

of Michigan

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

# GARDEN CITY PUBLIC SCHOOLS

Coverage for: Individual/Family | Plan Type: PPO

Community Blue PPOSM LG

the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. 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

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. of your BCBSM ID card. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined 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 or call the number on the back

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Important Questions	Answers In-Network Out-of-Network	Why This Matters:
What is the overall deductible?	\$2,500 Individual/ \$5,000 Family \$10,000 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 deductible?	Are there services covered before Yes. Preventive care services are covered before you meet your deductible.	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</u> <u>services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive</u> services 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 <u>out-of-pocket limit</u> for this <u>plan?</u> (May include a <u>coinsurance</u> maximum)	\$6,350 Individual/ \$12,700 Individual/ \$12,700 Family \$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 out-of-pocket limit?	Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn't 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 (http://www.bcbsm.com) or call the number on the back of your BCBSM ID card for a list of network providers.	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</u> charge 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 specialist you choose without a referral.



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

		District Control of Co		
Common Medical Event	Services You May Need	What You in-Network Provider (You will pay the least)	What You Will Pay der Out-of-Network Provider east) (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$30 copay/office visit; deductible does not apply	40% coinsurance	None
If you visit a health care	Specialist visit	\$30 <u>copay</u> /visit, <u>deductible</u> does not apply	40% coinsurance	None
provider's office or clinic	Preventive care/ screening/ immunization	No Charge; <u>deductible</u> 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.
	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
ir you nave a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	May require preauthorization
If you need drugs to treat	Generic or select prescribed over-the- counter drugs	\$10 copay for retail 30-day supply; \$20 copay for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive 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.
More information about prescription drug coverage is available at	Preferred brand-name drugs	\$40 <u>copay</u> for retail 30-day supply; \$80 <u>copay</u> for retail or mail order 90-day supply; deductible does not apply	In-Network <u>copay</u> plus an additional 25% of the approved amount; <u>deductible</u> does not apply	Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not covered out of network. Pharmacy Specialty drugs obtained from
www.boballicollingingingingingingingingingingingingingi	Nonpreferred brand-name drugs	\$80 <u>copay</u> for retail 30-day Nonpreferred brand-name supply; \$160 <u>copay</u> 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	Network provider will not be covered. Select diabetic supplies and devices may be covered under the prescription drug program.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

or have other special health needs	If you need help recovering				If you are pregnant	disorder)	If you need behavioral health services (mental health and substance use		If you have a hospital stay		If you need immediate medical attention		Common Medical Event
Habilitation services	Rehabilitation services	Home health care	Childbirth/delivery facility services	Childbirth/delivery professional services	Office visits	Inpatient services	Outpatient services	Physician/surgeon fee	Facility fee (e.g., hospital room)	Urgent care	Emergency medical transportation	Emergency room care	Services You May Need
20% coinsurance for Applied Behavioral Analysis; 20% coinsurance for Physical, Speech and Occupational Therapy	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	No Charge; <u>deductible</u> does not apply	20% coinsurance	20% <u>coinsurance</u>	20% coinsurance	20% coinsurance	\$30 copay/visit; deductible does not apply	20% coinsurance	\$150 copay/visit; deductible does not apply	What Y In-Network Provider (You will pay the least)
20% coinsurance for Applied Behavioral Analysis; 40% coinsurance for Physical, Speed and Occupational Therapy	40% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance	40% coinsurance	40% coinsurance	20% coinsurance for mental health; 40% coinsurance for substance use disorder	40% coinsurance	40% coinsurance	40% coinsurance	20% coinsurance	\$150 copay/visit; deductible doe not apply	What You Will Pay  der Out-of-Network Provider east) (You will pay the most)
20% <u>coinsurance</u> for Applied Applied behavioral analysis (ABA) treatment for Behavioral Analysis; 40% Autism - when rendered by an approved board-coinsurance for Physical, Speech certified behavioral analyst - is covered through age 18, subject to preauthorization.	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.	Physician certification required.	None	None	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services cost share may apply. Cost sharing does not apply for preventive services.	Preauthorization is required.	Your cost share may be different for services performed in an office setting	None	Preauthorization is required	None	Mileage limits apply	\$150 copay/visit; deductible does Copay waived if admitted or for an accidental not apply	Limitations, Exceptions, & Other Important Information

	pediatric vision or dental, contact your plan administrator	eye care	If your child needs dental or Children's eye exam				Common Medical Event
	Children's dental check- up	Children's glasses	r Children's eye exam	Hospice services	Durable medical equipment	Skilled nursing care	Services You May Need
	Not covered	Not covered	Not covered	No Charge; <u>deductible</u> does not apply	20% coinsurance	20% coinsurance	What Y In-Network Provider (You will pay the least)
	Not covered	Not covered	Not covered	No Charge; <u>deductible</u> does not apply	40% coinsurance	20% coinsurance	What You Will Pay der Out-of-Network Provider east) (You will pay the most)
4 of 8	None	None	None	Physician certification required. Visit limits apply.	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.	Preauthorization is required. Limited to 120 days per member per calendar year	Limitations, Exceptions, & Other Important Information

ervices Your Plan Generally Does NC	T Cover (Check your policy or plan document fo	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	<ul> <li>Infertility treatment</li> </ul>	<ul> <li>Routine foot care</li> </ul>
Cosmetic surgery	<ul><li>Long term care</li></ul>	<ul> <li>Weight loss programs</li> </ul>
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•		Chiropractic care
ites. • Non-emergency care when traveling outside the U.S.	<ul> <li>Coverage provided outside the United States.</li> </ul>	

Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or <a href="https://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>, or the Department of Health and Human Services, 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: Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. 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 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 or by

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 Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card. 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 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

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

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

of specific EHB categories, for example prescription drugs, through another carrier.) 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 (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 If your <u>plan</u> 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

Language Access Services: See Addendum

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

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

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

■ Other coinsurance	Hospital (facility) coinsurance	Specialist copayment	■ The plan's overall deductible
20%	20%	\$30	\$2,500

#### Vlanaging Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ Other coinsurance	Hospital (facility) coinsurance	■ Specialist copayment	■ The plan's overall deductible
20%	20%	\$30	\$2,500

The plan's overall deductible \$2,500 Specialist copayment \$30 Hospital (facility) coinsurance 20% Other coinsurance 20%

Mia's Simple Fracture

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

(ample Cost	0 0 0 0	1
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Specialist visit (anesthesia)

\$4,070	The total Peg would pay is
\$60	Limits or exclusions
The state of the s	What isn't covered
\$1,500	Coinsurance
\$10	Copayments
\$2,500	Deductibles
	Cost Sharing
	In this example, Peg would pay:

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Total Example Cost

\$1,720	The total Joe would pay is
\$20	Limits or exclusions
	What isn't covered
\$0	Coinsurance
\$800	Copayments
\$900	Deductibles
	Cost Sharing
i i i i i i i i i i i i i i i i i i i	In this example, Joe would pay:

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Diagnostic tests (x-ray)  Diagnostic tests (x-ray)  Durable medical equipment (crutches)  Rehabilitation services (physical therapy)	

\$1,870	The total Mia would pay is
\$0	Limits or exclusions
	What isn't covered
\$0	Coinsurance
\$70	Copayments
\$1,800	Deductibles
	Cost Sharing
	in this example, illia would pay:

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

## ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

## We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un

إذا كلت أنت أو شخص أخر تساعده بحاجة أمساعدة، فلديك الحق في الحصول على المساعدة و المعلومات الضرورية بليقاقه بون أية تكلفة، للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو يرقع TTY:711 873-469-478، إذا لم تكن مشتركا بالفعل.

如果您,或是您正在協助的對象,需要協助,您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員,請撥在您的卡背面的客戶服務電話:如果您還不是會員,請撥電話 877-469-2583, TTY: 711。

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Nếu quý vị, hay người mà quý vị đang giúp đổ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với mội thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

877-469-2583. TTY: 711) までお電話ください。

ービスの電話番号 (メンバーでない方は

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 무담 없이 얼을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 그객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583. TTY: 711로 전화하실시오. 제다 제약에도 제 제계에 되된게 후했는데 3차에 하ば다, 되된데 없대하여 관리. 이번에 제가이다 이번에 기된게 3 연제 위상건데 제약하도 제가이다 (하는데 2호하여 (비)이기를 되면 하역 조리 인간에 하는당 (역단에 1호하여 (비)이기를 되면 하여 호하여 집 877-469-2583. TTY: 711 지역 첫에서당 제외에 된다 제 역간 위상에

Ješli Ty lub osoba, której pomagasz, potrzebujecie pomocy masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Se tu o qualcuno che stai aiutando avete bisogno di 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Falls Sie oder jemand, dem Sie helfen, Unterstützung 877-469-2583, TTY: 711 se non sei ancora membro. interprete, rivolgiti al Servizio Assistenza al numero nella tua lingua gratuitamente, Per parlare con un Informationen in Ihrer Sprache zu erhalten. Um mit einem benötigt, haben Sie das Recht, kostenlose Hilfe und とされる方でご質問がございましたら、ご希望の言語 indicato sul retro della tua scheda o chiama il assistenza, hai il diritto di ottehere aiuto e informazioni Kundendienstes auf der Rückseite Ihrer Karte an oder 合はお持ちのカードの裏面に記載されたカスタマーサ できます。料金はかかりません。通訳とお話される場 でサポートを受けたり、情報を入手したりすることが ご本人様、またはお客様の身の回りの方で支援を必要

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTV: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TV: 711 kung ikaw ay hindi pa isang miyembro.

### Important disclosure

grievance, the Office of Civil Rights Coordinator is available 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226 already a member. If you believe that Blue Cross Blue and Blue Care Network provide free auxiliary aids and age, disability, or sex. Blue Cross Blue Shield of Michigan discriminate on the basis of race, color, national origin, comply with Federal civil rights laws and do not email: CivilRights@bcbsm.com. If you need help filing a phone: 888-605-6461, TTY: 711, fax: 866-559-0578, with: Office of Civil Rights Coordinator, you can file a grievance in person, by mail, fax, or email basis of race, color, national origin, age, disability, or sex provide services or discriminated in another way on the Shield of Michigan or Blue Care Network has failed to back of your card, or 877-469-2583, TTY: 711 if you are not these services, call the Customer Service number on the interpreters and information in other formats. If you need effectively with us, such as qualified sign language services to people with disabilities to communicate Blue Cross Blue Shield of Michigan and Blue Care Network to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.isf">https://ocrportal.hhs.gov/ocr/portal/lobby.isf</a> or by mail phone, or email at: U.S. Department of Health & Human

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.