**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, or call 1-866-887-4338. 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/healthreform.com or call 1-855-756-4448 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $500 / individual or $1,000 / family for in-network; $1,000 / individual or $2,000 / family for out-of-network | 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. In-network preventive care is 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?** | For network providers $2,000 individual / $4,000 family; for out-of-network providers $4,000 individual / $8,000 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?** | Copayments, out- of-network balance-billing, deductible, 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 1-877-790-2583 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 | $30 copay/office visit | 30% coinsurance after deductible | Out-of-Network providers may balance bill. |
| | Specialist visit | $30 copay/visit | 30% coinsurance after deductible | Out-of-Network providers may balance bill. |
| | Preventive care/screening/ immunization | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance after deductible | 30% coinsurance after deductible | Out-of-Network providers may balance bill. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance after deductible | 30% coinsurance after deductible | Out-of-Network providers may balance bill. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.bcbsm.com/pharmacy | Generic drugs (Tier 1) | $10 copay 1-30 day; $20 copay 84-90 day supply | $10 copay plus an additional 25% of BCBSM approved amount for the drug. | For information on women's contraceptive coverage, contact your Administrator.<br><br>Mail order drugs are not covered out-of-network. |
| | Preferred brand drugs (Tier 2) | $40 copay 1-30 day; $80 copay 84-90 day supply | $40 copay plus an additional 25% of BCBSM approved amount for the drug. | |
| | Non-preferred brand drugs (Tier 3) | $80 copay 1-30 day; $160 copay 84-90 day supply | $80 copay plus an additional 25% of BCBSM approved amount for the drug. | |
| | Specialty drugs | Prior authorization must be obtained. | | Limited to a 30 day supply of a covered prescription drug. |

| 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 have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible | 30% coinsurance after deductible | Out-of-Network providers may balance bill. |
| | Physician/surgeon fees | 20% coinsurance after deductible | 30% coinsurance after deductible | Out-of-Network providers may balance bill. |
| **If you need immediate medical attention** | Emergency room care | $100 copay/visit | $100 copay/visit | Copayment waived in admitted or for an accidental injury. Out-of-Network providers may balance bill. |
| | Emergency medical transportation | 20% coinsurance after deductible | 20% coinsurance after deductible | Must be medically necessary. Out-of-Network providers may balance bill. |
| | Urgent care | $30 copay/visit | 30% coinsurance after deductible | Out-of-Network providers may balance bill. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance after deductible | 30% coinsurance after deductible | Unlimited days; must be pre-certified; not pre-certified $500 penalty. |
| | Physician/surgeon fees | 20% coinsurance after deductible | 30% coinsurance after deductible | Out-of-Network providers may balance bill. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance after deductible | 30% coinsurance after deductible | Out-of-Network providers may balance bill. |
| | Inpatient services | 20% coinsurance after deductible | 30% coinsurance after deductible | Out-of-Network providers may balance bill. |
| **If you are pregnant** | Office visits | 0% coinsurance for prenatal and postnatal care. | 30% coinsurance after deductible | Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Out-of-Network providers may balance bill. |
| | Childbirth/delivery professional services | 20% coinsurance after deductible | 30% coinsurance after deductible | |
| | Childbirth/delivery facility services | 20% coinsurance after deductible | 30% coinsurance after deductible | Non-participating facilities are not covered. |

| 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 help recovering or have other special health needs** | Home health care | 20% coinsurance after deductible | 20% coinsurance after deductible | Must be medically necessary and provided by a participating home health care agency. Out-of-Network providers may balance bill. |
| | Rehabilitation services | 20% coinsurance after deductible | 30% coinsurance after deductible | Physical, Occupational, Speech therapy is limited to a combined maximum of 60 visits per member per calendar year. Out-of-Network providers may balance bill. |
| | Habilitation services | Not covered | Not covered | None. |
| | Skilled nursing care | 20% coinsurance after deductible | 20% coinsurance after deductible | Must be provided by a participating skilled nursing facility. Limited to a maximum of 120 days per member per calendar year. |
| | Durable medical equipment | 20% coinsurance after deductible | 20% coinsurance after deductible | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. |
| | Hospice services | 0% coinsurance after deductible | 0% coinsurance after deductible | Provided through a participating hospice program only. |
| **If your child needs dental or eye care** | Children's eye exam | $5 copay for exam; | Reimbursed up to $50 less $5 copay for exam; | Limited to one exam in any period of 12 consecutive months. |
| | Children's glasses | $7.50 copay for glasses | $7.50 copay plus difference of approved amount for glasses | Limited to one pair of lenses and one frame in any period of 12 consecutive months. |
| | Children's dental check-up | 0% coinsurance for preventive services only | | $1,200 maximum benefit per person per calendar year. |

## 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
- Naprapath services and treatment
- 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 (if medically necessary)
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- 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, Employee Benefits Security Administration, 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 the Fund Office at 1-866-887-4338. 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.

**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 1-866-887-4338.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-887-4338.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-887-4338.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-887-4338.

*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 | $30 |
| 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 | $500 |
| Copayments | $10 |
| Coinsurance | $1,900 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,470** |

### 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 | $30 |
| 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* | $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 | $500 |
| Specialist copayment | $30 |
| 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* | $500 |
| Copayments | $200 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,000** |

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