



WALLED LAKE CONSOLIDATED SCHOOL DISTRICT

High Deductible Health Plan

Coverage for: All Contract Types | 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, visit www.bcbsm.com or call 1-800-662-6667. 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 1-800-662-6667 to request a copy.

| Important Questions | Answers: Member / Family | Why This Matters: |
|---|---|---|
| What is the overall <u>deductible</u> ? | \$3,300/\$6,600 | 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> 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 <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> ? | \$6,900/\$13,800 | 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> , balance billed charges 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 <u>network provider</u> ? | Yes. See (www.BCBSM.com) or call customer service for a list of <u>network providers</u> and out-of-state coverage. 1-800-662-6667 | 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> ? | 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 | 20% <u>coinsurance</u> | Not covered | 20% <u>coinsurance</u> for online visits with a BCN participating online <u>provider</u> . |
| | <u>Specialist visit</u> | 20% <u>coinsurance</u> | Not covered | Requires <u>referral</u> . 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 | <u>Deductible</u> does not apply to <u>preventive services</u> . 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. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>coinsurance</u> | Not covered | May require <u>preauthorization</u> . <u>Deductible</u> does not apply to <u>preventive services</u> |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | Not covered | Requires <u>preauthorization</u> |

| 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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsm.com/hcdl | Preferred Generic Tier | \$4 <u>copay</u> /30 days | Not covered | Prior-auth & step therapy apply to select drugs. No charge for Preferred Generic contraceptives and <u>preventive</u> drugs. Your <u>plan</u> includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum. 50% <u>coinsurance</u> for sexual dysfunction drugs. No charge for Tier 1A contraceptives. 84-90 day retail & 31-90 day mail order <u>copays</u> are 3x the 30-day <u>copay</u> minus \$10. |
| | Non-Preferred Generic Tier | \$15 <u>copay</u> /30 days | Not covered | |
| | Preferred Brand Tier | \$40 <u>copay</u> /30 days | Not covered | |
| | Non-Preferred Brand Tier | \$80 <u>copay</u> /30 days | Not covered | |
| | Preferred <u>Specialty</u> Tier | 20% <u>coinsurance</u> | Not covered | |
| | Non-Preferred <u>Specialty</u> Tier | 20% <u>coinsurance</u> | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | Not covered | May require <u>preauthorization</u> /50% <u>coinsurance</u> for weight reduction, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | Not covered | See "Outpatient surgery facility fee" |
| If you need immediate medical attention | <u>Emergency room care</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | Non-emergent transport is covered when preauthorized |
| | <u>Urgent care</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | 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) | 20% <u>coinsurance</u> | Not covered | <u>Preauthorization</u> is required. 50% <u>coinsurance</u> for weight reduction procedures. 50% <u>coinsurance</u> for TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy |
| | Physician/surgeon fee | 20% <u>coinsurance</u> | Not covered | See "Hospital stay facility fee" |
| If you need behavioral health services (mental health and substance use disorder) | Outpatient services | 20% <u>coinsurance</u> | Not covered | None |
| | Inpatient services | 20% <u>coinsurance</u> | Not covered | <u>Preauthorization</u> is required |
| If you are pregnant | Office visits | No charge | Not covered | Nonroutine prenatal and postnatal office visits- 20% <u>coinsurance</u> / <u>Deductible</u> applies except for routine maternity care |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | Not covered | None |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> | Not covered | 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 need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>coinsurance</u> | Not covered | Requires <u>preauthorization</u> . Custodial care not covered. |
| | <u>Rehabilitation services</u> | 20% <u>coinsurance</u> | Not covered | Requires <u>preauthorization</u> /Up to 60 visits per calendar year for any combination of outpatient <u>rehabilitation</u> therapies. Subject to meaningful improvement within 60 days. |
| | <u>Habilitation services</u> | ABA - 20% <u>coinsurance</u> | Not covered | <u>Habilitation services</u> are covered only for the treatment of autism. PT/OT/ST for autism spectrum disorder has unlimited visits. Requires <u>preauthorization</u> . |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | 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. Diabetic supplies covered with 20% <u>coinsurance</u> .. Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable pharmacy cost-sharing will apply. |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> | 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 your benefit administrator for coverage information. |
| | Children's glasses | Not covered | Not covered | Contact your benefit administrator for coverage information. |
| | Children's dental check-up | Not covered | Not covered | Contact your 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 when traveling outside 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 (Limited to one per lifetime. Requires preauthorization)
- Chiropractic care
- Infertility treatment (Coverage includes diagnosis/counseling/treatment of infertility when medically necessary and preauthorized by BCN. See Certificate of Coverage for exclusions)

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/healthreform, 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, <http://www.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, <http://www.michigan.gov/difs> or 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 the Minimum Value Standard? 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.)

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:



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 | \$3300 |
| ■ Specialist coinsurance | 20% |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

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:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$3,300 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$1,900 |
| <u>What isn't covered</u> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$5,270 |

Managing Joe's Type 2 Diabetes

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

| | |
|-----------------------------------|--------|
| ■ The plan's overall deductible | \$3300 |
| ■ Specialist coinsurance | 20% |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

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:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$3,300 |
| <u>Copayments</u> | \$300 |
| <u>Coinsurance</u> | \$100 |
| <u>What isn't covered</u> | |
| 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 | \$3300 |
| ■ Specialist coinsurance | 20% |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

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

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$2,800 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |
| <u>What isn't covered</u> | |
| 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 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.

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

