**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, go to www.metrodetroitlaborers.org or call 1-800-228-0048. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-855-756-4448 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $0 / individual or $0 / family for in-network and out-of-network services | See the chart starting on page 2 for how much you pay for covered services. As noted there is **no** deductible. |
| **Are there services covered before you meet your deductible?** | Yes. There is **no** deductible required for services to be covered. | You don't have any deductibles for services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Are there other deductibles for specific services?** | No | There are **no** deductibles. |
| **What is the out-of-pocket limit for this plan?** | $8,150 / Individual or $16,300 / Family in-network and $8,150 / Individual or $16,300 / Family out-of-network. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. **Note:** Within the out-of-pocket limit above there is a $1,000 coinsurance family maximum for in-network. Copayments noted throughout do not apply to the coinsurance maximum noted here. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, pharmacy penalties, health care this plan doesn't cover and certain other amounts. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.bcbsm.com or call 1-855-575-2461 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 20% coinsurance/ office visit | 30% coinsurance | Out-of-network providers may balance bill. |
| | Specialist visit | 20% coinsurance/visit | 30% coinsurance | Out-of-network providers may balance bill. |
| | Preventive care/screening/ immunization | No charge | 30% coinsurance | You may have to pay in-network cost sharing for services that are not preventive. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits. Out-of-network providers may balance bill. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 30% coinsurance | Out-of-network providers may balance bill. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 30% coinsurance | Preauthorization may be required for select imaging tests. Out-of-network providers may balance bill. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at **www.bcbsm.com/pharmacy.**<br><br>For more information about the Coupon Program contact the Fund Office. | Generic drugs (Tier 1) | $20 copay 1-30 days; $40 copay 84-90 days | In-network copay **plus** 25% coinsurance based on BCBSM approved amount. | Step therapy, quantity limits and/or prior authorization may apply.<br><br>**Prescription Drug Manufacturer Coupon Assistance Program is mandatory for Participants with prescription drugs (including Specialty drugs) that cost $400 or more and a manufacturer's coupon is available.** Health Plan Advocate, the program administrator, will contact the Participant.<br><br>If a Manufacturer Coupon is not used, the Participant's cost sharing is 50% of the cost of the prescription drug. |
| | Preferred brand drugs (Tier 2) | $60 copay 1-30 days; $120 copay 84-90 days | In-network copay **plus** 25% coinsurance based on BCBSM approved amount. | |
| | Non-preferred brand drugs (Tier 3) | $100 copay 1-30 days; $200 copay 84-90 days | In-network copay **plus** 25% coinsurance based on BCBSM approved amount. | |

| 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) | |
| | Generic and preferred brand-name specialty drugs (Tier 4) | 20% copay with a maximum of $200 for a 30-day supply | In-network copay **plus** 25% coinsurance based on BCBSM approved amount. | Step therapy, quantity limits and/or prior authorization may apply.<br><br>Prescription Drug Manufacturer Assistance Program mandatory. (see above for details)<br><br>**31-90 day supply not covered for specialty drugs** in or out-of-network. |
| | Non-preferred brand-name specialty drugs (Tier 5) | 25% copay with a maximum of $300 for a 30-day supply | In-network copay **plus** 25% coinsurance based on BCBSM approved amount. | |
| | Lifestyle Drugs | **Not Covered** | **Not Covered** | Examples of lifestyle drugs are fertility, impotence, weight loss, etc. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 30% coinsurance | Services must be rendered in a participating ambulatory surgery center. |
| | Physician/surgeon fees | 20% coinsurance | 30% coinsurance | Out-of-network providers may balance bill. |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | 20% coinsurance | Out-of-network providers may balance bill. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Must be medically necessary. Mileage limits apply. Out-of-network providers may balance bill. |
| | Urgent care | 20% coinsurance | 30% coinsurance | In the event of an emergency, out-of-network coinsurance would be 20%. Out-of-network providers may balance bill. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 30% coinsurance | Non-emergency services must be rendered in a participating hospital. Preauthorization is required. |
| | Physician/surgeon fees | 20% coinsurance | 30% coinsurance | Out-of-network providers may balance bill. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance | 30% coinsurance | Must be performed in an approved facility. Out-of-network providers may balance bill. Preauthorization is required. |
| | Inpatient services | 20% coinsurance | 30% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you are pregnant** | Office visits | Prenatal care covered (no coinsurance)<br><br>20% coinsurance for postnatal care. | 30% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services cost share may apply. Cost sharing does not apply for preventive services. Out-of-network providers may balance bill. |
| | Childbirth/delivery professional services | 20% coinsurance | 30% coinsurance | Out-of-network providers may balance bill. |
| | Childbirth/delivery facility services | 20% coinsurance | 30% coinsurance | Non-participating facilities are **not** covered |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 20% coinsurance | Must be provided by a participating home health care agency. Physician certification required. |
| | Rehabilitation services | 20% coinsurance | 30% coinsurance | Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization<br><br>Services at non-participating outpatient physical therapy facilities are **not** covered. |
| | Habilitation services | 20% coinsurance for Applied Behavioral Analysis; 20% coinsurance for Physical, Speech and Occupational Therapy. | 20% coinsurance for Applied Behavioral Analysis; 20% coinsurance plus an additional 20% out-of-network coinsurance for Physical, Speech and Occupational Therapy | |
| | Skilled nursing care | 20% coinsurance | 20% coinsurance | Must be in a participating skilled nursing facility. Preauthorization is required. |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | Out-of-network providers may balance bill. |
| | Hospice services | 0% coinsurance | 0% coinsurance | Provided through a participating hospice program only. Physician certification required. Visit limits apply. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If your child needs dental or eye care** | Children's eye exam | Covered (no copay) for exams, lenses and medically necessary contact lenses; $350 frame allowance; $250 elective contact lens allowance; $60 copay for fit and follow-up for contact lens | Member responsible for difference between BCBSM approved amount and provider's charge for eye exam, lens and frames and contact lens. Eye exam reimbursed up to $45; frames reimbursed up to $70; medically necessary contact lens reimbursed up to $210; elective contact lens reimbursed up to $105. | Eye exams, lenses and frames and/or contact lenses covered once every calendar year. Benefits are reduced if using a non-participating provider. Prior authorization required for medically necessary contact lens coverage. Must use VSP provider for progressive lens to be covered. |
| | Children's glasses | | | |
| | Children's dental check-up | 0% co-insurance for preventive services only | | Out-of-network providers may balance bill. |

## Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Routine foot care (not medically necessary)
- Weight loss programs

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

- Autism Spectrum Disorder
- Bariatric surgery (medical necessity)
- Chiropractic care
- Routine dental care (Adult)
- Routine eye care (Adult)
- Hearing aids
- Care when traveling outside the U.S.
- Private-duty nursing

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling the number on the back of your BCBSM ID card. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 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 on how 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: www.metrodetroitlaborers.org or 1-800-228-0048. You may also contact the Department of Laborer Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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

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

**Does this plan meet the 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.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-228-0048.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-228-0048.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-228-0048.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-228-0048.

***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 | $0 |
| Specialist coinsurance | 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)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $10 |
| Coinsurance | $1,000 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,070** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist coinsurance | 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)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $0 |
| Copayments | $1,500 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,820** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist coinsurance | 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)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $0 |
| Copayments | $30 |
| Coinsurance | $600 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$630** |

The plan would be responsible for the other costs of these EXAMPLE covered services.