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

Pontiac School District
BCN HMO $500/10%

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 09/01/2015
Coverage for: All Contract Types **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsm.com or by calling 1-800-662-6667.

Important Questions	Answers: Member/Family	Why this Matters:
What is the overall deductible?	$500/$1000 Doesn't apply to preventive care, DME/P&O, PCP office visits, urgent care, allergy injections and lab services.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, $6600/$13200, Coinsurance Maximum - $1500/$3000	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balanced billed charges and health care this plan does not cover	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of BCN providers, see www.BCBSM.com or call (800) 662-6667	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes, in-network only. Paper or electronic.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See you policy or plan document for additional information about **excluded services**.

Group Number 0000-0000

Questions: Call 1-800-662-6667 or visit us at www.bcbsm.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-662-6667 to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1500 for an overnight stay and the **allowed amount** is $1000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use Providers:		Limitations & Exceptions
		In-Network	Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay/visit	Not covered	-- none --
	Specialist visit	$30 co-pay/visit	Not covered	Requires referral. 50% co-insurance for allergy office visit/$5 co-pay for allergy injections
	Other practitioner office visit	$30 co-pay/visit	Not covered	Requires referral / 30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician
	Preventive care/screening/immunization	No charge	Not covered	-- none --
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance	Not covered	May require prior authorization/Deductible applies except for lab services
	Imaging (CT/PET scans, MRIs)	$150 co-pay	Not covered	Requires prior authorization/Deductible applies
If you need drugs to treat your illness or condition More information about **prescription**	Tier 1-Generics	$4 co-pay value generics, $15 co-pay generics	Not covered	30 day supply, 90 day mail order and retail co-pays are 3x the standard retail co-pays minus $10, 50% co-insurance for sexual dysfunction drugs, preventive drugs covered in full
	Tier 2-Preferred Brand	$40 co-pay	Not covered	
	Tier 3-Non-Preferred Drugs	$80 co-pay	Not covered	

Common Medical Event	Services You May Need	Your cost if you use Providers:		Limitations & Exceptions
		In-Network	Out-of-Network	
	Specialty drugs	20% co-insurance, preferred co-pay max $200, non-preferred co-pay max $300	Not covered	Limited to a 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	Not covered	May require prior authorization/Deductible applies/50% co-insurance for weight reduction procedures,TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy
	Physician/surgeon fees	10% co-insurance	Not covered	See "Outpatient surgery facility fee"
If you need immediate medical attention	Emergency room services	$150 co-pay/visit	$150 co-pay/visit	Copay waived if admitted/Deductible applies
	Emergency medical transportation	10% co-insurance	10% co-insurance	Non-emergency transport is covered if authorized/Deductible applies
	Urgent care	$35 co-pay/visit	$35 co-pay/visit	-- none --
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	Not covered	Requires prior authorization/Deductible applies/50% co-insurance for weight reduction procedures, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy
	Physician/surgeon fee	10% co-insurance	Not covered	See "Hospital stay facility fee"

Common Medical Event	Services You May Need	Your cost if you use Providers:		Limitations & Exceptions
		In-Network	Out-of-Network	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay/visit	Not covered	Requires prior authorization
	Mental/Behavioral health inpatient services	10% co-insurance	Not covered	Requires prior authorization/Deductible applies
	Substance use disorder outpatient services	$20 co-pay/visit	Not covered	Requires prior authorization
	Substance use disorder inpatient services	10% co-insurance	Not covered	Requires prior authorization/Deductible applies
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	Postnatal and non-routine prenatal office visits-$20 copay
	Delivery and all inpatient services	10% co-insurance	Not covered	Deductible applies
If you need help recovering or have other special health needs	Home health care	$30 co-pay/visit	Not covered	Deductible applies
	Rehabilitation services	$30 co-pay/visit	Not covered	Requires prior authorization/ One period of treatment for any combination of therapies within 60 consecutive days per Calendar Year/deductible applies
	Habilitation services	$20 co-pay/visit for ABA;$30 co-pay/visit for PT/OT/ST	Not covered	PT/OT/ST for autism spectrum disorder has unlimited visits. Requires prior authorization/deductible applies
	Skilled nursing care	10% co-insurance	Not covered	Requires prior authorization/Limited to 45 days per calendar year/Deductible applies
	Durable medical equipment	50% coinsurance	Not covered	Must be authorized and obtained from a BCN supplier/Diabetic supplies covered with a 10% coinsurance
	Hospice service	No charge	Not covered	Inpatient care requires authorization/Deductible applies
If your child needs dental or eye care	Eye exam	Not covered	Not covered	See plan administrator for coverage information
	Glasses	Not covered	Not covered	See plan administrator for coverage information
	Dental check-up	Not covered	Not covered	See plan administrator for coverage

Common Medical Event	Services You May Need	Your cost if you use Providers:		Limitations & Exceptions
		In-Network	Out-of-Network	
				information

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental Care (Adult)
- Hearing aids
- Long term care
- Non emergency care outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs
- Elective Abortion

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium,** which may be significantly higher than the premium you pay while covered under the plan. Other limitation on your rights to continue coverage may apply.

For more information on your rights to continue coverage, contact the plan at 1-800-662-6667. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Blue Care Network, Appeals and Grievance Unit, MC C248, P.O. Box 284, Southfield, MI 48086 or fax 1-888-458-0716.

For state of Michigan assistance contact the Office of Financial and Insurance Regulation, Healthcare Appeals Section, Office of General Counsel, 611 Ottawa, 3rd Floor, P. O. Box 30220, Lansing, MI 48909-7720, michigan.gov/ofir; call 1-877-999-6442 or fax: 517-241-4168.

For Department of Labor assistance contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP), Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720, michigan.gov/difs; Ofir-hicap@michigan.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides. (IMPORTANT: Blue Care Network of Michigan is assuming that your coverage provides for all Essential Health Benefits (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage for specific EHB categories, for example prescription drugs, through another carrier.)

Translation available

To get help reading in your language call the customer service number on the back of your ID card.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,200
- **Patient pays** $1,340

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Co-pays	$10
Co-insurance	$680
Limits or exclusions	$150
Total	**$1,340**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,410
- **Patient pays** $990

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Co-pays	$280
Co-insurance	$130
Limits or exclusions	$80
Total	**$990**

If you are also covered by an account-type plan such as an integrated health reimbursement arrangement (HRA), and/or an health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses-like deductible, co-payments, or co-insurance or benefits not otherwise covered.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- Coverage examples are calculated based on individual coverage.
- The coverage examples assume you have a combined medical and pharmacy out-of-pocket maximum.
- The coverage calculator examples do not include the Coinsurance Maximum if applicable to your coverage.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.