



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](http://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](http://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](http://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 <a href="#">deductible</a> ?                                | \$ 1,000 Individual /<br>\$2,000 Family   | \$2,000 Individual<br>/ \$4,000 Family   | Generally, you must pay all of the costs from <a href="#">providers</a> 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 <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> 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 don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$10,600 Individual /<br>\$21,200 Family  | \$21,200 Individual /<br>\$42,400 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, any <a href="#">pharmacy</a> penalty 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 the number on the back of your BCBSM ID card for a list of <a href="#">network providers</a> .  |  | This <a href="#">Plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">Plan's 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 <a href="#">provider's</a> charge and what your <a href="#">Plan</a> pays ( <a href="#">balance billing</a> ). Be aware that 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 a <a href="#">referral</a> .  |



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<br>(You will pay the least)   | Out-of-Network Provider<br>(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 co-pay  | 40% <a href="#">coinsurance</a>                                    | <a href="#">Out-of-network</a> non-participating <a href="#">providers</a> may <a href="#">balance bill</a> .  |
|   | <a href="#">Specialist</a> visit                       | \$20 co-pay  | 40% <a href="#">coinsurance</a>                                    | <a href="#">Out-of-network</a> non-participating <a href="#">providers</a> may <a href="#">balance bill</a> .  |
|   | <a href="#">Preventive care/screening/immunization</a> | No charge.   | Not covered.   | You may have to pay for services that are not preventive. Ask your <a href="#">provider</a> if the services needed are preventive.   |
| <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>                                    | <a href="#">Out-of-network</a> non-participating <a href="#">providers</a> may <a href="#">balance bill</a> .  |
|   | Imaging (CT/PET scans, MRIs)                           | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>                                    | <a href="#">Out-of-network</a> non-participating <a href="#">providers</a> may <a href="#">balance bill</a> . May require <a href="#">preauthorization</a> .   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.bcbsm.com/druglists">www.bcbsm.com/druglists</a> | 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    | <a href="#">Preauthorization</a> , step therapy and quantity limits may apply to select drugs. Without <a href="#">Preauthorization</a> , you may be responsible for the full cost of the drug. <a href="#">Preventive</a> 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.<br><br>You pay 50% of the approved amount up to a maximum of \$250 for weight loss drugs.<br><br>For certain high-cost drugs, co-pays are increased to 30%, but the Fund has a program which will assist you by identifying available manufacturer assistance coupons. |
|   | 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    |  |
|   | <a href="#">Specialty drugs</a>                        | Same as above based on class; generic, preferred or non-preferred.                         | Same as above based on class; generic, preferred or non-preferred. |  |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)         | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>                           | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>   | <a href="#">Out-of-network</a> non-participating <a href="#">providers</a> may <a href="#">balance bill</a> .  |
|   | Physician/surgeon fees                                 | 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>                           | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>   | <a href="#">Out-of-network</a> non-participating <a href="#">providers</a> may <a href="#">balance bill</a> .  |

| Common Medical Event  | Services You May Need                            | What You Will Pay                              |  | Limitations, Exceptions, & Other Important Information   |
|---|--|--|--|--|
|   |  | Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$150 <u>copayment</u>                         | \$150 <u>copayment</u>                             | <u>Copayment</u> waived if admitted or for an accidental injury.   |
|   | <a href="#">Emergency medical transportation</a> | 20% <u>coinsurance</u> after <u>deductible</u> | 40% <u>coinsurance</u> after <u>deductible</u>     | Mileage limits apply. Must be medically necessary.   |
|   | <a href="#">Urgent care</a>                      | \$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 non-participating 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            | <a href="#">Home health care</a>                 | 20% <u>coinsurance</u> after <u>deductible</u> | 40% <u>coinsurance</u> after <u>deductible</u>     | <u>Preauthorization</u> is required.   |
|   | <a href="#">Rehabilitation services</a>          | 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.   |

| Common Medical Event                          | Services You May Need                     | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information  |
|---|---|---|---|---|
|   |   | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)  |   |
|   | <a href="#">Habilitation services</a>     | 20% <u>coinsurance</u> after <u>deductible</u> for Applied Behavior Analysis (ABA) and Physical, Speech and Occupational Therapy. | 20% <u>coinsurance</u> after <u>deductible</u> for ABA; 40% <u>coinsurance</u> after <u>deductible</u> for Physical, Speech and Occupational Therapy. | ABA treatment for autism must be provided by an approved, licensed behavior analyst and subject to <u>preauthorization</u> .  |
|   | <a href="#">Skilled nursing care</a>      | 20% <u>coinsurance</u> after <u>deductible</u>  | 20% <u>coinsurance</u> after <u>deductible</u>  | Limited to a maximum of 120 days per member per calendar year. Must be in a participating skilled nursing facility.   |
|   | <a href="#">Durable medical equipment</a> | 20% <u>coinsurance</u> after <u>deductible</u>  | 20% <u>coinsurance</u> after <u>deductible</u>  | Excludes bath, exercise and deluxe equipment, comfort and convenience items, and items without a prescription.  |
|   | <a href="#">Hospice services</a>          | No charge.  | No charge.  | <u>Preauthorization</u> required. Must be provided through a participating hospice program.   |
| <b>If your child needs dental or eye care</b> | 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 [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/healthreform](http://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](http://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](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 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](http://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](mailto: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.

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

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## 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 <u>deductible</u>   | \$1,000 |
| ■ <u>Specialist copayment</u>            | \$20    |
| ■ <u>Hospital (facility) coinsurance</u> | 20%     |
| ■ Other <u>coinsurance</u>               | 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>\$12,700</b> |
|---------------------------|-----------------|

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

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,000        |
| Copayments                        | \$20           |
| Coinsurance                       | \$1,800        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,870</b> |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|  |         |
|--|---------|
| ■ The Plan's overall <u>deductible</u>   | \$1,000 |
| ■ <u>Specialist copayment</u>            | \$20    |
| ■ <u>Hospital (facility) coinsurance</u> | 20%     |
| ■ Other <u>coinsurance</u>               | 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>\$5,600</b> |
|---------------------------|----------------|

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

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$900          |
| Copayments                        | \$600          |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,520</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|  |         |
|--|---------|
| ■ The Plan's overall <u>deductible</u>   | \$1,000 |
| ■ <u>Specialist copayment</u>            | \$20    |
| ■ <u>Hospital (facility) coinsurance</u> | 20%     |
| ■ Other <u>coinsurance</u>               | 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>\$2,800</b> |
|---------------------------|----------------|

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

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,000        |
| Copayments                        | \$50           |
| Coinsurance                       | \$200          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,250</b> |