**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.hr.msu.edu** or by calling the number on the back of your BCN ID card.

| Important Questions | Answers: Member/Family | | Why this Matters: |
|---|---|---|---|
| | In-Network | Out-of-Network | |
| **What is the overall deductible?** | **$100** Individual / **$200** Family | **$500** Individual / **$1000** Family | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services. Check your policy or plan document to see when the **deductible** starts over (usually but not always January 1st). See chart starting on pg. 2 for how much you pay for covered services after you meet the **deductible.** |
| **Are there other deductibles for specific services?** | No | | You don't have to meet **deductibles** for specific services, but see the chart starting on pg. 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | **$3,000** Indiv / **$6,000** Family | No. There is a co-insurance up to **$3,000** Indiv/**$6,000** family, plus deductible. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premiums, prescription drugs, balanced billed charges and health care this plan doesn't cover. | | Even though you pay these expenses, they don't count toward the **out-of-pocket limit.** |
| **Is there an overall annual limit on what the plan pays?** | No | | The chart starting on pg. 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of preferred providers, see www.bcbsm.com or call the number on the back of your BCN ID card. | | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No | | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | | Some of the services this plan doesn't cover are listed on page 5. See you policy or plan document for additional information about **excluded services**. |

**Questions:** Call **1-800-662-6667** or visit us at **www.bcbsm.com**. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary At **http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf** or call 1-800-662-6667to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $20) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use BCN **providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

| Common Medical Event | Services You May Need | Your cost if you use Providers: In-Network | Your cost if you use Providers: Out-of-network | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 co-pay per visit | Not covered | Preauthorization of out of network service may be required |
| | Specialist visit | $20 co-pay per visit | 20% co-insurance after deductible | Preauthorization of out of network service may be required |
| | Other practitioner office visit | $20 co-pay per visit | 20% co-insurance after deductible | Preauthorization of out of network service may be required |
| | Preventive care/screening/immunization | No charge | Not covered | Out of Network-select screenings have 20% coinsurance after deductible. Flu shots covered in full out of network |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge after deductible | 20% co-insurance after deductible | Preauthorization may be required/lab covered in full |
| | Imaging (CT/PET scans, MRIs) | No charge after deductible | 20% co-insurance after deductible | Preauthorization may be required |
| **If you need drugs to treat your illness or condition**<br><br>For more information about **prescription drug coverage** (if applicable), contact your employer. | Generic or prescribed over-the-counter drugs | $10 for 34-day supply<br>$20 for 90-day supply | Prescription Drug Coverage provided through CVS/Caremark. 90-day supply is only available via CVS/Caremark mail order and MSU Pharmacies. Generic contraceptives covered in full. | |
| | Formulary (preferred) brand-name drugs | $20 for 34-day supply<br>$40 for 90-day supply | Prescription Drug Coverage provided through CVS/Caremark. Some drugs require prior authorization. 90-day supply is only available via CVS/Caremark mail order and MSU Pharmacies. | |
| | Nonformulary (nonpreferred) brand-name drugs | $40 for 34-day supply<br>$80 for 90-day supply | Prescription Drug Coverage provided through CVS/Caremark. 90-day supply is only available via CVS/Caremark mail order and MSU Pharmacies. | |

| Common Medical Event | Services You May Need | Your cost if you use Providers: | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network | Out-of-network | |
| | Specialty drugs | $50 for 34 day supply | Prescription Drug Coverage provided through CVS/Caremark. Some drugs may require step therapy. 90-day supply is not available. | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge after deductible | 20% co-insurance after deductible | Preauthorization may be required |
| | Physician/surgeon fees | No charge after deductible | 20% co-insurance after deductible | Preauthorization may be required |
| **If you need immediate medical attention** | Emergency room services | $250 co-pay | | Co-pay waived if admitted or based on specific signs and symptoms. |
| | Emergency medical transportation | 20% co-insurance after deductible | | Non-emergent transport not covered |
| | Urgent care | $20 co-pay | | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge after deductible | 20% co-insurance after deductible | Requires preauthorization |
| | Physician/surgeon fee | No charge after deductible | 20% co-insurance after deductible | Requires preauthorization |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | No charge | 20% co-insurance after deductible | Requires preauthorization |
| | Mental/Behavioral health inpatient services | No charge after deductible | 20% co-insurance after deductible | Requires preauthorization |
| | Substance use disorder outpatient services | No charge after deductible | 20% co-insurance after deductible | Requires preauthorization |
| | Substance use disorder inpatient services | No charge after deductible | 20% co-insurance | Requires preauthorization |
| **If you are pregnant** | Prenatal and postnatal care | No charge | 20% co-insurance after deductible | None |
| | Delivery and all inpatient services | No charge after deductible | 20% co-insurance after deductible | Out of network - preauthorization may be required |

| Common Medical Event | Services You May Need | Your cost if you use Providers: | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network | Out-of-network | |
| **If you need help recovering or have other special health needs** | Home health care | No charge after deductible | 20% co-insurance after deductible | Combined in and out of network care limited to 60 days per calendar year |
| | Rehabilitation services | $20 co-pay per visit | 20% co-insurance after deductible | Limited to 60 combined visits per calendar year |
| | Habilitation services | $20 co-pay per visit | 20% co-insurance after deductible | Applied Behavioral Analysis (ABA) treatment for Autism – when rendered by an approved board-certified analyst – is covered through age 19 subject to prior authorization. ABA services must be obtained by an MSU-approved autism evaluation center (AAEC) prior to seeking ABA treatment. |
| | Skilled nursing care | No charge after deductible | 20% co-insurance after deductible | Deductible applies/limited to 100 days per calendar year in and out of network days combined |
| | Durable medical equipment | 20% co-insurance | Not covered | Must be authorized and obtained from a BCN supplier |
| | Hospice service | No charge after deductible | 20% co-insurance after deductible | Requires preauthorization |
| **If your child needs dental or eye care** | Eye exam | Not covered | | None |
| | Glasses | Not covered | | None |
| | Dental check-up | Not covered | | None |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long term care
- Non emergency care outside of the U.S.
- Private-duty nursing
- Hearing Aids
- Routine eye exam
- Routine foot care
- Weight loss programs

**Other Covered Services** **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery
- Infertility treatment
- Chiropractic care

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium,** which may be significantly higher than the premium you pay while covered under the plan. Other limitation on your rights to continue coverage may apply.

For more information on your rights to continue coverage, contact the plan at 1-800-662-6667. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Blue Cross® and Blue Shield® of Michigan, a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association, by calling the number on the back of your Insurance ID card. Or, you can contact Michigan Department of Insurance and Financial Services at www.michigan.gov/difs or 1-877-999-6442. For group health coverage subject to ERISA, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services

If you need assistance with understanding these materials due to language or accessibility barriers, please call 1-800-353-4434.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

# About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,370
- **Patient pays** $170

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $100 |
| Co-pays | $0 |
| Co-insurance | $0 |
| Limits or exclusions | $170 |
| **Total** | **$270** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,190
- **Patient pays** $3,210

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $100 |
| Co-pays | $180 |
| Co-insurance | $0 |
| Limits or exclusions | $2,930 |
| **Total** | **$3,210** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- Coverage examples are based on individual coverage.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.