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, go to www.michigancarpenters.org or call 1-800-273-5739. 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 https://www.healthcare.gov/sbc-glossary or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,000 / Individual or $2,000 / family for in-network; $2,000 / Individual or $4,000 / 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. Preventive care and primary 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.	There are no other deductibles.
What is the out-of-pocket limit for this plan?	Out-of-Pocket Limit: $6,350 Individual/$12,700 Family in-network; $12,700 Individual/ $25,400 Family out-of-network. NOTE: Within the out-of-pocket limits above there is a $5,350 Individual/$10,700 per family in-network coinsurance maximum; $10,700 Individual/$21,400 Family out-of-network coinsurance maximum	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. Coinsurance/Copayment amounts apply to the out-of-pocket maximums.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Non-covered services, premiums, balance-billing charges, pharmacy penalties, amount's you contribute to the plan and certain other amounts. Copayments do not apply to coinsurance maximums.	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.myibxtpabenefits.com or call 1-833-242-3330 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	$40 copay/office visit	40% coinsurance after deductible	Out-of-network providers may balance bill.
	Specialist visit	$40 copay/visit	40% 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	40% coinsurance after deductible	Preauthorization may be required for select imaging tests. Out-of-network providers may balance bill.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.express-scripts.com**. For information about the SaveOn's Coupon Program call 1-800-683-1074. For information about Specialty drugs call Accredo Specialty at 1-800-803-2523.	Generic drugs (Tier 1)	$20 copay 1-30 days; $40 copay 84-90 days	$20 copay 1-30 days; $40 copay 84-90 days plus 25% of Express Scripts approved amount.	Prior Authorization/Step Therapy for select drugs may be required. **Prescription Drug Manufacturer Coupon Assistance Program is mandatory for Participants taking specialty prescription drugs when a manufacturer's coupon is available.** SaveOn's Coupon Savings Program, the program administrator, will contact the Participant. If a Manufacturer Coupon is not used, the Participant's cost sharing is 30% of the cost of the prescription drug.
	Preferred brand drugs (Tier 2)	$60 copay 1-30 days; $120 copay 84-90 days	$60 copay 1-30 days; $120 copay 84-90 days plus 25% of Express Scripts approved amount.	
	Non-preferred brand drugs (Tier 3)	50% of the approved amount, up to a maximum of $300 copay	50% of the approved amount up to $300 copay plus 25% of Express Scripts approved amount.	
	Specialty drugs	Copay will vary based on drug class, limited to a 30-day supply, plus 25% coinsurance for out-of-network		Prior Authorization for Specialty drugs required. Specialty drugs can be generic, preferred or non-preferred drugs and must be filled through Accredo Specialty Pharmacy
	Lifestyle drugs	50% copay of the approved amount	50% copay plus 25% of Express Scripts approved amount.	Examples of lifestyle drugs are fertility, impotence, weight loss, etc.

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	40% coinsurance after deductible	Must be rendered in a participating ambulatory surgery center.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	Out-of-network providers may balance bill.
If you need immediate medical attention	Emergency room care	$250 copay	$250 copay	Copayment waived if admitted or for an accidental injury. Out-of-network providers may balance bill.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Mileage limits apply. Out-of-network providers may balance bill.
	Urgent care	$40 copay/visit	40% coinsurance	Out-of-network providers may balance bill.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Non-emergency services must be rendered in a participating hospital. Preauthorization is required.
	Physician/surgeon fees	20% coinsurance after deductible	40% 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	40% coinsurance after deductible	Out-of-network providers may balance bill. Treatment must be preauthorized and performed in an approved facility for inpatient services. Non-participating facilities are not covered.
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	
If you are pregnant	Office visits	No charge	40% coinsurance after deductible	Maternity care may include services described elsewhere in this SBC (e.g., lab tests) that are subject to cost sharing. Cost sharing does not apply to certain maternity services considered to be preventive. Out-of-network providers may balance bill. Non-participating facilities are not covered.
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	20% coinsurance after deductible	Physician certification required. Out-of-network providers may balance bill.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Services at non-participating outpatient physical therapy facilities are not covered.
	Habilitation services	20% coinsurance after	40% coinsurance after	Services at non-participating outpatient

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)	
		deductible	deductible	physical therapy facilities are not covered.
	Skilled nursing care	20% coinsurance after deductible	20% coinsurance after deductible	Preauthorization is required. Must be in a participating skilled nursing facility. Limited to 120 days per calendar year.
	Durable medical equipment	20% coinsurance after deductible	20% coinsurance after deductible	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required. Out-of-network providers may balance bill.
	Hospice services	No charge	No charge	Covered through a participating hospice program only. Physician certification required. Visit limits apply.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	0% coinsurance for preventive services subject to $1,000 per person annual limit.		Out-of-network dentists may balance bill

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
- Hearing aids
- Long-term care
- Routine foot care
- Vision
- 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
- Chiropractic care
- Routine dental care (Adult)
- Care when traveling outside of the U.S.
- Private-duty nursing

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 https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families. 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: www.michigancarpenters.org or 1-800-273-5739.

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 1-800-273-5739.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-273-5739.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-273-5739.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-273-5739.

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	$40
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	$0
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$2,970**

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	$40
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*	$1,000
Copayments	$920
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,020**

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

The plan's overall deductible	$1,000
Specialist copayment	$40
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	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,610**

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