay may apply.
Elective First Trimester Termination	Covered – 100%, one procedure every 24 months
Durable Medical Equipment	Covered – 100%
Prosthetic and Orthotic Appliances	Covered – 100%
Prescription Drugs	Covered - \$15 copay for generic, \$30 copay for brand name drugs. Mail order, 2 times copay for 90 day supply. Contraceptives included. Open formulary.

Deductible, Copays and Dollar Maximums

Deductible	None
Copays	
• Fixed Dollar Copay	\$5 for office visits, \$15 for outpatient mental health and outpatient substance abuse; \$10 for urgent care visits, \$25 for emergency room visits, and \$1,000 for weight reduction procedures.
• Percent Copay	50% for infertility services
Copay Dollar Maximums	
• Fixed Dollar Copay	None
• Percent Copay	None
Dollar Maximums	None