

**Blue Care  
Network**  
of Michigan

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# Online Benefit Information

**Resource guide for BCN groups**



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## Group Secured Services at bcbsm.com

If you need additional assistance, please contact us via email at [BCITSupport@bcbsm.com](mailto:BCITSupport@bcbsm.com).

### To log in:

1. Log in to Group Secured Services using the following link: [bcbsm.com/employers.html](http://bcbsm.com/employers.html)
2. Once you're logged in, you'll see the following page:

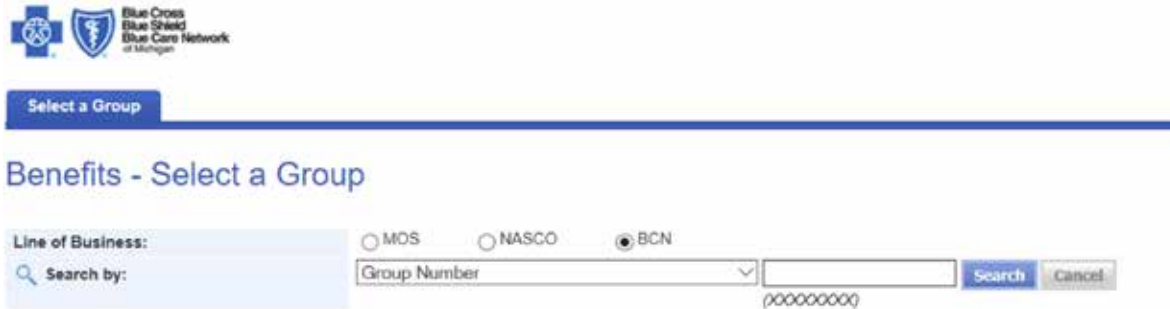


3. Navigate to *Online Benefit Information* from the *Membership and Group Tools* tab as shown below:



# To use Online Benefits Information tool

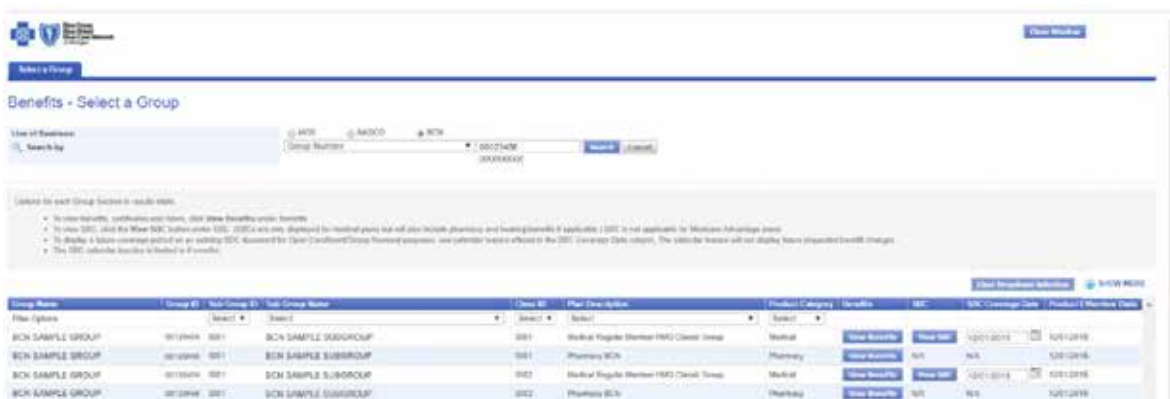
1. Select the *BCN* radio button



2. Enter a BCN Group Number
3. Once loaded, the group should populate. You can view the benefit details and a summary of benefits and coverage (SBC) by clicking the respective buttons: *View Benefits*, *View SBC*

**Note:** The calendar function doesn't apply to future requested benefit changes.

4. Once loaded, you can filter the group's information using the below categories if needed:
  - Subgroup ID
  - Subgroup Name
  - Class ID
  - Plan Description
  - Product Category



## To view and print an online benefit summary

1. Click *View Benefits*
2. You'll be routed to the *Benefits* tab, which allows you to see an online version of the benefits for the selected product
3. To print a formatted benefit summary, select *Print* in the upper right corner of the screen



## To view certificates and riders for BCN groups:

1. Click the *Certificates and Riders* tab. You'll see the certificate and riders pertaining to the selected subgroup, class, plan and product.
2. Click a hyperlinked certificate or rider to expand it.



**Note:** When available, a 'Future' column will appear displaying future-dated versions of the Certificate and Riders and their effective dates.



## To view and print a summary of benefits and coverage

1. Click the View SBC button or
2. Click the View Benefits button then click the View SBC tab:
  - If the group is fully insured, a PDF of the SBC will load when you click View SBC.
  - If the group is self insured, a Word template will load.
3. To print the SBC, select *File* then *Print* as you normally do in Word or your PDF viewer.

**Note:** The current coverage period will be displayed with the current benefits.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 11/01/2019 - 10/31/2020



SAMPLE GROUP NAME HERE

Blue Care Network

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](http://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.

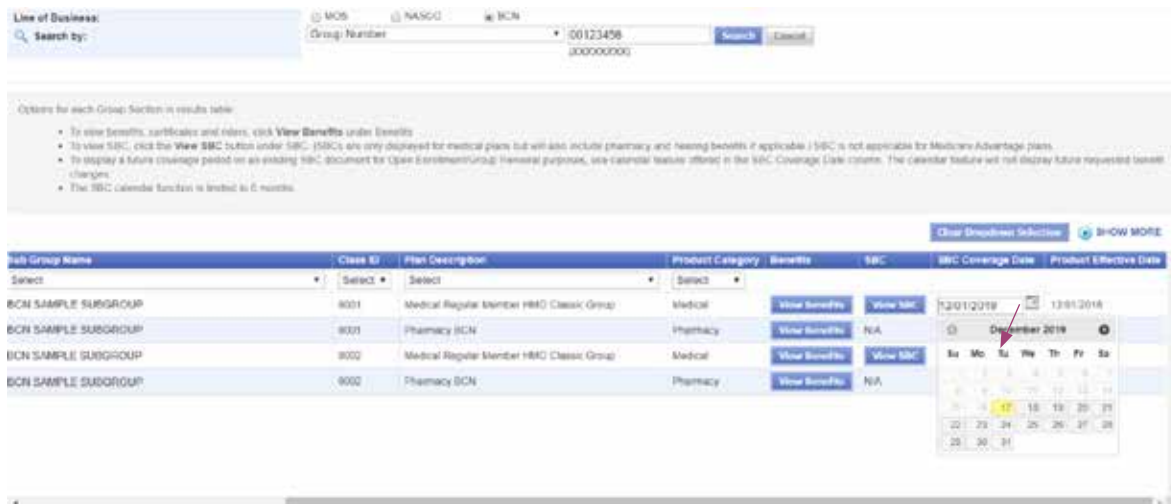
Important Questions	Answers: Member / Family	Why This Matters:
What is the overall deductible?	\$5,000/\$10,000	Generally, you must pay all of the costs from provider's up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet 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, urgent care, allergy injections, 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 ( <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> )
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?	\$6,350/\$12,700	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 ( <a href="http://www.BCBSM.com">www.BCBSM.com</a> ) or call the phone number on the back of your ID card for a list of network providers. (800)-662-6667 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.



## To change the SBC coverage period to a future date

1. Use the calendar feature and then click the *View SBC* button.

**Note:** You can only choose future effective dates up to six months in advance. The current benefits will be displayed with the future effective date and will not reflect future benefit changes.



2. Click *View SBC* to see document based on the effective date selected.

**Note:** If you don't select a future effective date, the document will reflect the current coverage period.

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services

**Coverage Period:** Beginning on or after 07/01/2020



SAMPLE GROUP NAME HERE

Blue Care Network

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](http://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?	\$5,000/\$10,000	Generally, you must pay all of the costs from <u>provider's</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 deductible?	Yes. Lab, <u>preventive care</u> , <u>DME/P&amp;O</u> , diabetic supplies, <u>PCP office visits</u> , <u>urgent care</u> , allergy injections, outpatient mental health and substance use services	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 ( <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> )
Are there other deductibles 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 plan?	\$6,350/\$12,700	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 ( <a href="http://www.BCBSM.com">www.BCBSM.com</a> ) or call the phone number on the back of your ID card for a list of <u>network providers</u> . (800)-662-6667 for a list of <u>network providers</u> .	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.



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