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.

MSUSTU

Michigan State University Graduate Assistant Summary of Benefits and Coverage: What this Plan Covers & What it Costs

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>www.bcbsm.com</u> or call 800-662-6667. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <u>https://www.healthcare.gov/sbc-glossary</u> or call 800-662-6667 to request a copy.

Important Questions	Answers: Member / Family	Why This Matters:
What is the overall <u>deductible</u> ?	\$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 <u>deductible</u> ?	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</u> <u>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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u>
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> ?	\$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 <u>out–</u> <u>of–pocket limit</u> ?	<u>Premium</u> s, 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 <u>network provider</u> ?	Yes. See <u>www.bcbsm.com</u> 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</u> <u>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</u> 's <u>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</u> 's 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 **<u>copayment</u>** and <u>**coinsurance**</u> costs shown in this chart are after your <u>**deductible**</u> has been met, if a <u>**deductible**</u> applies.

Common Medical Event Services You May Need Network Provider (You will pay the least) Out-of-Network Provider (You will pay the most) Limitations, Exception Inform Primary care visit to treat an injury or illness Primary care visit to treat an injury or illness \$15 copay/visit with Olin PCP; deductible does not Not covered First three medical office year are pre-paid by MS	nation e visits of each school
Primary care visit to treat an injury or PCP: deductible does not Not covered vear are pre-paid by MS	
illness apply at Olin students if provided at S	
If you visit a health care provider's office or clinic Specialist visit Visit Visit Visit Specialist visit Visit Specialist visit Visit Vis	e BCN <u>Network</u>
Preventive care/screening/immunization No charge; deductible does not apply 20% coinsurance Select services available have to pay for services Ask your provider if the s preventive. Then check if for.	that aren't preventive. services you need are
If you have a testDiagnostic test (x-ray, blood work)5% coinsurance20% coinsuranceSelect services available covered in full. May req No charge and deductib lab services.	uire preauthorization.
Imaging (CT/PET scans, MRIs) 5% coinsurance 20% coinsurance Requires preauthorization	<u>on</u> .
Tier 1 - Mostly Generics \$7.50/30 days; deductible does not apply Not covered Preauthorization & step-	-therapy apply to select
Tier 2 – Preferred Brand \$15/30 days; deductible does not apply Not covered Sexual dysfunction drug Tier 1 contraceptives are	
Tier 3 – Non-Preferred Brand Not covered Not covered	

		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Importar Information
If you need drugs to treat year illness or condition More information about prescription drug coverage is available at (www.bcbsm.com/customdruglist)	Specialty drugs	Tiered <u>copay</u> s listed above apply. <u>Deductible</u> does no apply		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 preauthorization.
	Physician/surgeon fees	5% <u>coinsurance</u>	20% coinsurance	See "Outpatient surgery facility fee."
If you need immediate medical	Emergency room care	\$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.
attention	Emergency medical transportation	5% <u>coinsurance;</u> deductible does not apply	5% <u>coinsurance;</u> deductible does not apply	Non-emergent transport is covered when authorized
	Urgent care	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 preauthorization.
n you nave a nospital stay	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 preauthorization
lf vou are pregnant	Office visits	\$15 <u>copay</u> /visit	20% coinsurance	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

		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	<u>Home health care</u>	5% <u>coinsurance</u>	20% <u>coinsurance</u>	Requires preauthorization
If you need help recovering or have other special health needs	Rehabilitation services	\$15 <u>copay</u> then 5% coinsurance/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. Subject to meaningful improvement. \$15 <u>copay</u> per visit at Olin; only PT available.
	Habilitation services	ABA - \$15 <u>copay/visit</u> PT/OT/ST - \$15 copay 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 preauthorization.
	Durable medical equipment	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% coinsurance	Inpatient care requires preauthorization
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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more informat	ion and a list of any other <u>excluded services</u> .)
 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 <u>plan</u> 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.doi.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. or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your plan documents also provide complete information to submit a <u>claim</u>, <u>appeal</u> or a <u>grievance</u> for any reason to your <u>plan</u>. 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, <u>http://www.michigan.gov/difs;</u> 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, <u>http://www.michigan.gov/difs</u> or <u>difs-HICAP@michigan.gov</u>

Does this Plan Provide Minimum Essential Coverage? Yes

If you don't have <u>Minimum Essential Coverage</u> 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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>. (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 <u>plan</u> may be affected if your <u>plan</u> does not cover certain EHB categories, such as <u>prescription drugs</u>, or if your <u>plan</u> provides coverage for specific EHB categories, for example, <u>prescription drugs</u>, through another carrier.)

Translation available

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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) <u>coinsurance</u>	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:

Cost Sharing		
Deductibles	\$125	
Copayments	\$60	
Coinsurance	\$900	
What isn't covered		
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:

Cost Sharing		
Deductibles	\$125	
Copayments	\$500	
Coinsurance	\$200	
What isn't covered		
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 <u>plan's</u> overall <u>deductible</u>	\$125
Specialist copayment	\$15
Hospital (facility) <u>coinsurance</u>	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:

Cost Sharing	
Deductibles	\$125
Copayments	\$70
Coinsurance	\$70
What isn't covered	
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 algui en a quien usted esta ayudando, necesita asistencia, ti ene derecho a obtener ayuda e informaci on en su idi oma si n costo alguno. Para hablar con un

interprete,llame al numero telef6nico de Servicio al cliente, que aparece en la parte trasera de su tarjeta,o 877-469-2583, TTY:711 si usted todavia no es un miembro.

Neu quyvhay ngl.fet irna quy v[dang giup $\mbox{AU},\mbox{dm tr}Q'$ gi up,quy V[se c6 quyen 0U'Q'C gi up va c6 them thong ti n

bang ngon ngllcua minh mit?n phi. De n6 ichuyn v6'i mqt thong d[ch vien,xin gQiso D[ch v1,1 Khach hang & mt sau the cua quy v[, hoc 877-469-2583, TTY: 711 neu quy v! chlla phaila mqt thimh vien.

Nese ju, ose di kush qe po ndi hmoni, ka nevoje per asi stence, keni te drejte te mermi ndihme dhe informacion falas ne gjuhen tuaj. Per te folur me nje perkthyes, telefononi numrin e Sherbimi t te Klientit ne anen e pasme te kartes tuaj, ose 877-469-2583, TTY: 711 nese nukjeni ende nje anetar. ::31T. en::31T>mFl1.!I<>"Im,>mFl1 .Fd⊘iiW'I⊳mFlI-3 SfI-31 .!1 ('11 1"SfiN (- S €{i-ffil'' 'I'''f G1877-469-2583, TTY: 711 ::31T

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Jel Ty lub osoba, kt6rej pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezptatnej informacji i pomocy we wtasnym j zyku. Aby porozmawiac z ttumaczem, zadzwori pod numer dział u obslugi kJienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeieli jeszcze nie masz cztonkostwa.

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

Se tu o qualcuno che stai a i utando avete bi sogno di assistenza,hai il dritto di ottenere aiuto e informazioni nella tua lingua gratui tamente.Per parlare con un interprete, rivolgi ti al Servizi o Assistenza al numero indicato sui retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

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Ec.ImBaM BJIH.rnnzy, KOTopo:\1)' BLI no oraere, H}')KIIa no o!I{I>,TO BhI IDteere npaao aa 6ecmraTHoe noJI)''eHHe noo!I(H H HH\$opMalIHH aa same:.JIJh!Ke. ,IIJIJI pa:1rosopa C nepeBO,zriHKOM IIO1BOHHTe no HOMepy TI'JiecPOHa OTAt'.JI:a O6C.iI 3HIDIKJIHeHTOB.)'Ka3aHHOM)' Ha o6paTHOH cropoae sameiiKapThI. III ino ao epy 877-469-2583, TIY: 711, ec:m y sac HeT 'IlleHcTBa. Ukoliko varna i ii nekome kome Vi pomazete treba pomoc, i mate pravo da besplatno dobijete pomoc i i nformacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisnicke sluibe sa zadnje strane kartice i ii 877-469-2583, TTY: 711 ako vee ni ste clan.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at i mpormasyon 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: 711kung ikaw ay hindipa isang mi yembro.

Important disclosure

Blue Cross Blue Shiel d 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 Ovil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CiviiRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is availabeto 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 avail lable at

https:llocrportal.hhs.gov.^f ocrlportal/lobby.;st 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: <u>OCRComplaint@hhs.gov</u>. Complaint forms are available at *http://www.hhs.qov!ocr.^f office/filef;ndex.html*.