Blue Care Network of Michigan

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

Evart Public Schools

BCN HSA℠ HMO $3400/0%

Coverage for: Family | **Plan Type: HMO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call **(800) 662-6667** or visit **www.bcbsm.com**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call (800) 662-6667 to request a copy.

Important Questions	Answers: individual/family	Why This Matters:
What is the overall deductible?	$3400/$6800	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and routine maternity care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Out-of-Pocket Maximum: $6900/$13800	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance 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.
Will you pay less if you use a network provider?	Yes. See www.bcbsm.com or call (800) 662-6667 for a list of network providers	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	No charge for medical online visits with a BCN participating online provider.
	Specialist visit	No charge	Not covered	Requires referral. 30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician.
	Preventive care/screening/ immunization	No charge; deductible does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	May require Prior authorization
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsm.com/customhmosixtier	Preferred Generic Tier	$4 copay/30 days	Not covered	Prior-auth & step therapy apply to select drugs. Sexual Dysfunction Drugs 50% coinsurance. No charge for Preferred Generic contraceptives and preventive drugs. Any out-of-pocket maxes apply. 84-90 day retail & 31-90 day mail order copays are 3x the 30-day copay minus $10. Your plan includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after discount applies toward the out of pocket maximum.
	Non-Preferred Generic Tier	$15 copay/30 days	Not covered	
	Preferred Brand Tier	$40 copay/30 days	Not covered	
	Non-Preferred Brand Tier	$80 copay/30 days	Not covered	
	Preferred Specialty Tier	20% coinsurance	Not covered	$200 copay max. Limited to a 30 day supply. Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.
	Non-Preferred Specialty Tier	20% coinsurance	Not covered	$300 copay max. Limited to a 30 day supply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Requires prior authorization/50% coinsurance for weight reduction procedures, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy.
	Physician/surgeon fees	No charge	Not covered	See "Outpatient surgery facility fee"
If you need immediate medical attention	Emergency room care	No charge	No charge	None
	Emergency medical transportation	No charge	No charge	Non-emergent transport is covered when with prior authorization
	Urgent care	No charge	No charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Requires prior authorization/50% coinsurance for weight reduction procedures, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy.
	Physician/surgeon fees	No charge	Not covered	See "Hospital stay facility fee"
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	No charge	Not covered	Requires prior authorization
	Inpatient services	No charge	Not covered	Requires prior authorization
If you are pregnant	Office visits	No charge for routine prenatal and postnatal visits. Deductible does not apply	Not covered	Non-routine visits apply your office visit cost share.
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Custodial care not covered.
	Rehabilitation services	No charge	Not covered	Requires prior authorization/Limited to 60 visits per calendar year for any combination of outpatient rehabilitation therapies. Subject to

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				meaningful improvement within 60 days.
	Habilitation services	No charge	Not covered	Requires prior authorization. PT/OT/ST for autism spectrum disorder has unlimited visits.
	Skilled nursing care	No charge	Not covered	Requires prior authorization. Limited to 45 days per calendar year. Custodial care not covered.
	Durable medical equipment	50% coinsurance	Not covered	Requires prior authorization and must be obtained from a BCN supplier. Convenience and comfort items not covered. Home use only. Diabetic supplies covered in full. Certain diabetic supplies are also covered through the pharmacy benefit, applicable pharmacy cost sharing will apply.
	Hospice services	No charge	Not covered	Inpatient care requires prior authorization. Housekeeping and custodial care not covered.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Contact benefit administrator for coverage information.
	Children's glasses	Not covered	Not covered	Contact benefit administrator for coverage information.
	Children's dental check-up	Not covered	Not covered	Contact benefit administrator for coverage information.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental Care (Adult)
- Elective Abortion
- 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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Care Network, Appeals and Grievance Unit, MC C248, P.O. Box 284, Southfield, MI 48086 or fax . 1-866-522-7345.
For state of Michigan assistance contact the Department of Insurance and Financial Services, Office of General Counsel-Appeals Section, 530 W. Allegan Street, 7th Floor, P. O. Box 30220, Lansing, MI 48909-7720, michigan.gov/difs; call 1-877-999-6442 or fax: 517-284-8838

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 plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.
(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.)

Language Access Services:

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 section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,400
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,400
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,470**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,400
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,400
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,400
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

The plan would be responsible for the other costs of these EXAMPLE covered services.