The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the Plan would share the cost for covered health care services. NOTE: Information about the cost of this Plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call 1-877-876-9357. 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.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-877-876-9357 to request a copy. Questions: call 1-877-876-9357 or visit www.outstatetroweltrades.org for more information, including a copy of the Summary Plan Description.

Important Questions	Answers		Why This Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$ 1,000 Individual / $2,000 Family	$2,000 Individual / $4,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this Plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.		This Plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this Plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$9,450 Individual / $18,900 Family	$18,900 Individual / $37,800 Family	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.
What is not included in the out-of-pocket limit?	Premiums, Balance-billing charges, any pharmacy penalty and health care this plan doesn't cover.		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 the number on the back of your BCBSM ID card 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 that 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 co-pay	40% coinsurance	Out-of-network non-participating providers may balance bill.
	Specialist visit	$20 co-pay	40% coinsurance	Out-of-network non-participating providers may balance bill.
	Preventive care/screening/ immunization	No charge.	Not covered.	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Out-of-network non-participating providers may balance bill.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Out-of-network non-participating providers may balance bill. May require preauthorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/druglists	Generic drugs	$15 co-pay for retail 30-day supply; $30 co-pay for retail or mail order 90-day supply	In-Network co-pay plus an additional 25% of the approved amount	Preauthorization, step therapy and quantity limits may apply to select drugs. Without Preauthorization, you may be responsible for the full cost of the drug. Preventive drugs covered in full. No coverage for 90-day supply out-of-network. No coverage for prescriptions filled at Sam's Club or Wal-Mart pharmacy. Select diabetic supplies and devices may be covered under the prescription drug program.
	Preferred brand drugs	$30 co-pay for retail 30-day supply; $60 co-pay for retail or mail order 90-day supply	In-Network co-pay plus an additional 25% of the approved amount	
	Non-preferred brand drugs	$60 co-pay for retail 30-day supply; $120 co-pay for retail or mail order 90-day supply.	In-Network co-pay plus an additional 25% of the approved amount	
	Specialty drugs	Same as above based on class; generic, preferred or non-preferred.	Same as above based on class; generic, preferred or non-preferred.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	Out-of-network non-participating providers may balance bill.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	Out-of-network non-participating providers may balance bill.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$150 copayment	$150 copayment	Copayment waived if admitted or for an accidental injury.
	Emergency medical transportation	20% coinsurance after deductible	40% coinsurance after deductible	Mileage limits apply. Must be medically necessary.
	Urgent care	$20 copayment	40% coinsurance after deductible	Must be medically necessary.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization may be required. Nonemergency services must be provided in a participating hospital.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	Out-of-network non-participating providers may balance bill.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Nonemergency services must be provided in a participating facility.
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization may be required.
If you are pregnant	Office visits	No charge.	40% coinsurance after deductible	Maternity care may include services described elsewhere in the SBC (i.e., tests) and cost share may apply. Cost sharing does not apply to certain maternity services considered to be preventive.
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	None.
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	None.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.

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)	
	Habilitation services	20% coinsurance after deductible for Applied Behavior Analysis (ABA) and Physical, Speech and Occupational Therapy.	20% coinsurance after deductible for ABA; 40% coinsurance after deductible for Physical, Speech and Occupational Therapy.	ABA treatment for autism must be provided by an approved, licensed behavior analyst and subject to preauthorization.
	Skilled nursing care	20% coinsurance after deductible	20% coinsurance after deductible	Limited to a maximum of 120 days per member per calendar year. Must be in a participating skilled nursing facility.
	Durable medical equipment	20% coinsurance after deductible	20% coinsurance after deductible	Excludes bath, exercise and deluxe equipment, comfort and convenience items, and items without a prescription.
	Hospice services	No charge.	No charge.	Preauthorization required. Must be provided through a participating hospice program.
If your child needs dental or eye care	Children's eye exam	$5 co-payment	Up to $45 less $5 co-payment plus responsible for any difference.	Eye exams covered once every 12 consecutive months; Out-of-network providers may balance bill.
	Children's glasses	$7.50 co-pay for lenses and frames. $7.50 co-pay for medically necessary contact lenses.	The difference between the approved amount and the amount charged.	Lenses and contact lenses covered once every 12 consecutive months; frames covered once every 24 consecutive months; Individuals may choose between prescription glasses (frames and lenses) or prescribed contact lenses, but not both. For prescribed contact lenses that are not medically necessary, coverage is limited to $35.
	Children's dental check-up	0% coinsurance for preventive services only	0% coinsurance for preventive services only	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.)

- Acupuncture treatment
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (medically necessary) • Chiropractic care • Coverage provided outside the U.S. (see http://provider.bcbs.com)	• Dental care (Adult) (Class I Only) • Non-Emergency care when traveling outside the U.S. (when coordinated through Blue Card)	• Private-duty nursing • Routine eye care (Adult)

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/heatlhreform, 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 options to continue coverage are available to you too, including buying individual insurance through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your Plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your Plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your Plan. For more information about your rights, this notice, or assistance, contact the Fund Office at 1-877-876-9357 or Blue Cross and Blue Shield of Michigan by calling the number on the back of your BCBSM ID card.

Additionally, a consumer assistance program can help you file your appeal. Contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or http://www.michigan.gov/difs or difs-HICAP@michigan.gov.

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, certain Medicare and Medicaid coverage, 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:
For assistance in a language below, please call the number on the back of your BCBSM ID card.
Spanish (Español): Para ayuda en Español, llame al número de servicio al cliente que se encuentra en este aviso ó en el reverso de su tarjeta de identificación.

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** **$1,000**
- **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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,870**

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

- **The Plan's overall deductible** **$1,000**
- **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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

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

- **The Plan's overall deductible** **$1,000**
- **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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$50
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,250**

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