



MITTEN EDUCATIONAL MANAGEMENT LLC

Classic

Coverage for: All Plan 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 (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 (800)-662-6667 to request a copy.

Important Questions	Answers: Member / Family	Why This Matters:
What is the overall deductible?	\$1,000/\$2,000	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 Lab, preventive care, DME/P&O, diabetic supplies, PCP office visits, specialist office visits, urgent care, allergy injections, prescription drugs, outpatient mental health and substance use services	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.healthcare.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?	\$8,150/\$16,300 Coinsurance Maximum - \$2,500/\$5,000	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 billed charges and health care this plan does not 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.BCBSM.com) or call customer service for a list of network providers and out-of-state coverage. (800)-662-6667	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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.



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 copay/visit. <u>Deductible</u> does not apply	Not covered	Only the <u>PCP</u> office visit is exempt from the deductible. Other services received in the office, <u>deductible</u> applies. \$20 <u>copay</u> for medical online visits.
	<u>Specialist visit</u>	\$40 copay/visit. <u>Deductible</u> does not apply	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>Deductible</u> applies for allergy testing
	<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.
	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> .	Not covered	May require <u>preauthorization</u> . No charge for lab services. <u>Deductible</u> does not apply to lab services.
If you have a test	Imaging (CT/PET scans, MRIs)	\$150 <u>copay</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 <u>prescription drug coverage</u> is available at www.bcbsm.com/hcdl	Preferred Generic Tier	\$10 <u>copay/30 days</u> . <u>Deductible</u> does not apply	Not covered	Prior-auth & step therapy apply to select drugs. No charge for Preferred Generic contraceptives and <u>preventive</u> drugs. Your plan includes a <u>prescription drug discount program</u> 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. <u>50% coinsurance</u> for sexual dysfunction drugs. No charge for Preferred Generic 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	\$30 <u>copay/30 days</u> . <u>Deductible</u> does not apply	Not covered	
	Preferred Brand Tier	\$60 <u>copay/30 days</u> . <u>Deductible</u> does not apply	Not covered	
	Non-Preferred Brand Tier	\$80 <u>copay/30 days</u> . <u>Deductible</u> does not apply	Not covered	
	Preferred <u>Specialty</u> Tier	20% <u>coinsurance</u> . <u>Deductible</u> does not apply	Not covered	\$200 <u>copay</u> max. Limited to a 30 day supply. <u>Specialty Drugs</u> are covered only within the <u>Exclusive Specialty Pharmacy Network</u> .
If you have outpatient surgery	Non-Preferred <u>Specialty</u> Tier	20% <u>coinsurance</u> . <u>Deductible</u> does not apply	Not covered	\$300 <u>copay</u> max. Limited to a 30 day supply. <u>Specialty Drugs</u> are covered only within the <u>Exclusive Specialty Pharmacy Network</u> .
	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	May require <u>preauthorization/50% coinsurance</u> for weight reduction procedures, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy, elective abortion
If you need immediate medical attention	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	See "Outpatient surgery facility fee"
	<u>Emergency room care</u>	\$250 <u>copay/visit</u> .	\$250 <u>copay/visit</u> .	<u>Copay</u> waived if admitted as inpatient.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Non-emergent transport is covered when preauthorized
	<u>Urgent care</u>	\$50 <u>copay/visit</u> . <u>Deductible</u> does not apply	\$50 <u>copay/visit</u> . <u>Deductible</u> does not apply	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, elective abortion
	Physician/surgeon fee	No charge	Not covered	See "Hospital stay facility fee"
	Outpatient services	\$20 <u>copay/visit</u> . <u>Deductible</u> does not apply	Not covered	<u>Preauthorization</u> may be required.
If you need behavioral health services (mental health and substance use disorder)	Inpatient services	20% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> is required.
	Office visits	No charge. <u>Deductible</u> does not apply	Not covered	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. Office visit <u>copay</u> applies to non-routine prenatal and postnatal office visits.. Only the routine prenatal and postnatal visit is exempt from the <u>deductible</u> . Other services, <u>deductible</u> applies
	Childbirth/delivery professional services	No charge	Not covered	None
If you are pregnant	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>	\$40 <u>copay</u> /visit	Not covered	Requires <u>preauthorization</u> . Custodial care not covered.
	<u>Rehabilitation services</u>	\$40 <u>copay</u> /visit	Not covered	Requires <u>preauthorization</u> / Limited 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>copay</u> per visit. \$40 <u>copay</u> per visit for PT/OT/ST. <u>Deductible</u> does not apply to ABA services	Not covered	<u>Habilitation services</u> are limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders. PT/OT/ST for autism spectrum disorder has unlimited visits. See <u>Rehabilitation services</u> for PT/OT/ST <u>cost share</u> . 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> . <u>Deductible</u> does not apply	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>Deductible</u> does not apply to diabetic supplies
	<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.
	Children's glasses	Not covered	Not covered	Contact benefit administrator for coverage.
	Children's dental check-up	Not covered	Not covered	Contact benefit administrator for coverage.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
• Acupuncture • Cosmetic surgery • Dental Care (Adult) • 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 <u>plan document</u> .)		
• 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.ccio.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 \$1000
- Specialist copayment \$40
- 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$10
Coinsurance	\$1,400
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,470

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.

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$1000
- Specialist copayment \$40
- 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,100
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,320

Mia's Simple Fracture

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

- The plan's overall deductible \$1000
- Specialist copayment \$40
- 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$500
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,700

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

We speak your language

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjyhen 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.

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 877-469-2383. ТТУ: 711. Если у вас нет членства.

<https://ocportal.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>.