
 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, BCBSM and Caremark for pharmacy questions.. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.BCBSM.com](http://www.BCBSM.com) or call 1-877-457-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$500/Individual or \$1,000/family for participating providers. \$1,000/Individual or \$2,000/family for non-participating providers.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Coinsurance Max- For participating providers <b>\$2,000</b> person / <b>\$4,000</b> family. For non-participating <b>\$4,000</b> person / <b>\$8,000</b> family. OOP Max- For participating <b>\$8,150</b> person / <b>\$16,300</b> family. For non-participating <b>\$16,300</b> person / <b>\$32,600</b> family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.BCBSM.com">www.BCBSM.com</a> or call 1-800-810-258 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without permission from this plan.

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <a href="#">copay/visit</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay/visit</a>	40% <a href="#">coinsurance</a>	If you receive services, in addition to office visit, additional copays or deductibles may apply.
	<a href="#">Chiropractic</a> visit	\$20 <a href="#">copay/visit</a>	40% <a href="#">coinsurance</a>	Up to 24 visits per year
	<a href="#">Preventive care/screening/immunization</a>	No charge	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Deductible applies. Covered at 100% in-network if related to a preventative exam
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs (Tier 1)	\$10 co-pay for retail at University Pharmacy, \$15 co-pay for retail 30-day supply; \$30 co-pay for retail or mail order 90-day supply	Copay plus additional 25% of the approved amount. Retail only.	Step therapy may apply. Certain contraceptives covered 100% according to PPACA. 90-day supply not covered out-of-network. Specialty drugs limited to a 15 or 30-day supply per fill.
	Preferred brand drugs (Tier 2)	\$20 co-pay for retail at University Pharmacy, \$30 co-pay for retail 30-day supply; \$60 co-pay for retail or mail order 90-day supply.		
	Non-preferred brand drugs (Tier 3)	\$60 co-pay for retail 30-day supply; \$120 co-pay for retail or mail order 90-day supply.		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Deductible applies
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	In-network presurgical consults covered at 100%.
<b>If you need immediate medical</b>	<a href="#">Emergency room care</a>	\$150 <a href="#">copay/visit</a>	\$150 <a href="#">copay/visit</a>	Copayment waived if admitted
	<a href="#">Emergency medical</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	In-network deductible applies

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>attention</b>	<a href="#">transportation</a>			
	<a href="#">Urgent care</a>	\$20 <a href="#">copay/visit</a>	40% <a href="#">coinsurance</a>	If you receive services in addition to urgent care, deductible or coinsurance may apply
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Deductible applies
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% coinsurance all other services.	20% coinsurance for facility and clinic. 40% <a href="#">coinsurance</a> for <a href="#">physician office</a>	In-network deductible applies for facility and clinic. Participating facilities only.
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you are pregnant</b>	Office visits	No charge	40% <a href="#">coinsurance</a>	Deductible applies. Includes services provided by certified nurse midwife
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Deductible applies; Must be provided by participating home care agency.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	60 visits/year. Includes physical therapy, speech therapy, and occupational therapy.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a> for Applied Behavioral Analysis; 20% <a href="#">coinsurance</a> for Physical, Speech and Occupational Therapy	20% <a href="#">coinsurance</a> for Applied Behavioral Analysis; 40% <a href="#">coinsurance</a> for Physical, Speech and Occupational Therapy	Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to <a href="#">preauthorization</a> .
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	120 visits/calendar year
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. In-Network deductible applies
	<a href="#">Hospice services</a>	No charge	No charge	<a href="#">none</a>
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- |                                                                                                                        |                                                                                                                                                                                         |                                                                                                                                                                   |
|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic Surgery</li><li>• Dental Care (Adult)</li></ul> | <ul style="list-style-type: none"><li>• Infertility Treatment</li><li>• Long-Term Care</li><li>• Massage Therapy</li><li>• Non-emergency care when traveling outside the U.S.</li></ul> | <ul style="list-style-type: none"><li>• Personal training</li><li>• Routine eye care (Adult)</li><li>• Routine Foot Care</li><li>• Weight Loss Programs</li></ul> |
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### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |                                                                                              |                                                                                            |                                                                        |
|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Autism Therapy</li><li>• Bariatric Surgery</li></ul> | <ul style="list-style-type: none"><li>• Chiropractic Care</li><li>• Hearing Aids</li></ul> | <ul style="list-style-type: none"><li>• Private Duty Nursing</li></ul> |
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**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: BCBSM, P.O. Box 230555, Grand Rapids, MI 49523-0555 or 1-888-890-5754. Caremark, [www.caremark.com](http://www.caremark.com) or 1-800-552-8159. Northern Michigan University, Attention: Human Resources Department, 906-227-1030. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? **Yes.**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet Minimum Value Standards? **Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

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

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**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*)

<b>Total Example Cost</b>	<b>\$12,731</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$80
Coinsurance	\$2,001
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,641</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**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*)

<b>Total Example Cost</b>	<b>\$7,390</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$500
Copayments	\$770
Coinsurance	\$372
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,698</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,042</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$500
Copayments	\$510
Coinsurance	\$215
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,225</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert].

\*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.