



HOW TO CHOOSE A MEDICAL PLAN

Finding the right coverage may seem complicated. Here are some important things to consider when evaluating your plan options. Detroit Public Schools Community District (DPSCD) will continue to offer six different medical plans in 2021.

- Blue Care Network (BCN) HMO – Four Plans
- Health Alliance Plan (HAP) HMO – One Plan
- Blue Cross / Blue Shield (BCBSM) PPO – One Plan

1. Access to Health Care Providers

It is important to understand the plan's requirements when it comes to doctors, hospitals, and other health care professionals.

- **HMO plans** cover health care services rendered by a health care provider in the HMO's network and referrals may be required for visits to specialists, hospital stays, and other services. Costs for non-emergency care received from a non-network provider (or without a referral if/when required) are your responsibility.
- **PPO plans** provide a higher level of coverage (and lower cost sharing) when you are seen by a health care provider in the PPO network. You may seek care from providers outside the PPO network, but you will share more of the costs in the form of higher deductibles, coinsurance, and copays. Referrals are not required, but some services require prior authorization.
- During open enrollment, determine whether your doctors and other providers are in the plan's network. Unless you are willing to change doctors, this is a good first step in choosing a plan. You can search for providers on the insurance carrier's website and call your doctor to verify that they are a member of the network.
- See the Key Features chart (on page 4) for more details on the provider networks for each plan.

2. Cost Sharing

The district pays a premium to the insurance company for your health insurance. You pay a portion of this premium in the form of **employee contributions** deducted from your paycheck. Employee contributions vary based on the plans in which you enroll and the number of dependents you enroll for coverage.

When you receive health care services, you pay a portion of the cost in the form of out-of-pocket expenses. **You are responsible for the following types of out-of-pocket costs in addition to your employee contribution.**

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- **Deductible:** A set dollar amount in medical expenses that you must pay before your health insurance pays. Here is how it works. You seek medical services and pay the cost of those services out of your pocket until your costs reach the deductible. Then the insurance carrier begins to pay all or a portion of the expenses for medical services you receive (*see coinsurance below*). The amount of the deductible depends on the plan you choose. Only covered expenses satisfy your deductible. Covered expenses accumulate towards the deductible on a calendar year basis and it resets every year on January 1.
- **Coinsurance:** A percentage of the cost of medical expenses that you may pay after meeting your calendar year deductible. For example: after your calendar year deductible is met, the plan may pay 80% and you pay 20% of the cost. The percentage of the costs you pay depends on the plan you choose.
- **Copay:** A set dollar amount (such as \$20) each time you receive services such as doctor office visits, urgent care facility visits, emergency room visits, or prescription drugs. If the cost of the service is more than the copay, the plan pays the balance.
- **Out-of-Pocket Maximum (OOPM):** The maximum amount you could potentially pay out-of-pocket for health care services during the calendar year. Your costs for deductible, coinsurance, and copayments will not exceed this amount; because the plan pays 100% for covered expenses after your out-of-pocket costs reach this level. The employee contributions deducted from your paycheck and health care costs that are not covered by your plan DO NOT apply to the out-of-pocket maximum.
- **The Cost Sharing Example (on page 3) illustrates how deductible, coinsurance, and out-of-pocket maximums work.**

NOTE: The deductible and coinsurance typically apply for services such as hospital stays, surgery, radiology, and diagnostic testing.

Some services such as office visits, specialist visits, and prescription drugs only require a flat dollar copay per service.

3. Benefit Use

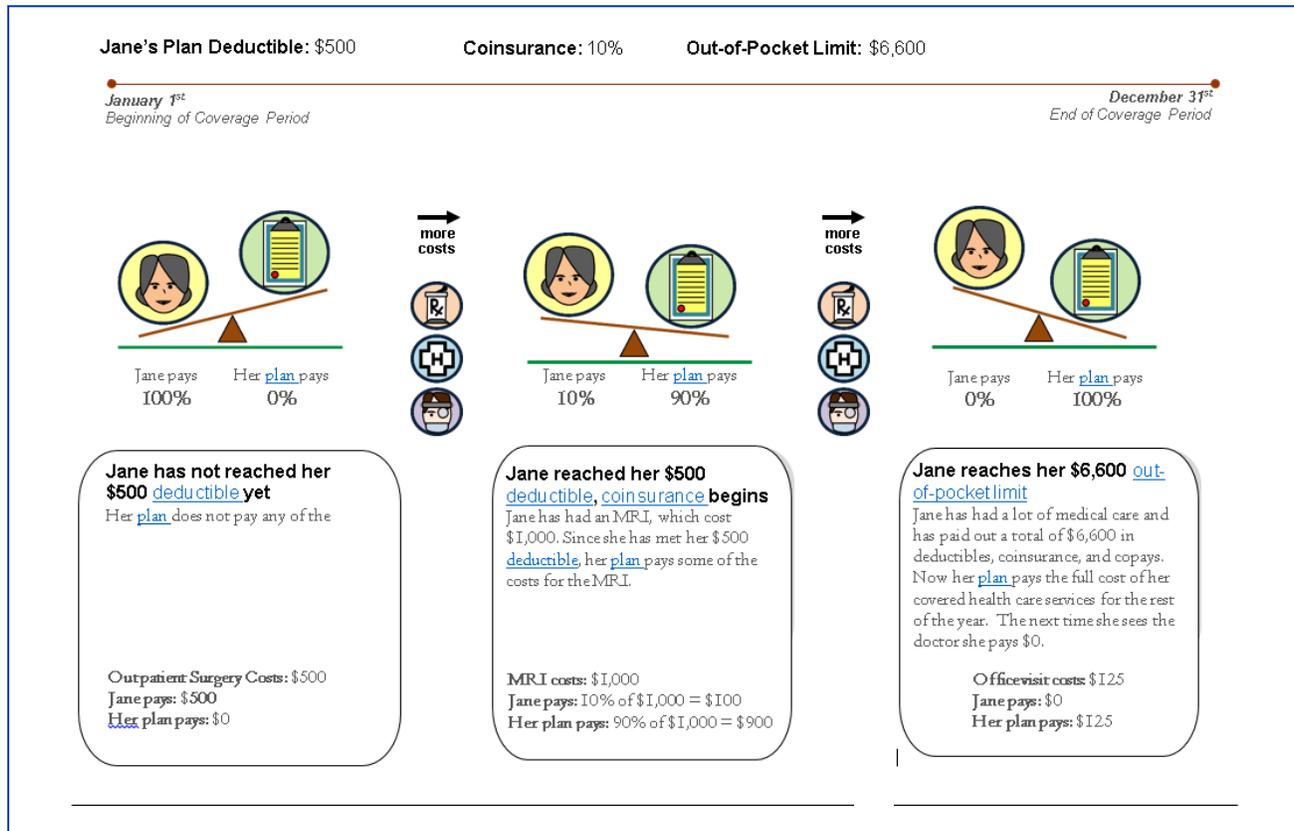
- **When you consider your health plan options, it is important to balance your cost to participate in the plan (employee contributions) with the level of out-of-pocket expenses you are likely to pay when you need health care services.**
- **If you know you will be using your benefits often,** you may choose a plan with a higher premium in exchange for a lower copays and deductibles. This means you will pay more in employee contributions from your paycheck throughout the year, but the amount you pay out-of-pocket when using your benefits will be less.
- **If much of the care you receive is routine or preventive,** you may want to consider a plan that offers a lower employee contribution from your paycheck throughout the year, but your deductible and coinsurance may be higher when you need services.

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4. Wellness Incentives

- All four of the **BCN HMO** plans, include steps you must take to earn Enhanced Benefits. Enhanced benefits are the highest level of benefits under the plans. If you do not take these steps, you will receive Standard Benefits which means that your out-of-pocket costs will be higher when you seek health care services.
- The **HAP HMO** plan has one level of benefits and does not require you to have an annual physical, complete a health risk assessment or participate in weight-management or smoking cessation programs.
- The **BCBSM PPO** plan does not require you to have an annual physical, complete a health risk assessment or participate in weight-management or smoking cessation programs. The plan has two levels of benefits depending on whether you use PPO providers or providers outside of the PPO network. You receive the highest level of benefits when you use PPO providers. You may see providers outside of the PPO network, but your out-of-pocket costs may be higher when you seek health care services from a provider outside of the PPO network.

Cost Sharing Example



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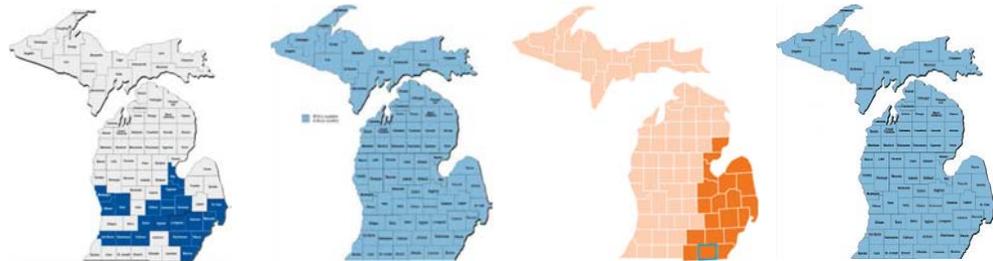


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Key Features	Blue Care Network HMO Core, Core Plus, and Economy Plan	Blue Care Network HMO Premium Plan Only	HAP HMO	Blue Cross Blue Shield Simply Blue PPO
Provider Network Access	PCP Focus network Limited to 20 counties in Michigan Applies for all plans except the Premium Plan	Michigan Statewide network	Limited to 20 counties in Michigan	Michigan statewide network plus access to Blue Cross/Blue Shield PPO providers in other states with Blue Card program
Primary Care Physician (PCP) Required?	Yes	Yes	Yes	No – but some services require prior authorization
Referral required for specialist visits?	Yes	Yes	Not required for most services, but certain specialists may require a referral before they will see you	No
"In-network" benefits?	Yes	Yes	Yes	Yes
"Out-of-Network" benefits?	Limited to emergency care	Limited to emergency care	Limited to emergency care	Yes; higher deductible and coinsurance than in-network
Premium Cost	\$	\$\$	\$	\$\$\$



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