

Health Insurance Information Packet 2011-2012

Table of Contents

	Page #
Health Insurance Policy.....	2
Health Insurance Summary of Options.....	3
Definitions	4
PPO 1 Benefits Option Detail.....	5
PPO 2 Benefits Option Detail.....	14
HMO Benefits Option Detail.....	22
Managed Care Networks General Information.....	26
Frequently Asked Questions (FAQs).....	28
Enrollment Form.....	33
Coverage Selection Form	34
Waiver Information	35
Waiver Application.....	37



Health Insurance Policy

All medical students are required to have health insurance as a condition of their enrollment in the medical school. Following the lead of many other medical schools across the country, the medical school has negotiated a very comprehensive group health plan on behalf of our students and has made it mandatory at a very reasonable price. This policy, through Blue Cross/Blue Shield of Michigan, is mandatory because we believe it to be the best value available in terms of the benefits package for the premium being charged. The benefits have been adjusted each year to meet the needs of the students based on student input through the Student Senate. This year the benefits include adult immunizations that are CDC approved and a rider for Domestic Partners. All students will be enrolled in the Blue Cross Blue Shield of Michigan (BCBSM) Group Health Benefits Plan, unless they are eligible for a waiver as described in this packet.

Wayne State School of Medicine 2011

BENEFIT COVERAGE	PPO 1	PPO 2	HMO
Deductible In Network	\$250 Per Member \$500 Per Family	\$1500 Per Member \$3000 Per Family	\$500 Per Member \$1000 Per Family
Office Visit Copay	\$10 Copay	\$40 Copay	\$30 Copay
Co- Insurance/ Percent Copays	20% for General service after the Deductible is met	20% for General service after the Deductible is met	20% for General service after the Deductible is met
Co Insurance Out-of – Pocket Max In Network	\$1,000 Per Member \$2,000 Per Family	\$2,500 Per Member \$5,000 Per Family	\$1,500 Per Member \$3,000 Per Family
Preventive Services	Covered at 100%	Covered at 100%	Covered at 100%
Mammograms	Covered at 100%	Covered at 100%	Covered at 100%
Hospital, & Surgical Services	Covered at 80% after the Deductible is met	Covered at 80% after the Deductible is met	Covered at 80% after the Deductible is met
Emergency Room (ER) Urgent Care (UC)	\$50.00 ER Copay \$10.00 UC Copay	\$150.00 ER Copay \$40.00 UC Copay	\$100.00 ER Copay \$60.00 UC Copay
Prescription Drug Coverage	\$10 for Generic \$40 for Brand Name \$80 for Non formulary Brand Name	\$10 for Generic \$60 for Brand Name	\$10 for Generic \$40 for Brand Name
Mental Health Care and Substance Abuse Treatment	Covered at 80% after deductible is met	Covered at 80% after deductible is met	Inpatient - Covered at 80% after deductible is met Outpatient - \$30 copay after deductible
Durable Medical Equipment	Covered at 80% after deductible is met	Covered at 80% after deductible is met	Covered at 50%

Annual Premium Effective 8/1/11	PPO 1	PPO 2	HMO
1 Person	3290.64	2660.28	2142.72
2 Person	7897.44	6384.60	4928.28
Family	9871.80	7980.84	5571.12

Definitions for Summary of Options

Deductible:

The annual portion you must pay before the insurance starts paying. The deductible applies to the calendar year, not the school's insurance "year".

Copay/Coinsurance Percentage:

A copayment is applied to the insurance bill (charges) after the deductible. It is a percentage of the total bill.

Copay/Coinsurance Maximum:

This is the maximum you will spend (in addition to the deductible) in a calendar year.

Network:

PPO – Community Blue PPO
HMO – Blue Care Network

In Network:

Providers (hospitals, physicians etc) that participate in the network.

Out of Network:

PPO - Providers (hospitals, physicians etc) that DO NOT participate in the Community Blue PPO network. You will spend more money by using non participating providers.
HMO – No out of network providers.

Office Visit Copay:

You will pay this for every physician office visit (not part of the annual deductible and copayment)

Emergency Room Copay:

You will pay this for every emergency room visit (not part of the deductible and copayment)

Urgent Care Copay:

You will pay this for every Urgent Care visit (not part of the deductible and copayment)

Prescription Drug Copayment:

You will pay this for each prescription drug. (not part of the deductible and copayment)

Annual Premium:

The total 12-month cost for the insurance, from August 1 to July 31.

1 Person

Student only

2 Person

Student and spouse
(or domestic partner)

Family

Student and family
(including children of
domestic partner)

Please Note:

The amount of premium you pay "up front" for insurance coverage is directly related to the deductibles and copayments you will pay "out of pocket". More premium paid means less deductibles and copayments. Less premium paid means more deductible and copayments.

The difference between PPO1 and PPO2 are the annual premium relative to the deductibles and co-pays. PPO1 has the higher annual premium but lower deductibles and copays. PPO2 has the lower annual premium but higher deductibles and copays.

PPO 1



Community BlueSM PPO Benefits-at-a-Glance for WSU School of Medicine

PPO 1

The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This BAAG is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits, please see the applicable BCBSM certificates and riders if your group is underwritten or your summary plan description if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

	In-network	Out-of-network *
Member's responsibility (deductibles, copays and dollar maximums)		
Deductibles	\$250 for one member, \$500 for the family (when two or more members are covered under your contract) each calendar year Note: Deductible may be waived if service is performed in a PPO physician's office.	\$500 for one member, \$1,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network deductible amounts also apply toward the in-network deductible.
Fixed dollar copays	<ul style="list-style-type: none"> \$10 copay for office visits \$50 copay for emergency room visits 	\$50 copay for emergency room visits
Percent copays Note: Copays apply once the deductible has been met.	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing 20% of approved amount for most other covered services (copay waived if service is performed in a PPO physician's office) See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing 40% of approved amount for most other covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.
Annual copay dollar maximums – applies to copays for all covered services – including mental health and substance abuse services – but does not apply to fixed dollar copays and private duty nursing percent copays Note: For groups with 50 or fewer employees or groups that are not subject to the MHP law, mental health care and substance abuse treatment copays do not contribute to the copay dollar maximum.	\$1,000 for one member, \$2,000 for two or more members each calendar year	\$3,000 for one member, \$6,000 for two or more members each calendar year Note: Out-of-network copays also apply toward the in-network maximum.
Lifetime dollar maximum	None	

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



In-network

Out-of-network *

Preventive care services

Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay), one per member per calendar year	Not covered
Gynecological exam	100% (no deductible or copay), one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay), one per member per calendar year	Not covered
Well-baby and child care visits	100% (no deductible or copay) <ul style="list-style-type: none"> • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit 	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay)	Not covered
Fecal occult blood screening	100% (no deductible or copay), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	60% after out-of-network deductible Note: Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
	One per member per calendar year	
Colonoscopy – routine or medically necessary	100% for the first billed colonoscopy (no deductible or copay) Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	60% after out-of-network deductible
	One per member per calendar year	

Physician office services

Office visits	\$10 copay per office visit	60% after out-of-network deductible, must be medically necessary
Outpatient and home medical care visits	80% after in-network deductible	60% after out-of-network deductible, must be medically necessary
Office consultations	\$10 copay per office visit	60% after out-of-network deductible, must be medically necessary
Urgent care visits	\$10 copay per office visit	60% after out-of-network deductible, must be medically necessary

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



In-network

Out-of-network *

Emergency medical care

Hospital emergency room	\$50 copay per visit (copay waived if admitted or for an accidental injury)	\$50 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

Maternity services provided by a physician

Prenatal and postnatal care	100% (no deductible or copay)	60% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Skilled nursing care – must be in a participating skilled nursing facility	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% (no deductible or copay)	100% (no deductible or copay)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care – must be medically necessary and provided by a participating home health care agency	80% after in-network deductible	80% after in-network deductible
Home infusion therapy – must be medically necessary and given by participating home infusion therapy providers	80% after in-network deductible	80% after in-network deductible

Surgical services

Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay)	60% after out-of-network deductible
Voluntary sterilization	80% after in-network deductible	60% after out-of-network deductible

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In-network

Out-of-network *

Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay)	100% (no deductible or copay) – in designated facilities only
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Mental health care and substance abuse treatment

Note: If your employer has **51 or more** employees (including seasonal and part-time) and is subject to the MHP law, covered mental health and substance abuse services are subject to the following copays. Mental health and substance abuse copays are included in the annual copay dollar maximums for all covered services. See “Annual copay dollar maximums” section for this amount. If you receive your health care benefits through a collectively bargained agreement, please contact your employer and/or union to determine when or if this benefit level applies to your plan.

Inpatient mental health care	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Inpatient substance abuse treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Outpatient mental health care • Facility and clinic	80% after in-network deductible	80% after in-network deductible, in participating facilities only
	80% after in-network deductible **	60% after out-of-network deductible
• Physician's office	80% after in-network deductible **	60% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities only	80% after in-network deductible **	80% after in-network deductible

** Effective 1/1/2011, mental health and substance abuse procedures that are the equivalent of an office visit (consultative services rendered in the physician's office) will be treated and processed like an office visit, subject to the fixed dollar office visit copay.

Other covered services

Outpatient Diabetes Management Program (ODMP)	80% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$10 copay per office visit	60% after out-of-network deductible
	Limited to a combined maximum of 24 visits per member per calendar year	
Outpatient physical, speech and occupational therapy – provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a combined maximum of 60 visits per member per calendar year	
Durable medical equipment	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing	50% after in-network deductible	50% after in-network deductible

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Rider CI, contraceptive injections
Rider PCD, prescription contraceptive devices
Rider PD-CM, prescription contraceptive medications

Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and intrauterine devices, and FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered).

Note: These riders are only available as part of a prescription drug package.

Riders CI and PCD are part of your medical-surgical coverage, subject to the same deductible and copay, if any, you pay for medical-surgical services. (Rider PCD waives the copay for services provided by a network provider.)

Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



Blue Preferred[®] Rx Prescription Drug Coverage with \$10 Generic/\$40 Formulary Brand/\$80 Nonformulary Brand Triple-Tier Copay Open Formulary Benefits-at-a-Glance for WSU School of Medicine

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Specialty Drugs – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel[®] and Humira[®]) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at bcbsm.com. Log in under "I am a Member." If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days) once applicable deductible has been met.

		90-day retail network pharmacy	* Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
Member's responsibility (copays)					
Tier 1 – Generic or prescribed over-the-counter drugs	1 to 30-day period	\$10 copay	\$10 copay	\$10 copay	\$10 copay <i>plus</i> an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$20 copay	No coverage	No coverage
	84 to 90-day period	\$20 copay	\$20 copay	No coverage	No coverage
Tier 2 – Formulary brand-name drugs	1 to 30-day period	\$40 copay	\$40 copay	\$40 copay	\$40 copay <i>plus</i> an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$80 copay	No coverage	No coverage
	84 to 90-day period	\$80 copay	\$80 copay	No coverage	No coverage
Tier 3 – Nonformulary brand-name drugs	1 to 30-day period	\$80 copay	\$80 copay	\$80 copay	\$80 copay <i>plus</i> an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$160 copay	No coverage	No coverage
	84 to 90-day period	\$160 copay	\$160 copay	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.

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	90-day retail network pharmacy	* Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
Covered services				
FDA-approved drugs	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
State-controlled drugs	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no copay.	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	75% of approved amount less plan copay for the insulin or other covered injectable legend drug

* **Note:** BCBSM will not pay for drugs obtained from non-network mail order providers, including Internet providers.

Features of your prescription drug plan

Mandatory preauthorization	A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. Step Therapy , an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at bcbsm.com . Log in under <i>I am a Member</i> and click on <i>Prescription Drugs</i> .
Mandatory maximum allowable cost (MAC) drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the difference in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug plus your applicable copay regardless of whether you or your physician requests the brand name drug. Exception: If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. Note: This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
Physician-administered injectable drugs	Injectable drugs administered by a health care professional (not self-administered) are not covered under the pharmacy benefit, but may be covered under your medical benefit.
Drug interchange and generic copay waiver	Certain drugs may not be covered for future prescriptions if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at bcbsm.com . If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at bcbsm.com .



Optional riders

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Rider PCD, prescription contraceptive devices
Rider PD-CM, prescription contraceptive medications

Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and IUDs, and FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered).

Note: These riders are only available as part of a prescription drug package.

Riders CI and PCD are part of your medical-surgical coverage, subject to the same deductible and copay/coinsurance, if any, you pay for medical-surgical services. (Rider PCD waives the copay/coinsurance for services provided by a **network** provider.)

Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.

PPO 2



**Community BlueSM PPO
Benefits-at-a-Glance for WSU School of Medicine
37439/002**

PPO2

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	In-network	Out-of-network *
Member's responsibility (deductibles, copays and dollar maximums)		
Deductibles	\$1,500 for one member, \$3,000 for the family (when two or more members are covered under your contract) each calendar year Note: Deductible may be waived if service is performed in a PPO physician's office.	\$3,000 for one member, \$6,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network deductible amounts also apply toward the in-network deductible.
Fixed dollar copays	<ul style="list-style-type: none"> \$40 copay for office visits \$150 copay for emergency room visits 	\$150 copay for emergency room visits
Percent copays Note: Copays apply once the deductible has been met.	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing 20% of approved amount for most other covered services (copay waived if service is performed in a PPO physician's office) See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing 40% of approved amount for most other covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.
Annual copay dollar maximums – applies to copays for all covered services – including mental health and substance abuse services – but does not apply to fixed dollar copays and private duty nursing percent copays Note: For groups with 50 or fewer employees or groups that are not subject to the MHP law, mental health care and substance abuse treatment copays do not contribute to the copay dollar maximum.	\$2,500 for one member, \$5,000 for two or more members each calendar year	\$5,000 for one member, \$10,000 for two or more members each calendar year Note: Out-of-network copays also apply toward the in-network maximum.
Lifetime dollar maximum	None	

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15



In-network

Out-of-network *

Preventive care services

Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay), one per member per calendar year	Not covered
Gynecological exam	100% (no deductible or copay), one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay), one per member per calendar year	Not covered
Well-baby and child care visits	100% (no deductible or copay) <ul style="list-style-type: none"> • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit 	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay)	Not covered
Fecal occult blood screening	100% (no deductible or copay), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	60% after out-of-network deductible Note: Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
	One per member per calendar year	
Colonoscopy – routine or medically necessary	100% for the first billed colonoscopy (no deductible or copay) Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	60% after out-of-network deductible
	One per member per calendar year	

Physician office services

Office visits	\$40 copay per office visit	60% after out-of-network deductible, must be medically necessary
Outpatient and home medical care visits	80% after in-network deductible	60% after out-of-network deductible, must be medically necessary
Office consultations	\$40 copay per office visit	60% after out-of-network deductible, must be medically necessary
Urgent care visits	\$40 copay per office visit	60% after out-of-network deductible, must be medically necessary

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



In-network

Out-of-network *

Emergency medical care

Hospital emergency room	\$150 copay per visit (copay waived if admitted or for an accidental injury)	\$150 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services – must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

Maternity services provided by a physician

Prenatal and postnatal care	100% (no deductible or copay)	60% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	80% after in-network deductible	60% after out-of-network deductible
Unlimited days		
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Skilled nursing care – must be in a participating skilled nursing facility	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% (no deductible or copay)	100% (no deductible or copay)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care – must be medically necessary and provided by a participating home health care agency	80% after in-network deductible	80% after in-network deductible
Home infusion therapy – must be medically necessary and given by participating home infusion therapy providers	80% after in-network deductible	80% after in-network deductible

Surgical services

Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay)	60% after out-of-network deductible
Voluntary sterilization	80% after in-network deductible	60% after out-of-network deductible

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



In-network

Out-of-network *

Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay)	100% (no deductible or copay) – in designated facilities only
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Mental health care and substance abuse treatment

Note: If your employer has 51 or more employees (including seasonal and part-time) and is subject to the MHP law, covered mental health and substance abuse services are subject to the following copays. Mental health and substance abuse copays are included in the annual copay dollar maximums for all covered services. See “Annual copay dollar maximums” section for this amount. If you receive your health care benefits through a collectively bargained agreement, please contact your employer and/or union to determine when or if this benefit level applies to your plan.

Inpatient mental health care	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Inpatient substance abuse treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Outpatient mental health care • Facility and clinic	80% after in-network deductible	80% after in-network deductible, in participating facilities only
	80% after in-network deductible **	60% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities only	80% after in-network deductible **	80% after in-network deductible

** Effective 1/1/2011, mental health and substance abuse procedures that are the equivalent of an office visit (consultative services rendered in the physician’s office) will be treated and processed like an office visit, subject to the fixed dollar office visit copay.

Other covered services

Outpatient Diabetes Management Program (ODMP)	80% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$40 copay per office visit Limited to a combined maximum of 24 visits per member per calendar year	60% after out-of-network deductible
Outpatient physical, speech and occupational therapy – provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a combined maximum of 60 visits per member per calendar year	
Durable medical equipment	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing	50% after in-network deductible	50% after in-network deductible

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<p>Rider CI, contraceptive injections Rider PCD, prescription contraceptive devices Rider PD-CM, prescription contraceptive medications</p>	<p>Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and intrauterine devices, and FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered).</p> <p>Note: These riders are only available as part of a prescription drug package. Riders CI and PCD are part of your medical-surgical coverage, subject to the same deductible and copay, if any, you pay for medical-surgical services. (Rider PCD waives the copay for services provided by network providers.) Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.</p>
<p>Rider DP, domestic partners</p>	<p>Allows the subscriber's same gender domestic partner to be covered under the subscriber's contract when specific requirements are met.</p>

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



Blue Preferred[®] Rx Prescription Drug Coverage with \$10 Generic / \$60 Brand Name Fixed Dollar Copay Benefits-at-a-Glance for WSU School of Medicine 37439/002

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is **not a contract**. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

Note: The mail order pharmacy for **specialty drugs** is Option Care, an independent company. Specialty prescription drugs (such as Enbrel[®] and Humira[®]) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Option Care will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blue members.) A list of specialty drugs is available on our Web site at bcbsm.com. Log in under "I am a Member." If you have any questions, please call Option Care customer service at 866-515-1355.

	Network pharmacy	Non-network pharmacy
Member's responsibility (copays)		
Generic prescription drugs	\$10 copay for each drug	\$10 copay for each drug plus 25% of BCBSM approved amount for the drug
Prescribed over-the-counter drugs – when covered by BCBSM	\$10 copay for each drug	\$10 copay for each drug plus 25% of BCBSM approved amount for the drug
Brand name prescription drugs	\$60 copay for each drug	\$60 copay for each drug plus 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	Copay for up to a 34 day supply: <ul style="list-style-type: none"> • \$10 copay for each generic drug • \$60 copay for each brand name drug Copay for a 35 to 90 day supply: <ul style="list-style-type: none"> • \$20 copay for each generic drug • \$120 copay for each brand name drug 	No coverage

Note: If your prescription is filled by any type of network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber has not indicated "Dispensed as Written" (DAW) on the prescription, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic **plus** the applicable copay.

Covered services		
"Rx only" drugs	Covered – 100% less plan copay	Covered – 75% less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	Covered – 100% less plan copay	Covered – 75% less plan copay
State-controlled drugs	Covered – 100% less plan copay	Covered – 75% less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no copay.	Covered – 100% less plan copay for the insulin or other covered injectable legend drug	Covered – 75% less plan copay for the insulin or other covered injectable legend drug
Mail order (home delivery) prescription drugs – up to a 90-day supply of medication by mail from Medco (BCBSM network mail order provider)	Covered – 100% less plan copay	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.

Note: A **network** pharmacy is a Preferred Rx pharmacy in Michigan or a MedImpact pharmacy outside Michigan. MedImpact is an independent company providing pharmacy benefit services for Blue members. A **non-network** pharmacy is a pharmacy NOT in the Preferred Rx or MedImpact networks.



Features of your plan

<p>Drug interchange and generic copay waiver</p>	<p>Certain drugs may not be covered for future prescriptions if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at bcbsm.com.</p> <p>If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.</p>
<p>Quantity limits</p>	<p>Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at bcbsm.com.</p>
<p>Rider CI, contraceptive injections Rider PCD, prescription contraceptive devices Rider PD-CM, prescription contraceptive medications</p>	<p>Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and IUDs, and "Rx only" oral or injectable contraceptive medications.</p> <p>Note: These riders are only available as part of a prescription drug package.</p> <p>Riders CI and PCD are part of your medical-surgical coverage, subject to the same deductible and copay, if any, you pay for medical-surgical services. (Rider PCD waives the copay for services provided by a network provider.)</p> <p>Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.</p>
<p>Prescription drug preferred therapy</p>	<p>A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications before prescribing a more expensive brand-name drug. It applies only to prescriptions being filed for the first time of a targeted medication.</p> <p>Before filling your initial prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at bcbsm.com, along with the preferred medications.</p> <p>If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect all targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.</p>

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

HMO



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HMO

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

The information in this document is based on BCN's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This BAAG is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

Deductible, Copays and Dollar Maximums

Deductible	\$500 per member / \$1,000 per family
Copays	\$30 for office visits, \$60 for urgent care visits, \$100 for emergency room visits and \$5 for allergy injections
• Fixed Dollar Copay	
• Percent Copay	20% or 50% for select services as noted below
Copay Dollar Maximums	
• Fixed Dollar Copay	None
• Percent Dollar Copay – medical services; excludes services with a 50% coinsurance	\$1,500 per member, \$3,000 per family per calendar or plan year
Dollar Maximums	None

Preventive Services

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%

Mammography

Mammography Screening	Covered – 100%
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Physician Office Services

Office Visits	Covered – \$30 copay
Consulting Specialist Care – when referred for other than preventive services	Covered – \$30 after deductible

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered – \$100 copay after deductible
Urgent Care Center	Covered – \$60 copay
Ambulance Services – medically necessary	Covered – 80% after deductible

Diagnostic Services

Laboratory and Pathology Tests	Covered – Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered – 80% after deductible
Radiation Therapy	Covered – 80% after deductible



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Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – \$30 copay
Delivery and Nursery Care	Covered – 100% for professional services after deductible; see Hospital Care for facility charges

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered –80% after deductible, unlimited days
Outpatient Surgery – see member certificate for specific surgical copays	Covered – 80% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 80% after deductible up to 45 days per calendar year
Hospice Care	Covered – 100% after deductible
Home Health Care	Covered – \$30 after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia. See member certificate for specific surgical copays.	Covered –80% after deductible
Voluntary Sterilization	Covered – 50% after deductible on all associated costs
Human Organ Transplants	Covered – 80% after deductible; subject to medical criteria

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	Mental Health Care: Covered – 80% after deductible Substance Abuse Care: Covered – 80% after deductible
Outpatient Mental Health Care	Covered – \$30 copay after deductible
Outpatient Substance Abuse Care	Covered – \$30 copay after deductible

Other Services

Allergy Testing and Therapy	Covered – 50% after deductible
Allergy Injections	Covered – \$5 copay
Chiropractic Spinal Manipulation – when referred	Covered –\$30 copay after deductible
Outpatient Physical, Speech and Occupational Therapy – subject to significant improvement within 60 days	Covered –\$30 copay after deductible, limited to 60 consecutive days per episode for a combination of therapies
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible on all associated costs
Durable Medical Equipment	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%
Weight Reduction	Covered – 50% after deductible

BCN 10, CO30,ER100,UR60,MHSAP,500DED,20%CR,1500CM

BGK 3-3-11

Benefits-at-a-Glance for \$10/\$40 Prescription Drug Coverage

WSU School of Medicine

00401167



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Covered Services

Formulary Drug – Generic	Covered – \$10 copay
Formulary Drug – Brand Name	Covered – \$40 copay
Formulary Brand Name when Generic is available	Covered – Difference in cost between brand name drug and generic drug plus \$40
Non-Formulary Drugs	Not Covered
Sexual Dysfunction Drugs	Covered – 50%
Contraceptives	Covered – Applicable generic or brand copay will apply
Mail Order Prescription Drugs	Covered – \$20 copay generic, \$80 copay brand up to a 90 day supply. Sexual Dysfunction drugs 50%.

Definitions

BCN Formulary	A list of all prescription drugs which have been approved for use by BCN and which shall be dispensed through participating pharmacies to members.
Brand Name Drugs	Prescription drugs which are manufactured and marketed under a registered trade name or trademark.
Covered Drugs	Prescription drugs (Generic, Brand Name, Compounded Medication, or Health Habit) which are prescribed by a BCN affiliated provider and obtained through a participating pharmacy. Certain covered drugs are a benefit only if a BCN affiliated provider certifies to BCN and BCN agrees that the covered drug in question is medically necessary. Those drugs are not payable without preauthorization by BCN.
Generic Drugs	Prescription drugs which have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark.
Mail Order Prescription Drugs	Up to a 90-day supply of covered drugs
Participating Pharmacy	A network of licensed pharmacies selected by or authorized by BCN

BGK 3-4-11 1040DC, MOPD2C

Managed Care Networks

All managed care plans contract with doctors, hospitals, clinics, and other health care providers such as pharmacies, labs, x-ray centers, and medical equipment vendors. This group of contracted health care providers is known as the health plan's "network."

In some types of managed care plans, you may be required to receive all your health care services from a network provider. In other managed care plans, you may be able to receive care from providers who are not part of the network, but you will pay a larger share of the cost to receive those services.

Health Maintenance Organizations (HMOs)

If you are enrolled in a health maintenance organization (HMO) you will need to receive most or all of your health care from a network provider. HMOs require that you select a primary care physician (PCP) who is responsible for managing and coordinating all of your health care.

Your PCP will serve as your personal doctor to provide all of your basic healthcare services. PCPs include internal medicine physicians, family physicians, and in some HMOs, gynecologists who provide basic healthcare for women. For your children, you can select a pediatrician or a family physician to be their PCP.

If you need care from a physician specialist in the network or a diagnostic service such as a lab test or x-ray, your primary care physician (PCP) will have to provide you with a referral. If you do not have a referral or you choose to go to a doctor outside of your HMO's network, you will most likely have to pay all or most of the cost for that care.

Preferred Provider Organizations (PPOs)

A preferred provider organization (PPO) is a health plan that has contracts with a network of "preferred" providers from which you can choose. You do not need to select a PCP and you do not need referrals to see other providers in the network.

If you receive your care from a doctor in the preferred network you will only be responsible for your annual deductible (a feature of some PPOs) and a copayment for your visit. If you get health services from a doctor or hospital that is not in the preferred network (known as going "out-of-network") you will pay a higher amount. And, you will need to pay the doctor directly and file a claim with the PPO to get reimbursed.

How HMOs and PPOs Differ

The following outline compares some of the features of HMOs and PPOs. These are general rules and you should speak with your human resources office at work or directly with your health plan. If you are in the process of deciding between enrolling in a HMO or PPO, you often can compare the plans by going online to the plans' websites to learn about the available benefits and costs.

Which health care providers must I choose?

- HMO: You must choose doctors, hospitals, and other providers in the HMO network.
- PPO: You can choose doctors, hospitals, and other providers from the PPO network or from out-of-network. If you choose an out-of-network provider, you most likely will pay more.

Do I need to have a primary care physician (PCP)?

- HMO: Yes, your HMO will not provide coverage if you do not have a PCP.
- PPO: No, you can receive care from any doctor you choose. But remember, you will pay more if the doctors you choose are not "preferred" providers.

How do I see a specialist?

- HMO: You will need a referral from your PCP to see a specialist (such as a cardiologist or surgeon) except in emergency situations. Your PCP also must refer you to a specialist who is in the HMO network.
- PPO: You do not need a referral to see a specialist. However, some specialists will only see patients who are referred to them by a primary care doctor. And, some PPOs require that you get a prior approval for certain expensive services, such as MRIs.

Do I have to file any insurance claims?

- HMO: All of the providers in the HMO network are required to file a claim to get paid. You do not have to file a claim, and your provider may not charge you directly or send you a bill.
- PPO: If you get your healthcare from a network provider you usually do not need to file a claim. However, if you go out of network for services you may have to pay the provider in full and then file a claim with the PPO to get reimbursed. The money you receive from the PPO will most likely be only part of the bill. You are responsible for any part of the doctor's fee that the PPO does not pay.

How do I pay for services in the network?

- HMO: The only charges you should incur for in-network services are deductibles and copayments for doctor's visits and other services such as procedures and prescriptions.
- PPO: In most PPO networks you will only be responsible for the deductibles and copayment. The deductibles double if you are Out of Network.

How do I pay for services out of the network?

- HMO: Except for certain types of care that may not be available from a network provider, you are not covered for any out-of-network services.
- PPO: If you choose to go outside the PPO network for your care, you will need to pay the provider and then get reimbursed by the PPO. Most likely, you will have to pay an annual deductible and coinsurance. For example, if the out-of-network doctor charged you \$200 for a visit, you are responsible for the full amount if you have not met your deductible. If you have met the deductible, the PPO may pay 60%, or \$120 and you will pay 40%, or \$80.

Frequently Asked Questions (FAQs)

1. Why is health insurance policy mandatory?
 2. Why am I NOT allowed to purchase my own insurance?
 3. What coverage through a parent qualifies for the waiver?
 4. I was approved for a waiver, so why am I now being contacted to provide additional documentation?
 5. Could I be denied coverage?
 6. Why do I have to pay a second deductible?
 7. How does the 1 person deductible differ from a family deductible?
 8. What is a copayment dollar maximum?
 9. Will the copayment I pay for prescription drugs apply towards the copayment maximum?
 10. What is the total out of pocket amount I will pay in a calendar year?
 11. How do I find a Physician that participates “in the network”?
 12. What if I need services while traveling outside of Michigan?
 13. When will I receive my Blue Cross ID card?
 14. Can I add dental or vision coverage?
 15. Once I enroll, may I change my mind about the plan I selected?
 16. I am currently enrolled in the school’s Group Health Benefits plan, but now I meet the conditions of a waiver?
 17. Can I enroll mid-year, e.g. as the result of my waiver coverage ending?
 18. What if I get married or have a baby? Can I add them to the plan?
 19. Can I add a domestic partner?
 20. How will health insurance be assessed?
 21. How do I pay for coverage with my financial aid award?
 22. I do not want to use my financial aid to pay for health insurance. How do I pay for health insurance?
 23. I do not receive financial aid. How do I pay for insurance?
 24. When is payment due?
 25. Am I purchasing insurance for a 12-month term? Will my insurance automatically terminate in a year if I do not renew it next year?
 26. Who do I call if I have additional questions about my insurance or I have concerns about claims?
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1. Why is health insurance policy mandatory?

Our experience before making health insurance mandatory was that many students purchased inadequate insurance plans for most illness and injury situations. By negotiating a comprehensive, and reasonably priced, benefits package from Blue Cross/Blue Shield of Michigan, we are ensuring that students have the coverage they need. By making the plan mandatory for a 12-month period we ensure that every registered student has adequate coverage for the entire year.

2. Why am I NOT allowed to purchase my own individual policy?

Our experience found that many students tended to buy the cheapest insurance, which left them with inadequate insurance coverage for illness or injury. In addition, some students merely purchased a policy so they could register, but later let it lapse. This left them open to the massive financial burden that illness or injury can bring. The School undertook a comprehensive review of a variety of policies and chose one that best meets the needs of medical students at a reasonable cost. Medical students participated in the selection of the current policy and its benefits.

3. What coverage through a parent qualifies for the waiver?

You must be included on a parent's GROUP health plan as a DEPENDENT through his/her employer (a group plan and being a dependent are the critical issues). You would NOT be eligible for a waiver if your parent merely purchased health insurance coverage for you. **Also note, as a general insurance rule, you will likely not be covered as a dependent on your parent's group plan if you are older than 26 years of age.**

4. I was approved for a waiver, so why am I now being contacted to provide additional documentation?

The School of Medicine determines whether your waiver application meets the criteria for the waiver. We have developed a streamlined process for applying for a waiver. Rather than require that every waiver application be accompanied by supporting documentation, we only require a one-page application during registration. The information on the waiver is not proof of coverage. Students may be contacted by MSMS and be asked to provide additional information to support the waiver request. If requested, you will need to provide the additional information within the required timeframe. Per School of Medicine policy, if you fail to respond, are unable to provide appropriate evidence of coverage, or the documentation you submit does not support a waiver, you will be required to enroll in the school's plan or face possible disenrollment.

5. Could I be denied coverage?

No, because Blue Cross of Michigan group health options are not medically underwritten, you will not be denied coverage because of medical history or current health status.

6. Why do I have to pay a second deductible?

The deductible applies to a calendar year, and does not match the school's coverage "year" (August through July). If you are hospitalized in October, and again in February, you would need to pay the deductible in both calendar years.

7. How does the 1 person deductible differ from a family deductible?

When only one member of your family is having services, then the 1 person deductible must be met before Blues will begin paying for covered services. When two or more family members are receiving covered services, then all of the members contribute toward the family deductible. Each family member is not expected to fulfill an individual requirement.

8. What is a copay/copayment dollar maximum?

A copay/copayment dollar maximum limits the amount you pay each calendar year in copayments. Once you meet the copayment maximum in a calendar year, covered services will be paid at 100 percent of the approved amount for the remainder of the year. Your copayment requirement begins each calendar year on January 1st.

9. Will the copay/copayment I pay for prescription drugs apply towards the copayment maximum?

No, the prescription drugs coverage is a rider on the insurance, and is subject to its own copayment.

10. What is the total out of pocket amount I will pay in a calendar year?

The deductible plus the sum of your copayments.

11. How do I find a Physician that participates “in the network”?

PPO Options

- Go to bcbsm.com, (Blues home page)
- Tab on I'm a member,
- Go to Find a Participating Provider,
- Tab on Physicians search
- Step 1 Choose a Plan - Tab on Community Blue / Blue Preferred PPO
- Scroll down the page and choose Option C or D and fill in the required boxes
- Tab on Search

HMO Option

- Go to mibcn.com
- Select plan – Blue Care Network
- Physician or Facility search

12. What if I need services while traveling outside of Michigan?

PPO

The Blue Card program provides coverage for our members from coast to coast. All you pay are the applicable deductible and co-pays when you receive care from a provider who participates with his or her local Blue Cross Blue Shield Plan.

HMO

Emergency Services only.

13. When will I receive my Blue Cross ID card?

Your card will be mailed to the address you provide within 3 weeks of receiving your application. If you need to use the coverage prior to receiving your ID card, simply provide your social security number.

14. Can I add dental or vision coverage?

Yes, but the medical school is not involved. You will need to contact the MSMS Physicians Insurance Agency directly add Delta Dental and Delta Vision on an Individual basis as requested. MSMS Physicians Insurance Agency will bill you directly.

15. Once I enroll, may I change my mind about the plan I selected?

No, the level of coverage you select (Basic, Medium, High) is effective for the entire 12-month policy period (August through July). Changes are not allowed during the enrollment year. Your

opportunity to select the level of coverage you desire occurs at the time of enrollment in the plan, or once a year--at the time of registration--if you are currently enrolled. However, you can change the number of individuals covered as your life circumstances change (e.g., if you get married during the year you could add your spouse and switch from 1 person to 2 person coverage).

16. I am currently enrolled in the school's Group Health Benefits plan, but now I meet the conditions of a waiver. How do I cancel my coverage and submit the waiver?

You only need to fill out a Student Waiver Application, indicating that you want to cancel your coverage. When your health insurance coverage is cancelled, your WSU student account health insurance assessment will be adjusted to reflect the change.

17. Can I enroll mid-year, e.g. as the result of my waiver coverage ending?

Yes, by submitting an enrollment form to the Records and Registration Office. Someone will help you enroll in the school's health insurance plan, so that you are correctly assessed and payment arrangements are made. In general, you should plan to submit the enrollment form one month before your coverage ends, to ensure that there are no gaps in coverage.

18. What if I get married or have a baby? Can I add them to the plan?

You can add a new spouse or baby mid-year, as long as you enroll them within 30 days of the marriage/birth. Use an enrollment form, as when you first enrolled, complete Section 1 and provide the requested information in Section 2 for the individual you are adding. Submit the enrollment form to the Records and Registration Office. Someone will help you determine the premium increase and arrange for payment. Your student account health insurance assessment will then be updated to reflect the additional coverage. A birth certificate is only required if enrolling the new baby more than 30 days after the birth. A new spouse can only be added within 30 days of the marriage during the year (although spouses and dependents can be added at the beginning of the year).

19. Can I add a domestic partner?

Yes. For further information contact MSMS Physicians Insurance Agency at 877-742-2758 (the Customer Service line for members of MSMS) or email msmsagency@msms.org.

20. How will health insurance be assessed?

Your health insurance will be assessed on your student account through Wayne State University. It is the same place that your tuition and student fees appear. If you are a financial aid recipient, half of the insurance premium will be assessed at the first disbursement of financial aid at the beginning of the year, and the second half will be assessed at the second disbursement. If you do not receive financial aid, the entire 12-month premium will be assessed at the beginning of the year. **Please note that any payments you make to your student account will be first applied to any outstanding tuition and fees. Your health insurance assessment will be the last thing to which payments are applied.**

21. How do I pay for coverage with my financial aid award?

If you receive financial aid, you will need to submit a Title IV authorization in order for the health insurance fee to be deducted from your award. Submit your Title IV authorization form to the SOM Financial Aid Office, or online at http://financialaid.wayne.edu/title_IV.php. You only have to submit the authorization once. If you have already done so in a prior year you are all set.

22. I do not want to use my financial aid award to pay for health insurance. How do I pay for health insurance?

You can pay half of the yearly amount by check at registration or make payments as described in #23 below. You will be assessed half of the cost initially and the other half mid-year at the time of the second financial aid disbursement. You cannot pay for the entire year at the beginning of the year because of the way you will be assessed.

23. I do not receive financial aid. How do I pay for health insurance?

You can pay for insurance at registration with a check or money order. After the health insurance assessment has been added to your student's account, payment can be made as follows:

By mail – Wayne State University, P.O. Box 02788, Detroit, MI 48202

In person – School of Medicine Cashier Office, 1230 Scott Hall

– Academic Administrative Building, 5700 Cass Ave, Room 1100

– Welcome Center, 42 W. Warren, Room 217

Internet – ACH (fee-free check payments):

<https://commerce.cashnet.com/default.asp?client=WAYNEACH>

Web Credit Card Payments (SmartPay; a convenience fee is charged) –

www.cashnet.smartpay.com

Telephone Credit Card Payment (SmartPay; a convenience fee is charged) –

1-866-520-7786

Please direct all payment questions to the Office of Records and Registration (577-1470).

Please note that any payments you make to your student account will be first applied to any outstanding tuition and fees. Your health insurance assessment will be the last thing to which payments are applied. You cannot earmark a payment to be applied to individual items on your bill, e.g., health insurance.

[Please note: If you add dental or vision coverage, you will be billed directly by the MSMS Physician Insurance Agency for the additional coverage.]

24. When is payment due?

Payment is due on or before the due date indicated on your WSU bill (along with tuition).

Payments not received by the due date are subject to partial payment and/or late payment fees according to University policy.

25. Am I purchasing insurance for a 12-month term? Will my insurance automatically terminate in a year if I do not renew it next year?

No. Although we collect money for 12 months at a time, once you enroll in the plan your health insurance coverage continues automatically month-to-month, year-to-year **UNLESS you cancel the insurance**. This means that you do not have to do anything for coverage to continue but you do have to do something for it to stop. Students who do not cancel in the appropriate way are responsible for any charges billed to the School. (Note: The exception is seniors, who will automatically be cancelled at the end of May.)

25. Who do I call if I have additional questions about my insurance or I have concerns about claims?

MSMS Physicians Insurance Agency at 877-742-2758 (this is the Customer Service line for members of MSMS) or email msmsagency@msms.org.



Wayne State School of Medicine BCN – HMO and BCBSM - PPO

Subscriber Information											
Social Security Number		Student ID#		Subscriber Last Name		Subscribers First Name		MI			
Street Address			City		State		Zip Code				
Area Code/ Phone Number		Birth Date		Male or Female		Single or Married		Email Address			
List all Dependants to be enrolled or terminated											
Check One			Last Name			First Name		Birth Date		Social Security #	
Spouse		Add _____ Delete _____						/ /			
Dependant 1		Add _____ Delete _____						/ /			
Dependant 2		Add _____ Delete _____						/ /			
HMO SUBSCRIBERS ONLY											
Physician Name			Physician's NPI #			Physicians Location		Seen this Physician in the last 12mo			
Subscriber								Yes _____ No _____			
Spouse								Yes _____ No _____			
Dependant 1								Yes _____ No _____			
Dependant 2								Yes _____ No _____			
I have read and understand the conditions on the reverse side of this form											
Sign and Date Here			Coverage Choice			Number of Insured		Level of Training			
			PPO - 1 _____ PPO - 2 _____ HMO _____			1 - Person _____ 2 - Person _____ Family _____		Year 1 _____ Year 2 _____ Year 3 _____ Year 4 _____			
Enrollment Date:											
Cancel Date:											

W

COVERAGE SELECTION FORM for academic year 2011-2012
Wayne State University School of Medicine (WSUSOM)

****ONLY FOR STUDENTS CURRENTLY ENROLLED IN THE SCHOOL'S PLAN****

DO NOT USE THIS FORM IF YOU ARE A NEW ENROLLEE

Directions: If you are currently enrolled in the school's Group Health Benefits Plan, please provide the requested information and indicate your desired level of coverage for the period August 1, 2011 through July 31, 2012. The number of individuals covered (1 person, 2 person, family) will remain as is. To add or remove individuals at any point, you will need to complete another Enrollment/Change of Status form.

I select the following level of health insurance for the coverage period from August 1, 2011 through July 31, 2012	
<input type="checkbox"/> PPO1	<input type="checkbox"/> 1 person
<input type="checkbox"/> PPO2	<input type="checkbox"/> 2 person
<input type="checkbox"/> HMO	<input type="checkbox"/> Family

Student Information	
Name: _____	WSU ID #: _____
Print Name	
Signature: _____	_____/_____/_____ Date

Waiver Information

Students may be able to waive out of the requirement to purchase health insurance through the school's group plan with Blue Cross/Blue Shield of Michigan. Please review the descriptions of eligible waiver coverage below. If you feel your current coverage qualifies for a waiver, complete the Student Waiver Application form. Your application will be reviewed and you will be notified whether or not a waiver has been granted. If a waiver is denied, you will be required to enroll in, and be billed for, the school's Group Health Benefits plan.

Streamlined Waiver Application Process

The waiver application process consists of personal information (name, address, date of birth, WSUSOM email address), the type of waiver for which you believe you are qualified, policy information of the alternate health insurance coverage (including the policy number and group), and your signature that you understand the Wayne State University School of Medicine policies regarding mandatory health insurance coverage for medical students and that you attest that your current alternate coverage meets the requirements of a waiver. **Submission of an application is not proof of coverage.** No additional evidence of coverage is required at the time you submit your waiver application, however, you may be asked to provide supporting documentation.

Eligible Waiver Coverage

The following types of waivers are listed and described below.

1. **OHIP (Canadian)** You are a Canadian citizen and have OHIP coverage administered by the province of Ontario.
2. **Medicaid** You are enrolled in Medicaid and have health insurance through it.
3. **Military** You are attending medical school on a military scholarship and have health insurance provided.
4. **My Spouse** You are included on your spouse's group health plan through her/his employer. You would not be eligible for this waiver if your spouse merely purchased individual (month-to-month) coverage for you.
5. **My Parent** You are included on a parent's GROUP health plan as a DEPENDENT through his/her employer. You would NOT be eligible for this waiver if your parent merely purchased health insurance coverage for you. In most cases, you will not be covered as a dependent on your parent's group plan if you are older than 25 years of age. COBRA, which is a month-to-month extension of your health coverage available to you through your parent's employer after you turn 25, does not qualify for the waiver.
6. **Other Group Coverage** There may be additional situations that the school may accept as appropriate for a waiver. Those situations will be reviewed on a case by case basis. Be advised that **purchasing your own individual (month-to-month) health insurance coverage would NOT be eligible for a waiver**, and you would be required to enroll in

the school's Group Health Benefits plan. Specifically, **the Young Adult Blue plan from BCBS is individual insurance policy and therefore is not waiver-eligible.** Purchasing other insurance **simply because you desire less health insurance coverage than is contained in the school's plans, or because you want to pay a lower premium, would NOT be eligible for a waiver.** The group plans are considered by the School to be the minimum level of health insurance coverage for medical students.

Request for Supporting Documentation

We do not ask for proof of waiver coverage at the time of registration (the application is not proof of coverage). However, you may be asked to submit further evidence of coverage at a later point. The request for additional documentation can be made at any time throughout the year. Once contacted, a student will have ten (10) business days to provide the requested documentation or risk termination of the waiver. An insurance card is not proof of coverage. If a waiver is terminated, the student will need to enroll in, and will be billed for, the school's Group Health Benefits plan.

STUDENT WAIVER APPLICATION FOR ACADEMIC YEAR 2011-2012

Wayne State University School of Medicine (WSUSOM)
Blue Cross Blue Shield of Michigan (BCBSM) Group Health Benefits

Student Information

Name: _____ / ____ / ____
(Please Print) Date of Birth

Address: _____

WSUSOM Email: _____@med.wayne.edu WSU ID: _____

I Hereby APPLY FOR A WAIVER for Academic Year 2011-2012

Because I am covered under another group health plan through (please specify):
 OHIP (Canadian citizen) Medicaid Military My spouse My parent
 Other _____

You will be notified whether or not a waiver has been granted.

If you are currently enrolled in the school's health insurance plan, you must complete this section to CANCEL that coverage:

Social Security # _____ Date to cancel coverage: _____

Please circle your current coverage: HMO Basic Medium High

Insurance Information

Please complete this section if requesting a waiver:

Policyholder (Insured) Name: _____
Relationship to Student (if through someone else) _____
Insurance Company Name: _____
Policy Number: _____

The information above is true and accurate to the best of my knowledge. I believe that my current health insurance coverage meets the requirements for a waiver.

I understand that this application is **NOT Proof of Coverage**. I understand that WSUSOM **will conduct** audits of selected waivers and, if asked, I will provide all requested documentation within five (10) business days or risk termination of the waiver.

I understand that I am required to have Medical School approved the health insurance coverage throughout my tenure as a medical student at WSUSOM, either through the school's BCBSM plan or through alternative coverage that meets the requirements for an approved waiver. If a waiver is granted, I will immediately notify WSUSOM if my "waiver" health insurance lapses, in order that I may be enrolled in the school's BCBSM plan. If my waiver is denied, I understand that I am required to enroll in, and will be billed for, the school's Group Health Benefits plan from BCBSM.

(Student Signature)

(Date)