

As a self-funded group, you are solely responsible for compliance with the federal Summary of Benefit and Coverage (SBC) rules, including SBC creation and distribution. BCN does not assume any responsibility for SBC rule compliance relating to your group health plan, or for creation or disclosure of compliant SBCs. This SBC template document is being provided as an example that may contain useful information concerning your BCN administered coverage as you create your own group health plan's SBC. This SBC template document being provided is not fully compliant with the SBC federal rules. It is your responsibility to work with your legal counsel to ensure proper compliance with the federal SBC rules. This SBC template document does not constitute legal, tax, actuarial, accounting, benefit design, compliance or other advice. BCN disclaims any liability or responsibility for any non-compliance by your group health plan with SBC rules and regulations relating to creation, disclosure or other requirements. You should also note that there may be additional special circumstances which may be applicable to your specific group health plan situation which may affect SBC content, including but not limited to account type arrangements such as flexible spending accounts (FSA), health reimbursement arrangements (HRA), and health savings accounts, (HSA), or for example, wellness programs, reference based pricing or benefits, or coverage not administered by BCN, or whether the coverage provides minimum essential coverage.



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: Member / Family	Why This Matters:
What is the overall deductible?	\$125/\$250: BCN <u>Network</u> \$250/\$500: Out of <u>Network</u>	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. In-network: Lab, <u>preventive care</u> , emergency room, ambulance, Olin Health Center visits	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 deductibles for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$1,500/\$3,000: BCN <u>Network</u> \$2,300/\$4,600: Out of <u>Network</u>	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 out-of-pocket limit?	<u>Premiums</u> , balance billed charges and health care this <u>plan</u> doesn't cover, pediatric vision	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.
Will you pay less if you use a network provider?	Yes. See www.bcbsm.com 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.

Important Questions	Answers: Member / Family	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	<u>Referral</u> needed to see a BCN <u>network</u> doctor within a 45-mile radius of SHS at Olin. Does not apply to dependent children.	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 at Olin	Not covered	First three medical office visits of each school year are pre-paid by MSU for enrolled students if provided at SHS @ Olin.
	<u>Specialist visit</u>	\$15 <u>copay</u> /visit	20% <u>coinsurance</u>	<u>Deductible</u> waived if seen at Olin. <u>Referral</u> from Olin required to see BCN <u>Network</u> doctors within a 45-mile radius of Olin.
	<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 preventive. Ask your <u>provider</u> if the services you need are preventive. 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>	20% <u>coinsurance</u>	Select services available at Olin and are covered in full. May require <u>preauthorization</u> . No charge and deductible does not apply for lab services.
	Imaging (CT/PET scans, MRIs)	5% <u>coinsurance</u>	20% <u>coinsurance</u>	Requires <u>preauthorization</u> .
	Tier 1 - Mostly Generics	\$7.50/30 days; <u>deductible</u> does not apply	Not covered	<u>Preauthorization</u> & step-therapy apply to select drugs. Sexual dysfunction drugs not covered. Tier 1 contraceptives are covered in full.
	Tier 2 – Preferred Brand	\$15/30 days; <u>deductible</u> does not apply	Not covered	
	Tier 3 – Non-Preferred Brand	Not covered	Not covered	

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 prescription drug coverage is available at www.bcbsm.com/customdruglist	Specialty drugs	Tiered <u>copays</u> listed above apply. <u>Deductible</u> does not apply	Not covered	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</u> /visit; <u>deductible</u> does not apply	\$50 <u>copay</u> then 5% <u>coinsurance</u> /visit; <u>deductible</u> does not apply	<u>Copay</u> waived if admitted to the hospital.
	<u>Emergency medical transportation</u>	5% <u>coinsurance</u> ; <u>deductible</u> does not apply	5% <u>coinsurance</u> ; <u>deductible</u> does not apply	Non-emergent transport is covered when authorized
	<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>	May require <u>preauthorization</u> .
	Physician/surgeon fee	No charge	No charge	See "Hospital stay facility fee."
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	\$15 <u>copay</u> /visit with Olin PCP	20% <u>coinsurance</u>	Requires <u>preauthorization</u> . 3 visits per lifetime are pre-paid by MSU for graduate assistants when provided at Olin Health Center. Deductible waived at Olin.
	Inpatient services	5% <u>coinsurance</u>	20% <u>coinsurance</u>	Requires <u>preauthorization</u>
If you are pregnant	Office visits	\$15 <u>copay</u> /visit	20% <u>coinsurance</u>	Prenatal office visits in- <u>network</u> are covered in full.
	Childbirth/delivery professional services	No charge	20% <u>coinsurance</u>	None
	Childbirth/delivery facility services	5% <u>coinsurance</u>	20% <u>coinsurance</u>	None

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 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>
	Rehabilitation services	\$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. 30 separate visits for 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> PT/OT/ST - \$15 <u>copay</u> then 5% <u>coinsurance</u> /visit	20% <u>coinsurance</u>	Requires <u>preauthorization</u> ; Limited to 30 visits per condition per member per benefit year for PT and OT. 30 separate visits for ST. \$15 <u>copay</u> per visit at Olin; only PT available.
	Skilled nursing care	5% <u>coinsurance</u>	20% <u>coinsurance</u>	Requires <u>preauthorization</u> .
	<u>Durable medical equipment</u>	5% <u>coinsurance</u>	Not covered	Must be authorized and obtained from a BCN approved supplier. Only certain items are available at Olin.
	Hospice services	5% <u>coinsurance</u>	20% <u>coinsurance</u>	Inpatient care requires <u>preauthorization</u>
If your child needs dental or eye care	Children's eye exam	No charge	Difference between the BCN approved amount and the amount charged by the <u>provider</u> .	Limited to once in a calendar year for members up to the age of 19
	Children's glasses	No charge	Difference between the BCN approved amount and the amount charged by the <u>provider</u> .	Frames (chosen from a select collection) and lenses are covered once in a calendar year for members up to the age of 19
	Children's dental check-up	Contact your benefit administrator for coverage information.	Not covered	Contact your 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 (if prescribed for rehabilitation purposes)
- 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 (Limited to one per lifetime. Requires preauthorization)
- Chiropractic care
- Elective Abortion
- Infertility treatment (Coverage includes diagnosis/counseling/treatment of infertility when medically necessary and preauthorized by BCN. See Certificate of Coverage for exclusions)

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: U.S. 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, <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 the Minimum Value Standard? 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 Care Network of Michigan is assuming that your coverage provides for all Essential Health Benefits (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 for 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 page.*—————

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 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
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$125
Copayments	\$60
Coinsurance	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,145

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
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$125
Copayments	\$500
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$885

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
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$125
Copayments	\$70
Coinsurance	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$265

