




Freemont Public School

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services


Coverage Period: Beginning on or after 01/01/2018

BCN HMO HSA \$6350/0% MVP

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 <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call (800) 662-6667 to request a copy.**

Important Questions	Answers: individual/family	Why This Matters:
What is the overall deductible?	\$6350/\$12700	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Preventive care and routine maternity care	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Out-of-Pocket Maximum: \$6350/\$12700	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balanced billed charges</u> and health care this <u>plan</u> does not cover	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.bcbsm.com or call (800) 662-6667 for a list of <u>network providers</u>	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 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	None
	<u>Specialist</u> visit	No charge	Not covered	Requires <u>referral</u> . \$5 <u>copay</u> for allergy injections/50% <u>coinsurance</u> for allergy office visit and testing/30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply.	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what <u>your plan will pay for</u> .
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	May require <u>Preauthorization</u>
	<u>Imaging</u> (CT/PET scans, MRIs)	No charge	Not covered	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbsm.com/customdruglist	Tier 1A - Value Generics	No charge	Not covered	Any overall <u>deductible/out-of-pocket</u> maxes apply 84-90 day retail & 31-90 day mail order <u>copays</u> are 2x the 30-day <u>copay</u> . 50% <u>coinsurance</u> for sexual dysfunction drugs. Tier 1 contraceptives covered in full. Preventive Drugs covered in full.
	Tier 1B – Generics	No charge	Not covered	
	Tier 2 - Preferred Brand	No charge	Not covered	
	Tier 3 - Non-Preferred Brand	No charge	Not covered	
	Tier 4 - Preferred Specialty	No charge	Not covered	
Tier 5 - Non-Preferred Specialty	No charge	Not covered	Limited to a 30 day supply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Requires <u>preauthorization/50% coinsurance</u> 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	<u>Emergency room care</u>	No charge	No charge	None
	<u>Emergency medical transportation</u>	No charge	No charge	Non-emergent transport is covered when <u>preauthorized</u>
	<u>Urgent care</u>	No charge	No charge	None

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 have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Requires <u>preauthorization/50% coinsurance</u> 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 mental health, behavioral health, or substance use disorder services	Outpatient services	No charge	Not covered	Requires <u>preauthorization</u>
	Inpatient services	No charge	Not covered	
If you are pregnant	Office visits	No charge	Not covered	Postnatal and non-routine prenatal office visits - No charge. Deductible does not apply to routine maternity care
	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	<u>Home health care</u>	No charge	Not covered	Requires <u>preauthorization</u> . Custodial care not covered.
	<u>Rehabilitation services</u>	No charge	Not covered	Requires <u>preauthorization</u> . Limited to 60 visits per calendar year for any combination of therapies. Subject to meaningful improvement within 60 days.
	<u>Habilitation services</u>	No charge	Not covered	Requires <u>preauthorization</u> . PT/OT/ST for autism spectrum disorder has unlimited visits.
	<u>Skilled nursing care</u>	No charge	Not covered	Requires <u>preauthorization</u> . Limited to 45 days per calendar year. Custodial care not covered.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	Not covered	Requires <u>preauthorization</u> and must be obtained from a BCN supplier. Convenience and comfort items not covered. Home use only. Diabetic supplies covered in full.
	<u>Hospice services</u>	No charge	Not covered	Inpatient care requires <u>preauthorization</u> . 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

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)	
				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.)

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| <ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental Care (Adult) • Hearing aids | <ul style="list-style-type: none"> • Long term care • Non emergency care outside of the U.S. • Private-duty nursing | <ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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| <ul style="list-style-type: none"> • Bariatric surgery | <ul style="list-style-type: none"> • Chiropractic care | <ul style="list-style-type: none"> • Infertility treatment |
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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.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 \$6,350
- 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
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In this example, Peg would pay:
Cost Sharing

Deductibles	\$6,350
Copayments	\$0
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,410

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

- The plan's overall deductible \$6,350
- 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	\$7,400
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In this example, Joe would pay:
Cost Sharing

Deductibles*	\$6,350
Copayments	\$0
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$6,410

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

- The plan's overall deductible \$6,350
- 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	\$1,900
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In this example, Mia would pay:
Cost Sharing

Deductibles*	\$1,900
Copayments	\$0
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

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, copayments, or coinsurance or benefits not otherwise covered. *Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

