

MSU Graduate Assistants

Blue Care Network ASC

Coverage Period: Beginning on or after 8/15/2017

Coverage for: Individual/Family | Plan Type: TPA

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



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 Per Member/Per Family	Why this Matters:
What is the overall <u>deductible</u> ?	BCN Network: \$125/\$250 Out-of-Network: \$250/\$500	Generally, you must pay all of the costs from <u>providers</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 <u>deductible</u> ?	Yes. Does not apply to services received from SHS @ Olin. In-network: lab, <u>preventive care</u> , emergency room, ambulance and prescription drugs.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> limit for this <u>plan</u> ? (May include a <u>coinsurance</u> maximum)	BCN Network: \$1,500/\$3,000 Out-of-Network: \$2,300/\$4,600	The <u>out-of-pocket</u> limit 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</u> limits until the overall family <u>out-of-pocket</u> limit has been met.
What is not included in the <u>out-of-pocket</u> limit?	Premiums, balance billed charges, health care this <u>plan</u> doesn't cover and pediatric vision.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.
Will you pay less if you use a <u>network</u> provider?	Yes. See www.bcbsm.com or call the number on the back of your ID card for a list of <u>network</u> providers.	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network</u> provider, and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network</u> provider might use an <u>out-of-network</u> provider for some services (such as lab work). Check with your <u>provider</u> before you get services.

Important Questions	Answers Per Member/Per Family	Why this Matters:
Do you need a <u>referral</u> to see a <u>specialist</u>?	Yes, to see a BCN network doctor within a 45 mile radius of SHS @ Olin. Does not apply to dependent children and COBRA members.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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	\$15 <u>copay</u> /visit with Olin PCP; <u>deductible</u> does not apply	Not covered	First 3 medical office visits of each school year are pre-paid by MSU for Graduate Assistants when received at SHS @ Olin.
	<u>Specialist</u> visit	\$15 copay/visit	20% <u>coinsurance</u>	<u>Deductible</u> waived at Olin. Referral from Olin required to see BCN Network doctors within a 45 mile radius of Olin. Chiropractic care limited to 30 visits per condition per member year combined with osteopathic visits- \$15 copay after <u>deductible</u> then 5% <u>coinsurance</u> .
	<u>Preventive care/ screening/ immunization</u>	No Charge; <u>deductible</u> does not apply	20% <u>coinsurance</u>	Select services available at Olin. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	5% <u>coinsurance</u> ; deductible does not apply to lab services	20% <u>coinsurance</u>	May require <u>preauthorization</u> . No charge for lab services; deductible does not apply. Select services available at Olin and are covered in full.
	Imaging (CT/PET scans, MRIs)	5% <u>coinsurance</u>	20% <u>coinsurance</u>	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/customdruglist	Tier 1 – Mostly Generics	\$7.50/30 days; <u>deductible</u> does not apply	Not covered	<u>Preauthorization</u> and step-therapy apply to select drugs. Drugs for the treatment of sexual dysfunction are not covered. Preventive Drugs and Tier 1 contraceptives are covered in full. 90- day retail available for 2 times the copay.
	Tier 2 – Preferred Brand	\$15/30 days; <u>deductible</u> does not apply	Not covered	
	Tier 3 – Non-Preferred Brand	Not covered	Not covered	
	Specialty drugs	Tiered <u>copays</u> listed above apply. <u>Deductible</u> does not apply.	Not covered	Specialty drugs limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% <u>coinsurance</u>	20% <u>coinsurance</u>	May require <u>preauthorization</u> .
	Physician/surgeon fees	5% <u>coinsurance</u>	20% <u>coinsurance</u>	See “Outpatient surgery facility fee”
If you need immediate medical attention	<u>Emergency room care</u>	\$50 <u>copay</u> then 5% <u>coinsurance/visit</u> ; <u>deductible</u> does not apply	\$50 <u>copay</u> then 5% <u>coinsurance/visit</u> ; <u>deductible</u> does not apply	<u>Copay</u> waived if admitted as an inpatient.
	<u>Emergency medical transportation</u>	5% <u>coinsurance</u> ; <u>deductible</u> doesn't apply	5% <u>coinsurance</u> ; <u>deductible</u> doesn't apply	Non-emergent transport is covered when <u>preauthorized</u> .
	<u>Urgent care</u>	5% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	5% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	Physician/surgeon fee	No charge	No charge	See “Hospital stay facility fee”
If you need mental health, behavioral health, or <u>substance use disorder</u> services	Outpatient services	\$15 <u>copay/visit</u>	\$15 <u>copay/visit</u>	Requires <u>preauthorization</u> . 3 visits per lifetime are pre-paid by MSU for graduate assistants when provided at Olin Health Center. <u>Deductible</u> waived at Olin.
	Inpatient services	5% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	\$15 copay	20% <u>coinsurance</u>	Routine Prenatal office visits in-network are covered in full.

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)	
	Childbirth/delivery professional services	No charge	20% <u>coinsurance</u>	None
	Childbirth/delivery facility services	5% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	5% <u>coinsurance</u>	20% <u>coinsurance</u>	Requires <u>preauthorization</u> . Custodial care is not covered.
	<u>Rehabilitation services</u>	\$15 <u>copay</u> then 5% <u>coinsurance/visit</u>	20% <u>coinsurance</u>	Requires <u>preauthorization</u> ; Limited to 30 visits per condition per member per benefit year for PT and OT combined with habilitative. 30 visits for ST combined with Habilitative ST. Subject to meaningful improvement. \$15 <u>copay</u> per visit at Olin; only PT available.
	<u>Habilitation services</u>	ABA- \$15 <u>copay/visit</u>	20% <u>coinsurance</u>	PT/OT/ST for autism spectrum disorder has unlimited visits. Requires <u>preauthorization</u> .
	<u>Skilled nursing care</u>	5% <u>coinsurance</u>	20% <u>coinsurance</u>	Requires <u>preauthorization</u> . Custodial care is not covered.
	<u>Durable medical equipment</u>	5% <u>coinsurance</u>	Not covered	Requires <u>preauthorization</u> and must be obtained from a BCN supplier. Convenience and comfort items not covered. Home use only. Diabetic supplies covered with 5% coinsurance.
	<u>Hospice services</u>	5% <u>coinsurance</u>	20% <u>coinsurance</u>	Inpatient care requires <u>preauthorization</u> . Housekeeping and custodial care are not covered.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	No charge	Difference between the BCN approved amount and the amount charged by the provider.	Limited to once in a calendar year through the last day of the year in which an individual turns age 19.
	Children's glasses	No charge	Difference between the BCN approved amount and the amount charged by the provider.	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.

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)	
	Children's dental check-up	Contact your benefit administrator for coverage information.	Not covered	Contact benefit administrator for coverage information.

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.)

- 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 plan document.)

- Bariatric surgery
- Chiropractic spinal manipulation
- Infertility Treatment

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, 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.cciio.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 or <http://www.michigan.gov/difs> or difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.)

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 section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care in-network. 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 \$125
- Specialist copayment \$15
- Hospital (facility) coinsurance 5%
- Other coinsurance 5%

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:

<i>Cost Sharing</i>	
Deductibles	\$125
Copayments	\$45
Coinsurance	\$450
<i>What isn't covered</i>	
Limits or exclusions	\$100
The total Peg would pay is	\$720

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$125
- Specialist copayment \$15
- Hospital (facility) coinsurance 5%
- Other coinsurance 5%

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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$125
Copayments	\$90
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
The total Joe would pay is	\$4,615

Mia's Simple Fracture

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

- The plan's overall deductible \$125
- Specialist copayment \$15
- Hospital (facility) coinsurance 5%
- Other coinsurance 5%

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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$125
Copayments	\$105
Coinsurance	\$35
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$265

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تحتاجه لمساعدة، ف لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711. إذا لم تكن مشتركاً بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

میں نے آپ کو یا کسی کو مدد کرنے کی ضرورت ہے، تو آپ کو مدد کرنے کا حق ہے، اور آپ کو مدد کرنے کی ضرورت ہے، تو آپ کو مدد کرنے کا حق ہے۔ اگر آپ یا آپ کی مدد کرنے والی شخص کو مدد کرنے کی ضرورت ہے، تو آپ کو مدد کرنے کا حق ہے۔ 877-469-2583 TTY:711

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

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

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন (দাভাষীর সাথে) কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の方の身の方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号(メンバーでない方は 877-469-2583, TTY: 711)までお電話ください。

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 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

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. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.