Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Benefits-at-a-Glance for MSU Student Health Plan 2016 - 2017

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract**. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificate and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

Note:

- You will be assigned a Student Health Services at Olin Health Center (SHS) provider as your PCP. Pediatric members are not eligible to be seen at SHS but will be assigned a BCN pediatrician within a 45 mile radius of Olin.
- A referral is needed from SHS at Olin before receiving benefits provided by a BCN Network provider located within a 45 mile radius of Olin. The referral requirement is waived for dependent children, Visiting Scholars, Optional Practical Training (OPT) students, College of Law, Osteopathic Medicine and Veterinary students.
- SHS at Olin does not need to provide a referral for benefits received by a BCN Network provider located outside of a 45 mile radius of Olin.
- Some services require your physician to obtain preauthorization BCN.
- The first three medical office visits of each school year are pre-paid by Michigan State University for enrolled students when provided at Olin Health Center.

Member's Responsibility: Deductible, Copays, Coinsurance and Dollar Maximums

	SHS at Olin Health Center	BCN Network	Out-of-Network
Deductible Select fixed dollar copays and coinsurance apply once the deductible has been met. **Note:** The **Deductible** will apply to certain services as defined below.	None – waived for services received from SHS @ Olin Health Center	$150 per member/ $300 per contract per benefit year	$300 per member/ $600 per contract per benefit year
Fixed Dollar Copays	$10 for office visit , $10 for physical therapy visits, $10 per outpatient mental health visit	$10 copay for specialist visits, $100 copay per Emergency Room visit, $10 copay per outpatient mental health and sub abuse visit, $10 copay for PT/OT/ST visits	$100 for emergency room visits, $15 copay per outpatient mental health and sub abuse visit
Coinsurance	None	10% for select services as noted below	30% for select services as noted below
Out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays Not included in the Out-of-Pocket Maximum • Balanced billed charges • Health care this plan doesn't cover • Non referred or non authorized service • Pediatric vision and dental	$2,100 per member / $4,200 per contract per benefit year		$4,200 per member/$8,400 per contract per benefit year

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Preventive services – as defined by the Affordable Care Act and included in your Benefit Document. Additional Preventive and Early Detection Services such as tobacco and depression screenings are included in your Certificate of Coverage.

	SHS at Olin Health Center	BCN Network	Out-of-Network
Health Maintenance Exam	Covered – 100%	Covered – 100%	Covered – 30% coinsurance of the allowed amount after deductible
Annual Gynecological Exam	Covered – 100%	Covered – 100%	Covered – 30% coinsurance of the allowed amount after deductible
Pap Smear Screening – laboratory services only	Covered – 100%	Covered – 100%	Covered – 30% coinsurance of the allowed amount after deductible
Well-Baby and Child Care	Not applicable	Covered – 100%	Covered – 30% coinsurance of the allowed amount after deductible
Preventive Care Immunizations	Covered – 100%; travel immunizations not available	Covered – 100%	Covered – 30% coinsurance of the allowed amount after deductible
Flu shots	Covered – 100%	Covered – 100%	Covered – 30% coinsurance of the allowed amount after deductible
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%	Covered – 100%	Covered – 30% coinsurance of the allowed amount after deductible
Fecal Occult Blood Screening	Covered – 100%	Covered – 100%	Covered – 30% coinsurance of the allowed amount after deductible
Routine Colonoscopy	Not applicable	Covered – 100%	Covered – 30% coinsurance of the allowed amount after deductible
Flexible Sigmoidoscopy Exam	Not applicable	Covered – 100%	Covered – 30% coinsurance of the allowed amount after deductible
Mammography Screening	Not applicable	Covered – 100%	Covered – 30% coinsurance of the allowed amount after deductible
Voluntary Female Sterilization	Not applicable	Covered – 100%	Covered – 30% coinsurance of the allowed amount after deductible
Office administered Contraceptives including counseling	Covered 100%	Covered – 100%	Covered – 30% coinsurance of the allowed amount after deductible
Breast Pumps - DME guidelines apply	Not applicable	Covered – 100% - must be obtained from BCN Participating DME provider	
Maternity Pre-Natal Care	Not applicable	Covered – 100%	Covered – 30% coinsurance of the allowed amount after deductible

Physician office services	SHS at Olin Health Center	BCN Network	Out-of-Network
Olin PCP Office Visits	Covered – $10 copay per visit	Not applicable	Not applicable
Online Visits	Not applicable	Covered – $10 copay per visit	
Other office visits - for other than preventive services	Covered – $10 copay per visit	Covered – $10 copay after deductible per visit	Covered – 30% coinsurance of the allowed amount after deductible

Emergency medical care			
Hospital Emergency Room – copay waived when admitted as an inpatient	Not applicable	Covered – $100 copay then 10% coinsurance	Covered – $100 copay then 10% coinsurance
Urgent Care Services	Not applicable	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance after deductible
Ambulance Services – medic ally necessary ground & air service	Not applicable	Covered – 10% coinsurance	Covered – 10% coinsurance

Diagnostic services			
Laboratory and Pathology Tests	Covered – 100% through JVHL		
Diagnostic Tests and X-rays	Covered – 100%; some services are not provided at Olin	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance of the allowed amount after deductible
Radiation Therapy	Not applicable	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance of the allowed amount after deductible
High technology scans – C.A.T.; MRI; PET; Require preauthorization	Not applicable	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance of the allowed amount after deductible

Maternity services provided by a physician			
Post-Natal Care. See Preventive Services section for routine Pre-Natal Care	Not applicable	Covered – $10 copay after deductible per visit	Covered – 30% coinsurance of the allowed amount after deductible
Delivery and Nursery Care	Not applicable	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance of the allowed amount after deductible

Hospital Care	SHS at Olin Health Center	BCN Network	Out-of-Network
General Nursing Care, Hospital Services and Supplies – requires preauthorization	Not applicable	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance of the allowed amount after deductible
Outpatient Surgery	Not applicable	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance of the allowed amount after deductible

Alternatives to hospital care			
Skilled Nursing Care Note :Must meet medical necessity guidelines for skilled care	Not applicable	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance of the allowed amount after deductible
		Unlimited days	
Hospice Care	Not applicable	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance of the allowed amount after deductible
Home Health Care	Not applicable	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance of the allowed amount after deductible
		Unlimited visits	

Surgical services			
Surgery – includes all related surgical services and anesthesia.	Not applicable	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance of the allowed amount after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Not applicable	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance of the allowed amount after deductible
Elective Abortion	Not applicable	Not covered	Not covered
Human Organ Transplants and related services - subject to medical criteria; requires preauthorization	Not applicable	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance of the allowed amount after deductible
Reduction mammoplasty (subject to medical criteria)	Not applicable	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance of the allowed amount after deductible
Male Mastectomy (subject to medical criteria)	Not applicable	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance of the allowed amount after deductible
Temporomandibular Joint Syndrome – includes physician's charges for treatment of TMJ including occlusal splint.	Not applicable	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance of the allowed amount after deductible

Surgical services, continued	**SHS at Olin Health Center**	**BCN Network**	**Out-of-Network**
Orthognathic Surgery	Not applicable	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance of the allowed amount after deductible
Weight Reduction Procedures (subject to medical criteria) – one procedure per lifetime	Not applicable	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance of the allowed amount after deductible

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care **Note**: Services require preauthorization from BCN Behavioral Health Management	Not applicable	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance of the allowed amount after deductible
Inpatient Substance Abuse Care **Note**: Services require preauthorization from BCN Behavioral Health Management	Not applicable	Covered – 10% coinsurance after deductible	Covered – 30% coinsurance of the allowed amount after deductible
Outpatient Mental Health Care	Covered – $10 copay	Covered – $10 copay after deductible	Covered –$10 copay after deductible
	When preauthorized by BCN Behavioral Health Management		
Outpatient Substance Abuse Care	Not applicable	Covered – $10 copay after deductible	Covered – 30% coinsurance of the allowed amount after deductible
		When preauthorized by BCN Behavioral Health Management	

Autism Spectrum Disorders, diagnoses and treatment

Applied behavioral analyses (ABA) treatment **Note**: Services require preauthorization from BCN Behavioral Health Management	Not applicable	Covered – $10 copay after deductible	Covered – 30% coinsurance of the allowed amount after deductible
Outpatient physical therapy, speech therapy, occupational therapy	Not applicable	Covered – $10 copay after deductible then 10% coinsurance when authorized	Covered – 30% coinsurance of the allowed amount after deductible
Other covered services, including mental health services for Autism Spectrum Disorder	See your outpatient mental health and medical office visit benefit	See your outpatient mental health and medical office visit benefit	See your outpatient mental health and medical office visit benefit

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Other services	SHS at Olin Health Center	BCN Network	Out-of-Network
Allergy testing, therapy and injections	Covered - 100% for Allergy injections. Allergy Testing and Therapy not available at Olin.	Covered – 10% coinsurance after deductible. Office visit copay may apply.	Covered – 30% coinsurance of the allowed amount after deductible. Office visit copay may apply.
Chiropractic treatment and spinal manipulation	Not applicable	Covered - $10 copay after deductible then 10% coinsurance. Office visit copay may apply.	Covered – 30% coinsurance of the allowed amount after deductible
		30 visits per condition per member per benefit year; osteopathic and chiropractic visits combined	
Rehabilitative services – subject to meaningful improvement within 90 days • Outpatient cognitive, physical and occupational therapy - Limited to a combined benefit maximum of 30 visits per condition per benefit year • Outpatient speech therapy – limited to 30 visits per benefit year	Covered – $10 copay (PT only. ST and OT not available at Olin)	Covered – $10 copay after deductible then 10% coinsurance; when authorized	Covered – 30% coinsurance of the allowed amount after deductible
Habilitative Services • Outpatient Physical and Occupational Therapy – limited to a combined benefit maximum of 30 visits per condition per benefit year • Outpatient Speech Therapy – limited to 30 visits per benefit year	Covered – $10 copay (PT only. ST and OT not available at Olin)	Covered – $10 copay after deductible then 10% coinsurance; when authorized	Covered – 30% coinsurance of the allowed amount after deductible
Durable Medical Equipment – requires preauthorization through Northwood	Certain items are available at Olin. BCN network cost share applies.	Covered – 10% coinsurance after deductible.	
Prosthetic and Orthotic Appliances – requires preauthorization through Northwood	Certain items are available at Olin. BCN network cost share applies.	Covered – 10% coinsurance after deductible. Hair prosthesis (wig or hair piece) for hair loss due to injury, sickness or the treatment of sickness is covered in full.	
Diabetic Supplies	Certain items are available at Olin. BCN network cost share applies.	Covered – 10% coinsurance after deductible through J&B Medical Supply	

Other services, continued	SHS at Olin Health Center	BCN Network	Out-of-Network
Infertility – services to diagnose and surgically treat the underlying medical cause; coverage determined by type and place of service; comprehensive infertility includes – ovulation induction with menotropins – limited to 6 cycles per lifetime – intrauterine insemination – limited to 6 cycles per lifetime	Not applicable	Covered – 10% coinsurance after deductible; office visit copay may apply	Covered – 30% coinsurance of the allowed after deductible;

Pediatric vision

Eye Exam – Limited to once per calendar year through the last day of the year in which an individual turns age 19. Prescription Glasses – Frames (chosen from a select collection) and lenses are covered once in a calendar year through the last day of the year in which an individual turns age 19	Not applicable	Covered-100%	Covered- 100% of the approved amount

Pediatric dental

Pediatric dental – Administered by Blue Cross Blue Shield of Michigan. For benefit questions call the dental customer service number on the back of your card.	**MSU Student Health Services at Olin Health Center**	**Blue Dental PPO dentists**	**Blue Par Select and nonparticipating dentists**
		To find a PPO dentist near you, please visit mibluedentist.com or call 1-888-826-8152	
Dental deductible	Not applicable	$25 per member/$75 per contract deductible per calendar year	$25 per member/$75 per contract deductible per calendar year
Dental out-of-pocket maximum -- applies to deductible and coinsurance amounts for covered dental services provided by Blue Dental PPO dentists. It does not apply to charges that exceed our approved PPO fee, services provided by non-PPO dentists or non-covered services.	Not applicable	$350 per member/ $700 per contract per calendar year	Not applicable

Pediatric dental, continued

Pediatric dental – Administered by Blue Cross Blue Shield of Michigan. For benefit questions call the dental customer service number on the back of your card.	**MSU Student Health Services at Olin Health Center**	**Blue Dental PPO dentists**	**Blue Par Select and nonparticipating dentists**
		To find a PPO dentist near you, please visit mibluedentist.com or call 1-888-826-8152	
Class I – Diagnostic and preventive services like oral exams, cleanings, fluoride, bitewing X-rays and sealants	Not applicable	Covered – 80% of approved fee	Covered – 80% of approved fee
Class II – Basic services like fillings, full-mouth X-rays, non-surgical endodontic and periodontic treatments and extractions of non-impacted teeth	Not applicable	Covered – 50% of approved fee after dental deductible	Covered – 50% of approved fee after dental deductible
Class III – Major services like crowns, surgical endodontic and periodontic treatments, oral surgery and dentures	Not applicable	Covered – 50% of approved fee after dental deductible	Covered – 50% of approved fee after dental deductible

Prescription drugs

Prescription drugs – Custom Select Drug List	Tier 1A Preferred Generic - $7.50 copay* Tier 1B Generics - $7.50 copay* Tier 2 Preferred Brand - $15 copay* Tier 3 Non-Preferred Brand – $15 copay* Tier 4 Preferred Specialty – 20% coinsurance (Max $200 copay) Tier 5 Non- Preferred Specialty – 20% coinsurance (Max $500 copay) * 30-day supply; a 90-day retail supply is available for 2 times the copay
	Drugs for the treatment of Sexual Dysfunction, Weight loss, Cough & Cold Remedies, Compounds and Select High Abuse Drugs – Not covered
	Tier 1A female contraceptives and other preventive medications are covered in full.
Mail Order prescription drugs	Not applicable