

As a self-funded group, you are solely responsible for compliance with the federal Summary of Benefit and Coverage (SBC) rules, including SBC creation and distribution. BCBSM does not assume any responsibility for SBC rule compliance relating to your group health plan, or for creation or disclosure of compliant SBCs. This SBC template document is being provided as an example that may contain useful information concerning your BCBSM administered coverage as you create your own group health plan's SBC. This SBC template document being provided is not fully compliant with the SBC federal rules. It is your responsibility to work with your legal counsel to ensure proper compliance with the federal SBC rules. This SBC template document does not constitute legal, tax, actuarial, accounting, benefit design, compliance or other advice. BCBSM disclaims any liability or responsibility for any non-compliance by your group health plan with SBC rules and regulations relating to creation, disclosure or other requirements. You should also note that there may be additional special circumstances which may be applicable to your specific group health plan situation which may affect SBC content, including but not limited to account type arrangements such as flexible spending accounts (FSA), health reimbursement arrangements (HRA), and health savings accounts, (HSA), or for example, wellness programs, reference based pricing or benefits, or coverage not administered by BCBSM, or whether the coverage provides minimum essential coverage. If you have an ASC Plan Modification, it may be defined here in only a limited way.

# ROCHESTER COMMUNITY SCHOOLS

Community Blue<sup>SM</sup> PPO ASC

**Note to ASC groups:** Before completing this template, please reference the disclaimer on the attached cover page.

Coverage for: Individual/Family | Plan Type: PPO



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, visit [www.bcbsm.com](http://www.bcbsm.com) or call the number on the back of your BCBSM ID card. 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 the number on the back of your BCBSM ID card to request a copy.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall <u>deductible</u> ?	\$500 Individual/ \$1,000 Family	\$1,000 Individual/ \$2,000 Family	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 <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .		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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.		You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? (May include a <u>coinsurance</u> maximum)	\$6,350 Individual/ \$12,700 Family	\$12,700 Individual/ \$25,400 Family	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 <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, any <u>pharmacy</u> penalty and health care this <u>plan</u> doesn't 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 <u>network provider</u> ?	Yes. See <a href="http://www.bcbsm.com">www.bcbsm.com</a> or call the number on the back of your BCBSM ID card 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 <u>referral</u> to see a <u>specialist</u> ?	No.		You can see the <u>specialist</u> you choose without a <u>referral</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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /office visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<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 needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	May require <u>preauthorization</u>
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.bcbsm.com/druglists">www.bcbsm.com/druglists</a>	Generic drugs	\$5 <u>copay</u> /prescription for retail 30-day supply; \$5 <u>copay</u> /prescription for retail or mail order 90-day supply; <u>deductible</u> does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	<u>Preauthorization</u> , step therapy and quantity limits may apply to select drugs. <u>Preventive</u> drugs covered in full. 90-day supply not covered out of network. Select diabetic supplies and devices may be covered under the prescription drug program.
	Preferred brand-name drugs	\$35 <u>copay</u> /prescription for retail 30-day supply; \$35 <u>copay</u> /prescription for retail or mail order 90-day supply; <u>deductible</u> does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	
	Nonpreferred brand-name drugs	\$50 <u>copay</u> /prescription for retail 30-day supply; \$50 <u>copay</u> /prescription for retail or mail order 90-day supply; <u>deductible</u> does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay/visit</u> ; <u>deductible</u> does not apply	\$250 <u>copay/visit</u> ; <u>deductible</u> does not apply	<u>Copay</u> waived if admitted or for an accidental injury.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Mileage limits apply
	<u>Urgent care</u>	\$20 <u>copay/visit</u> ; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required
	Physician/surgeon fee	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	10% <u>coinsurance</u>	10% <u>coinsurance</u> for mental health; 30% <u>coinsurance</u> for substance use disorder	Your cost share may be different for services performed in an office setting
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	Prenatal: No Charge; <u>deductible</u> does not apply Postnatal: No Charge; <u>deductible</u> does not apply	Prenatal: 30% <u>coinsurance</u> Postnatal: 30% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services <u>cost share</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Physician certification required.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	<u>Habilitation services</u>	10% <u>coinsurance</u> for Applied Behavior Analysis; 10% <u>coinsurance</u> for Physical, Speech and Occupational Therapy	10% <u>coinsurance</u> for Applied Behavior Analysis; 30% <u>coinsurance</u> for Physical, Speech and Occupational Therapy	Applied behavior analysis (ABA) treatment for Autism - when rendered by an approved licensed behavior analyst - subject to <u>preauthorization</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Preauthorization</u> is required. Limited to 120 days per member per calendar year
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	<u>Hospice services</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	Physician certification required. Visit limits apply.
<b>If your child needs dental or eye care</b> For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

## 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 treatment
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long term care
- 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
- Coverage provided outside the United States.  
See <http://provider.bcbs.com>
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine eye care (Adult)

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov) or by calling the number on the back of your BCBSM ID card. 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](http://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 Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card.

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 or <http://www.michigan.gov/difs> or [difs-HICAP@michigan.gov](mailto:difs-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 Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (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 of specific EHB categories, for example prescription drugs, through another carrier.)

#### **Language Access Services: See Addendum**

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*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)

■ <b>The plan's overall deductible</b>	<b>\$500</b>
■ <b>Specialist copayment</b>	<b>\$20</b>
■ <b>Hospital (facility) coinsurance</b>	<b>10%</b>
■ <b>Other coinsurance</b>	<b>10%</b>

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$900
<u>What isn't covered</u>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,470</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ <b>The plan's overall deductible</b>	<b>\$500</b>
■ <b>Specialist copayment</b>	<b>\$20</b>
■ <b>Hospital (facility) coinsurance</b>	<b>10%</b>
■ <b>Other coinsurance</b>	<b>10%</b>

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$40
<u>What isn't covered</u>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,260</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ <b>The plan's overall deductible</b>	<b>\$500</b>
■ <b>Specialist copayment</b>	<b>\$20</b>
■ <b>Hospital (facility) coinsurance</b>	<b>10%</b>
■ <b>Other coinsurance</b>	<b>10%</b>

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
Diagnostic tests (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$100
<u>What isn't covered</u>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$650</b>

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), 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 the deductible, copayments, or coinsurance, or benefits not otherwise covered.



