MICHIGAN TROWEL TRADES HEALTH AND WELFARE FUND

Coverage Period: 1/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers and What it Costs **Coverage for:** All Actives Individual/Family **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.outstatetroweltrades.org or by calling 1-877-876-9357.

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	With the exception of preventive care, you must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.		You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	$7,150 Individual/ $14,300 Family	$14,300 Individual/ $28,600 Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. The co-insurance maximum is $1,000 individual and $2,000 family in-network and $3,000 individual and $6,000 family out-of-network. The **out-of-pocket limit** for Individual coverage applies to all individuals (regardless of whether the individual has Individual or Family coverage). For example, a Family cannot have cost sharing exceed $7,150 for any individual family member on the contract.
What is not included in the out-of-pocket limit?	Balance-billed charges and health care services this plan doesn't cover.		Even though you pay these expenses, they do not count toward the **out-of-pocket limit**. Copayments and deductibles do not count toward the co-insurance maximum, but they do count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.bcbsm.com or call 1-877-790-2583.		If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.		You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.		Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-876-9357 or visit us at www.outstatetroweltrades.org. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-877-876-9357.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay	40% co-insurance after deductible	Out of network non-participating providers may balance bill.
	Specialist visit	$20 co-pay	40% co-insurance after deductible	Out of network non-participating providers may balance bill.
	Other practitioner office visit	$20 co-pay for chiropractic and osteopathic manipulative therapy	40% co-insurance after deductible for chiropractic and osteopathic manipulative therapy	Limited to 24 visits per year for chiropractic and osteopathic manipulative therapy. Out of network non-participating providers may balance bill.
	Preventive care/ screening/immunization	No Charge	Not Covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance after deductible	40% co-insurance after deductible	Out of network non-participating providers may balance bill.
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible	40% co-insurance after deductible	Out of network non-participating 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/druglists)	Generic or select prescribed over-the-counter 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	90-day supply not covered out-of-network. Prescriptions filled at Sam's Club or Wal-Mart pharmacy are not covered.
	Preferred brand-name 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	90-day supply not covered out-of-network. Prescriptions filled at Sam's Club or Wal-Mart pharmacy are not covered.
	Non-preferred brand-name 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	90-day supply not covered out-of-network. Prescriptions filled at Sam's Club or Wal-Mart pharmacy are not covered.
	Specialty drugs	Same as above based on class; generic, preferred or non-preferred.	Same as above based on class; generic, preferred or non-preferred.	Limited to a 15 or 30 day supply per fill. Prescriptions filled at Sam's Club or Wal-Mart pharmacy are not covered.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	40% co-insurance after deductible	Out of network non-participating providers may balance bill.
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	Out of network non-participating providers may balance bill.
If you need immediate medical attention	Emergency room services	$150 co-pay	$150 co-pay	Co-pay waived if admitted or for an accidental injury.
	Emergency medical transportation	20% co-insurance after deductible	40% co-insurance after deductible	Must be medically necessary.
	Urgent care	$20 co-pay	40% co-insurance after deductible	Must be medically necessary.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible	40% co-insurance after deductible	Nonemergency services must be provided in a participating hospital.
	Physician/surgeon fee	20% co-insurance after deductible	40% co-insurance after deductible	Out of network non-participating providers may balance bill.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	Nonemergency services must be provided in a participating hospital.
	Mental/Behavioral health inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	Nonemergency services must be provided in a participating hospital.
	Substance use disorder outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	Nonemergency services must be provided in a participating hospital.
	Substance use disorder inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	Nonemergency services must be provided in a participating hospital.
If you are pregnant	Prenatal and postnatal care	No Charge	40% co-insurance after deductible	Out of network non-participating providers may balance bill.
	Delivery and all inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	Out of network non-participating providers may balance bill.
If you need help recovering or have other special health needs	Home health care	20% co-insurance after deductible	40% co-insurance after deductible	Must be medically necessary and provided by a participating home health care agency.
	Rehabilitation services	20% co-insurance after deductible	40% co-insurance after deductible	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---

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs (cont'd)	Skilled nursing care	20% co-insurance after deductible	20% co-insurance 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% co-insurance after deductible	20% co-insurance after deductible	---none---
	Hospice service	No Charge	No Charge	Must be provided through a participating hospice program.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Eye exam	$5 co-pay	$5 co-pay plus 25% of the approved amount less the co-pay.	Eye exams covered once every 12 consecutive months; Out-of-network may balance bill.
	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 providers charge.	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.
	Dental check-up	0% co-insurance for preventive services only	0% co-insurance for preventive services only	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (medical necessity)
- Chiropractic Care
- 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:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-876-9357. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Fund by calling 1-877-876-9357. Or, you can contact Michigan Office of Financial and Insurance Regulation at **www.michigan.gov/ofir** or 1-877-999-6442. For group health coverage subject to ERISA, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This Plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Please note: Coverage examples are calculated based on individual coverage and calculations may not include a coinsurance maximum.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,370
- **Patient pays** $2,170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Co-pays	$20
Co-insurance	$1,000
Limits or exclusions	$150
Total	**$2,170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,420
- **Patient pays** $1,980

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,000
Co-pays	$680
Co-insurance	$220
Limits or exclusions	$80
Total	**$1,980**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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