Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Coverage Period: Beginning on or after 01/01/2025

MACOMB INTERMEDIATE SCHOOL DISTRICT

Community Blue PPO

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 dot bcbsm dot 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 dot healthcare dot gov/sbc-glossary or call the number on the back of your BCBSM ID card to request a copy.

General Plan Details

What is the overall deductible?

In-Network

$750 Individual/ $1,500 Family

Out-of-Network

$2,250 Individual/ $4,500 Family

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 services are covered before you meet your deductible.

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 dot healthcare dot 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?

(May include a coinsurance maximum)

In-Network

$6,600 Individual/ $13,200 Family

Out-of-Network

$13,200 Individual/ $26,400 Family

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-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 www dot bcbsm dot com or call the number on the back of your BCBSM ID card 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?

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.

Copayment and Coinsurance Information Relating to Common Medical Events

In-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

Section 1: Primary care visit to treat an injury or illness

In-Network

$30 copay per office visit; deductible does not apply

Out of network

50% coinsurance

Specialist visit

In-Network

$30 copay per office visit; deductible does not apply

Out of network

50% coinsurance

Preventive care/ screening/immunization

In-Network

No Charge; deductible does not apply

Out of network

Not covered.

Limitations, Exceptions, & Other Important Information 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.

Section 2: If you have a test

Diagnostic test (x-ray, blood work)

In-network

20% coinsurance

Out of network

50% coinsurance

Imaging (CT/PET scans, MRIs)

In-Network

20% coinsurance

Out of network

50% coinsurance

Limitations, Exceptions, & Other Important Information May require prior authorization

Section 3: If you need drugs to treat your illness or condition

More information about prescription drug coverage is available at www dot bcbsm dot com/druglists

Generic or select prescribed over-the-counter drugs

In-Network

$10 copay per prescription for retail 30-day supply; $20 copay per prescription for retail or mail order 90-day supply; deductible does not apply

Out of network:

In-Network copay plus an additional 25% of the approved amount; deductible does not apply Prior authorization, 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.

Preferred brand-name drugs

In-Network

$40 copay per prescription for retail 30-day supply; $80 copay per prescription for retail or mail order 90-day supply; deductible does not apply

Out of network

In-Network copay plus an additional 25% of the approved amount; deductible does not apply

Nonpreferred brand-name drugs

In-Network

$60 copay per prescription for retail 30-day supply; $120 copay per prescription for retail or mail order 90-day supply; deductible does not apply

Out of network

In-Network copay plus an additional 25% of the approved amount; deductible does not apply

Limitations, Exceptions, & Other Important Information Prior authorization, 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.

Section 4 If you have outpatient surgery

Facility fee (e.g., ambulatory surgery center)

In-Network

20% coinsurance

Out of network

50% coinsurance

Physician/surgeon fees

In-Network

20% coinsurance

Out of network

50% coinsurance

Section 5: If you need immediate medical attention

Emergency room care

In-Network

$200 copay per visit; deductible does not apply

Out of network

$200 copay per visit; deductible does not apply

Copay waived if admitted or for an accidental injury

Emergency medical transportation

In-Network

20% coinsurance

Out of network

20% coinsurance

Limitations, Exceptions, & Other Important Information Mileage limits apply

Urgent care

In-network

$30 copay per office visit; deductible does not apply

Out of network

50% coinsurance

Section 6: If you have a hospital stay

Facility fee (e.g., hospital room)

In-Network

20% coinsurance

Out of network

50% coinsurance

Limitations, Exceptions, & Other Important Information Prior authorization is required

Physician/surgeon fee

In-Network

20% coinsurance

Out of network

50% coinsurance

Section 7: If you need behavioral health services (mental health and substance use disorder)

Outpatient services

In-Network

20% coinsurance

Out of network

20% coinsurance for mental health; 50% coinsurance for substance use disorder

Limitations, Exceptions, & Other Important Information Your cost share may be different for services performed in an office setting

Inpatient services

In-Network

20% coinsurance

Out of network

50% coinsurance

Limitations, Exceptions, & Other Important Information Prior authorization is required.

Section 8: If you are pregnant

Office visits

Prenatal: No Charge; deductible does not apply

Postnatal: No Charge; deductible does not apply

Out of network Prenatal: 50% coinsurance

Out of network Postnatal: 50% coinsurance

Limitations, Exceptions, & Other Important Information 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.

Childbirth/delivery professional services

In-Network

20% coinsurance

Out of network

50% coinsurance

Childbirth/delivery facility services

In-network

20% coinsurance

Out of network

50% coinsurance

Section 9: If you need help recovering or have other special health needs

Home health care

In-Network

20% coinsurance

Out of network

20% coinsurance

Limitations, Exceptions, & Other Important Information Physician certification required.

Rehabilitation services

In-Network

$30 copay per visit; deductible does not apply

Out of network

50% coinsurance

Limitations, Exceptions, & Other Important Information Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.

Habilitation services

In-Network

20% coinsurance for Applied Behavior Analysis; 20% coinsurance for Physical, Speech and Occupational Therapy

Out of network

20% coinsurance for Applied Behavior Analysis; 50% coinsurance for Physical, Speech and Occupational Therapy

Limitations, Exceptions, & Other Important Information Applied behavior analysis (ABA) treatment for Autism - when rendered by an approved licensed behavior analyst - subject to prior authorization.

Skilled nursing care

In-Network

20% coinsurance

Out of network

20% coinsurance

Limitations, Exceptions, & Other Important Information Prior authorization is required. Limited to 120 days per member per calendar year

Durable medical equipment

In-Network

20% coinsurance

Out of network

20% coinsurance

Limitations, Exceptions, & Other Important Information Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.

Hospice services

In-Network

No Charge; deductible does not apply

Out of network

No Charge; deductible does not apply

Limitations, Exceptions, & Other Important Information Physician certification required. Visit limits apply.

Section 10: If your child needs dental or eye care

For more information on pediatric vision or dental, contact your plan administrator

Children's eye exam	Not covered

Children's glasses Not covered

Children's dental check-up Not covered

Section 11: 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

Dental care (Adult)

Infertility treatment

Long term care

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

Coverage provided outside the United States. See http://provider.bcbs.com

Hearing aids

Non-emergency care when traveling outside the U.S

Private-duty nursing

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 dot dol dot 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 dot cciio dot cms dot 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 dot HealthCare dot 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 dot michigan dot 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 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

————————————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	$750
Specialist copayment	$30
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:

Cost Sharing	
Deductibles	$750
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,620

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

The plan's overall deductible	$750
Specialist copayment	$30
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:

Cost Sharing	
Deductibles	$750
Copayments	$800
Coinsurance	$30
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,600

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

The plan's overall deductible	$750
Specialist copayment	$30
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:

Cost Sharing

Deductibles $750

Copayments $200

Coinsurance $100

What isn’t covered

Limits or exclusions $0

The total Mia would pay is $1,050

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.

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DESCRIMINATION

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 member ID card. 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. إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك. 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。 [illegible] . Nếu quý vị, hay người mà quý vị đang giúp đỡ, 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 một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị. 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. 만약 귀하

또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오. যদি আপনার, বা আপদন সাহাযয করছেন এমন কাছরা, সাহাযয প্রছ ◌াজন হ, তাহছে আপনার ভাষা দবনামূছেয সাহাযয ও তথ্য পাও ◌ার অদিকার আপনার রছ ছে। ককাছ্না একজন কিাভাষীর সাছথ্ কথ্◌া বেছত, আপনার কাছডে র কপেছন কিও ◌া গ্রাহক সহা তা নম্বছর কে করুন। Jeśli 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. Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an. Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda. ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の 言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話 される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号までお電話ください。 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 телефону отдела обслуживания клиентов, указанному на обратной стороне вашей карты. Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice. 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.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with federal civil rights laws and don't discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your member ID card. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by mail, fax or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226; phone: 1-888-605-6461, TTY: 711; fax: 1-866-559-0578; email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available 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 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:

1-800-368-1019, TTY: 1-800-537-7697; email: OCRComplaint@hhs.gov. Complaint forms are available at http://www dot hhs dot gov/ocr/office/file/index dot html.*