



Nonprofit corporations and independent licensees  
of the Blue Cross and Blue Shield Association

## Blue Cross Blue Shield of Michigan Rate Quote

### Group Wide Change Large Group Fully Insured PPO

**Agency:** agency name

**Client:** Madison School District

**Group(Subgroup/Suffix(Class) Specific Data**  
**Group/Suffix:** 0 000 **Effective Date:** 1/1/2024  
**Renewal Date:** 1/1/2024

**Agent:**

Adrian MI 49221

**County:** Lenawee  
**Zip:** 49221

**Total Eligibles:** 51  
**Customer Size:** 3  
**Suffix/Class Size:** 3  
**Number of FTE's:** 51

**Group SIC:** 8211 Elementary and secondary

	One Person	Two Person	Family	Med Suppl.
<b>Quoted Benefits</b>				
Simply Blue HSA PPO \$3200/20%, \$3,200 Deductible, 20% Co-Insurance, \$6,900 OOP Max	398.06	955.35	1194.19	475.59
PD-TTC \$10/\$40/\$80-RXCM	<u>87.45</u>	<u>209.88</u>	<u>262.36</u>	<u>578.18</u>
Total Medical and Drug Rate	485.51	1165.23	1456.55	1053.77
Medical and Drug Enrollment	<u>1</u>	<u>1</u>	<u>1</u>	<u>0</u>
Total Plan Rate	485.51	1165.23	1456.55	1053.77
<b>Total Monthly Premium</b>				<b>\$3,107.29</b>
<b>CDH Spending Account:</b> No Action				

We reserve the right to adjust rates if any of the assumptions or calculations used in the quoting process are incorrect.

Final rates will be determined based on actual group enrollment and participation.

Proposed rates do not include any fees associated with pharmacy benefit management carve out, nor do they include fees for additional wellness buy-up programs. If pharmacy benefits are carved out, a fee of \$5 per contract per month will be applied to the monthly invoice.

Plans and rates are not final until they have been approved by DIFS and CMS.

Your agent is providing a Summary of Benefits and Coverage with this quote.

To comply with the Patient Protection and Affordable Care Act, groups may be required to make changes to their health insurance coverage. This may result in an adjustment to the rates.

Please submit quote with enrollment documentation.

**Cross RRL = 3.5774, Shield RRL = 3.8631**

**Drug RRL = 11.5984, Dental RRL = 0.0000, Vision RRL = 0.0000**

Medical Forms: 204J,764L,817R, Comp: 0738,2014,2017,312D,4087,472B,509E,A902

Rx Forms: 709F, Comp: 709F,834E,A903

Blue Cross  
Blue Shield  
of MichiganA nonprofit corporation and independent licensee  
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## Madison School District

Simply Blue<sup>SM</sup> HSA PPO 3200/20%


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 <a href="#">deductible</a> ?	\$3,200 Individual /\$6,400 Family	\$6,400 Individual /\$12,800 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .		This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.		You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? (May include a <a href="#">coinsurance</a> maximum)	\$6,900 Individual /\$13,800 Family	\$13,800 Individual /\$27,600 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, any pharmacy penalty and health care this <a href="#">plan</a> 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 <a href="#">network provider</a> ?	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 <a href="#">network providers</a> .		This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.		You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Members 18 years and older have access to Virtual Primary Care visits via a BCBSM-selected vendor.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	May require <a href="#">preauthorization</a>
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.bcbsm.com/druglists">www.bcbsm.com/druglists</a>	Generic or prescribed over-the-counter drugs	\$10 <a href="#">copay</a> for retail 30-day supply; \$20 <a href="#">copay</a> for retail or mail order 90-day supply	\$10 <a href="#">copay</a> plus 20% of approved amount	<a href="#">Preauthorization</a> , step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not covered out of <a href="#">network</a> .
	Preferred brand-name drugs	\$40 <a href="#">copay</a> for retail 30-day supply; \$80 <a href="#">copay</a> for retail or mail order 90-day supply	\$40 <a href="#">copay</a> plus 20% of approved amount	
	Non-Preferred brand-name drugs	\$80 for 30-day supply; \$160 for retail or mail order 90-day supply	\$80 <a href="#">copay</a> plus 20% of approved amount	
	Generic and preferred brand-name <a href="#">Specialty drugs</a>	Standard tiered <a href="#">copays</a> apply	Standard tiered <a href="#">copays</a> apply	15 or 30-day supply per fill. <a href="#">Preauthorization</a> is required.
	Nonpreferred brand-name <a href="#">Specialty drugs</a>	Standard tiered <a href="#">copays</a> apply	Standard tiered <a href="#">copays</a> apply	15 or 30-day supply per fill. <a href="#">Preauthorization</a> is required.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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)	
	center)			
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Mileage limits apply
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required
If you are pregnant	Office visits	No charge for routine prenatal and postnatal visits. Deductible does not apply	40% <a href="#">coinsurance</a>	Non-routine visits apply your office visit <a href="#">cost share</a> .
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Physical, Speech, and Occupational Therapy is limited to a <b>combined</b> maximum of 30 visits per member per calendar year
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a> for Applied Behavioral Analysis; 20% <a href="#">coinsurance</a> for Physical Speech and Occupational Therapy	20% <a href="#">coinsurance</a> for Applied Behavioral Analysis; 40% <a href="#">coinsurance</a> for Physical Speech and Occupational Therapy	Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified analyst, subject to <a href="#">preauthorization</a> .
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Limited to 90 days per member per calendar year
	<a href="#">Durable medical</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Excludes bath, exercise and deluxe

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)	
	<a href="#">equipment</a>			equipment and comfort and convenience items. Prescription required.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Visit limits apply.
If your child needs dental or eye care	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](#).)**

- |                                                                                                                            |                                                                                                                             |                                                                                                                                           |
|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental Care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long term care</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- |                                                                                                    |                                                                                                                                                                                                                     |                                                                          |
|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Chiropractic care</li> </ul> | <ul style="list-style-type: none"> <li>• Coverage outside of the U.S., see <a href="http://provider.bcbs.com">http://provider.bcbs.com</a></li> <li>• Non-Emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> </ul> |
|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|

**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](tel: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](tel:1-877-267-2323) x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov) or by calling [1-800-752-1455](tel:1-800-752-1455). 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 [1-800-752-1455](tel:1-800-752-1455).

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, TRIRCARE, 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.*

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,200
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$3,200
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,670</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,200
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$3,200
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,620</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,200
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</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.



## We speak your language

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: 800-368-1019, TTD: 800-537-7697, email: [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.