
 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 <u>deductible</u> ?	\$ 1,000 Individual / \$2,000 Family	\$2,000 Individual / \$4,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>Plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .		This <u>Plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>Plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.		You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$8,550 Individual / \$17,100 Family	\$17,100 Individual / \$34,200 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>Plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Balance-billing</u> charges, any <u>pharmacy</u> penalty and health care this <u>plan</u> doesn't cover.		Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbsm.com or call the number on the back of your BCBSM ID card for a list of <u>network providers</u> .		This <u>Plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>Plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>Plan</u> pays (<u>balance billing</u>). Be aware that your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.		You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 .

For more information about limitations and exceptions, see the plan or policy document at www.outstatetroweltrades.org or by calling 1-877-876-9357.

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 <u>copayment</u>	\$150 <u>copayment</u>	<u>Copayment</u> waived if admitted or for an accidental injury.
	Emergency medical transportation	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	Must be medically necessary.
	Urgent care	\$20 <u>copayment</u>	40% <u>coinsurance</u> after <u>deductible</u>	Must be medically necessary.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> may be required. Nonemergency services must be provided in a participating hospital.
	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	<u>Out-of-network</u> non-participating <u>providers</u> may <u>balance bill</u> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	Nonemergency services must be provided in a participating facility.
	Inpatient services	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> may be required.
If you are pregnant	Office visits	No charge.	40% <u>coinsurance</u> after <u>deductible</u>	Maternity care may include services described elsewhere in the SBC (i.e., tests) and cost share may apply. <u>Cost sharing</u> does not apply to certain maternity services considered to be <u>preventive</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	None.
	Childbirth/delivery facility services	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	None.
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> is required.
	Rehabilitation services	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	Not covered.	Not covered.	None.

For more information about limitations and exceptions, see the plan or policy document at www.outstatetroweltrades.org or by calling 1-877-876-9357.

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)	
	Skilled nursing care	20% <u>coinsurance</u> after deductible	20% <u>coinsurance</u> 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% <u>coinsurance</u> after deductible	20% <u>coinsurance</u> after deductible	Excludes bath, exercise and deluxe equipment, comfort and convenience items, and items without a prescription.
	Hospice services	No charge.	No charge.	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; <u>Out-of-network</u> providers may <u>balance bill</u> .
	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% <u>coinsurance</u> for preventive services only	0% <u>coinsurance</u> for preventive services only	None.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Acupuncture treatment Cosmetic surgery Hearing aids 	<ul style="list-style-type: none"> Infertility treatment Long-term care Routine foot care 	<ul style="list-style-type: none"> Weight loss programs Applied Behavioral Analysis (ABA) treatment
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> Bariatric surgery (medically necessary) Chiropractic care Coverage provided outside the U.S. (see http://provider.bcbs.com) 	<ul style="list-style-type: none"> Dental care (Adult) (Class I Only) Non-Emergency care when traveling outside the U.S. (when coordinated through Blue Card) 	<ul style="list-style-type: none"> Private-duty nursing Routine eye care (Adult)

For more information about limitations and exceptions, see the plan or policy document at www.outstatetroweltrades.org or by calling 1-877-876-9357.

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 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$20
Coinsurance	\$2,000
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,080

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$1,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,220

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$200
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,400

The [Plan](#) would be responsible for the other costs of these EXAMPLE covered services.