

MICHIGAN STATE UNIVERSITY

BlueCard Out-of-State Plan

Coverage for: Individual/Family | Plan Type: PPO



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 the number on the back of your BCBSM ID card. 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 the number on the back of your BCBSM ID card to request a copy.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall <u>deductible</u> ?	\$175 Individual / \$350 Family	\$500 Individual / \$1,000 Family	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. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .		This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. 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 preventive services 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 limit</u> for this <u>plan</u> ? (May include a <u>coinsurance</u> maximum)	\$3,000 Individual / \$6,000 Family	\$3,000 Individual / \$6,000 family plus deductible	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> , <u>balance-billing</u> charges, any <u>pharmacy</u> penalty and health care this <u>plan</u> doesn't cover.		Prescription plan has a separate out-of-pocket limit: \$1,000 individual / \$2,000 family. 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 www.bcbsm.com or call the number on the back of your BCBSM ID card 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.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.		You can see the <u>specialist</u> you choose without a <u>referral</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
		In-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	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	20% <u>coinsurance</u> (after deductible)	None
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	20% <u>coinsurance</u> (after deductible)	None
	<u>Preventive care</u> / <u>screening</u> / immunization	No Charge; <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed 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)	No Charge (after deductible)	20% <u>coinsurance</u> (after deductible)	None
	Imaging (CT/PET scans, MRIs)	No Charge (after deductible)	20% <u>coinsurance</u> (after deductible)	Preauthorization may be required.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.cvscaremark.com .	Generic drugs	\$15 for 34-day supply \$30 for 90-day supply	Prescription Drug Coverage provided through CVS Caremark. 90-day supply only available through CVS Caremark mail order and select Maintenance Choice participating pharmacies.	
	Preferred brand-name drugs	\$30 for 34-day supply \$60 for 90-day supply	Prior authorization & step therapy may be required. Up to a 90-day supply at 2x the 34-day co-pay.	
	Non-preferred brand name drugs	\$75 for 34-day supply \$150 for 90-day supply	Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, visit the HR Benefits Prescription Drug Plan page, or call CVS Caremark at 800-565-7105.	
	Specialty drugs	\$100 for 34-day supply	Specialty drugs must be filled through the CVS Specialty Pharmacy (www.cvsspecialty.com). If enrolled in the PrudentRx Specialty Drug copay program, your co-pay will be reduced to \$0.00 once your deductible portion has been met.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge (after deductible)	20% <u>coinsurance</u> (after deductible)	Preauthorization may be required.
	Physician/surgeon fees	No Charge	20% <u>coinsurance</u> (after deductible)	None
If you need immediate medical attention	<u>Emergency room care</u>	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	<u>Copay</u> waived if admitted or for an accidental injury. Nonemergent visits to the emergency room are subject to a \$250 <u>copay</u> .
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> (after deductible)	20% <u>coinsurance</u> (after deductible)	Mileage limits apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Urgent care</u>	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	20% <u>coinsurance</u> (after deductible)	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge (after deductible)	20% <u>coinsurance</u> (after deductible)	<u>Preauthorization</u> is required
	Physician/surgeon fee	No Charge	20% <u>coinsurance</u>	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	No Charge	20% coinsurance (after deductible)	Your cost share may be different for services performed in an office setting
	Inpatient services	No Charge (after deductible)	20% <u>coinsurance</u> (after deductible)	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	Prenatal: No Charge; <u>deductible</u> does not apply Postnatal: No Charge; <u>deductible</u> does not apply	Prenatal: 20% <u>coinsurance</u> (after deductible) Postnatal: 20% <u>coinsurance</u> (after deductible)	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services, <u>cost share</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth / delivery professional services	No Charge (after deductible)	20% <u>coinsurance</u> (after deductible)	None
	Childbirth / delivery facility services	No Charge	20% <u>coinsurance</u> (after deductible)	None
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge (after deductible)	No Charge (after deductible)	<u>Preauthorization</u> is required. Limited to a maximum 60 days, per member, per calendar year.
	<u>Rehabilitation services</u>	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	20% <u>coinsurance</u> (after deductible)	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits, per member, per calendar year.
	<u>Habilitation services</u>	Not covered	Not covered	Applied behavior analysis (ABA) treatment for Autism - when rendered by an approved licensed behavior analyst - subject to <u>preauthorization</u> .
	<u>Autism Spectrum Disorder</u>	No charge	20% <u>coinsurance</u> (after deductible)	
	<u>Skilled nursing care</u>	No Charge (after deductible)	No Charge (after deductible)	<u>Preauthorization</u> is required. Limited to 120 days, per member, per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Durable medical equipment</u>	0%-20% <u>coinsurance</u> (after deductible)	20% <u>coinsurance</u> (after deductible)	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	<u>Hospice services</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	Physician certification required. Visit limits apply.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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 treatment
- Hearing aids
- Routine foot care
- Cosmetic surgery
- Long term care
- Weight loss programs
- Dental care (Adult)
- Routine eye care (Adult)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Coverage provided outside the United States. See <http://provider.bcbs.com>
- Non-emergency care when traveling outside the U.S
- Chiropractic care
- Infertility treatment
- Private-duty nursing

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’s Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or www.cciio.cms.gov or by calling the number on the back of your BCBSM ID card. 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 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 Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card.

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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.)

Language Access Services: See Addendum

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. 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 <u>plan's</u> overall <u>deductible</u>	\$175
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$175
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Peg would pay is	\$175

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$175
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

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	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$175
<u>Copayments</u>	\$25
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Joe would pay is	\$200

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$175
■ <u>Specialist copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

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	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$175
<u>Copayments</u>	\$25
<u>Coinsurance</u>	\$250
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$450

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or coinsurance, or benefits not otherwise covered.

