MICHIGAN CARPENTERS HEALTH CARE FUND – STANDARD PLAN

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Coverage Period: 09/01/2018 – 08/31/2019
Coverage for: Individual + Spouse, Family | **Plan Type:** PPO

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 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?	$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 the costs for services up to the deductible amount before this plan begins to pay. NOTE: Services that require a copayment or are covered in full are not subject to the deductible. See below for these services. If you have other family members on the plan, costs for each family member are subject to the individual deductible maximum until the 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 services are covered before you meet your deductible (i.e., not subject to the deductible). Additionally, office visit services are not subject to the deductible but are subject to a copayment.	This plan covers some items and services even if you haven't yet met the deductible amount. For some services, a copayment or coinsurance may apply. For example, this plan covers certain preventive services without any cost-sharing. For office visits a fixed copayment would apply, but not the 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 (TROOP) 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 (also called the "TROOP" limit) is the most you could pay in a year for covered services. If you have other family members in this plan, each family member must meet the individual out-of-pocket limit until the overall family out-of-pocket limit has been met. Coinsurance/Copayment amounts apply to the out-of-pocket maximums.

What is not included in the out-of-pocket limit?	Non-covered services, premiums, balance billing charges, pharmacy penalties, amounts 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.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 more if you use an out-of-network provider. If you use a non-participating provider, you will be responsible for out-of-network cost sharing plus 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 permission from this plan.

Some 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 copayment/office visit	40% coinsurance after deductible	Copayments/Coinsurance/Deductible is waived for emergency/accidental care at an office or clinic. Non-participating providers may balance bill.
	Specialist visit	$40 copayment/office visit	40% coinsurance after deductible	Non-participating providers may balance bill.
	Preventive care/screening/ immunization	Covered: (deductible/coinsurance /copayment do not apply)	Not Covered	You may have to pay for services that aren't preventive. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after the deductible	40% coinsurance after the deductible	Preauthorization may be required for select imaging tests. Non-participating providers may balance bill.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after the deductible	40% coinsurance after the deductible	
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)	$20 copayment /prescription (1-30 days) $40 copayment (84-90 days)	$20 copayment/prescription (1-30 days); $40 copayment (84-90 days) plus 25% of BCBSM approved amount	Prior Authorization/Step Therapy for select drugs may be required.
	Preferred brand drugs (Tier 2)	$60 copayment /prescription (1-30 days) $120 copayment (84-90 days)	$60 copayment/prescription (1-30 days); $120 copayment (84-90 days) plus 25% of BCBSM approved amount	
	Non-preferred brand drugs (Tier 3)	50% of the approved amount, no more than $300 copayment per prescription	50% of the approved amount, no more than $300 copayment per prescription plus 25% of BCBSM approved amount	
	Specialty Drugs	Copayment will vary based on drug class. Limited to a 30-day supply. Additional 25% coinsurance applies Out-of-Network.		Specialty drugs can be generic, preferred or non-preferred drugs.
	Lifestyle Drugs	50% copayment of approved amount	50% copayment plus 25% BCBSM 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	20% coinsurance after deductible	Must be rendered in a participating ambulatory surgery center
	Physician/surgeon fees	20% coinsurance after the deductible	40% coinsurance after deductible	Non-participating providers may balance bill
If you need immediate medical attention	Emergency room care	$250 copayment	$250 copayment	Copayment waived if admitted or for an accidental injury. Non-participating providers may balance bill.
	Emergency medical transportation	20% coinsurance after the deductible	20% coinsurance after the deductible	Non-participating providers may balance bill
	Urgent care	$0 deductible/ coinsurance/copayment	$0 deductible/coinsurance/ copayment	Deductible/coinsurance/copayment waived for emergency services. Non-participating providers may balance bill
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after the deductible	40% coinsurance after the deductible	Non-emergency services must be rendered in a participating hospital.
	Physician/surgeon fees	20% coinsurance after the deductible	40% coinsurance after the deductible	Non-participating providers may balance bill
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after the deductible	40% coinsurance after the deductible	Non-participating 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 the deductible	40% coinsurance after the deductible	
If you are pregnant	Office visits	Prenatal/Postnatal Care: Covered (deductible/coinsurance /copayment does not apply)	40% coinsurance after the 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. See list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ Non-participating providers may balance bill. Non-participating facilities are not covered.
	Childbirth/delivery professional services	20% coinsurance after the deductible	40% coinsurance after the deductible	
	Childbirth/delivery facility services	20% coinsurance after the deductible	40% coinsurance after the deductible	

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 the deductible	20% coinsurance after the deductible	Non-participating providers are not covered.
	Rehabilitation services	20% coinsurance after the deductible	40% coinsurance after deductible	Services at non-participating outpatient physical therapy facilities are not covered.
	Habilitation services	20% coinsurance after the deductible	40% coinsurance after deductible	
	Skilled nursing care	20% coinsurance after the deductible	20% coinsurance after the deductible	Must be in a participating skilled nursing facility. Limited to 120 days per calendar year.
	Durable medical equipment	20% coinsurance	20% coinsurance	Non-participating providers may balance bill.
	Hospice services	Covered (deductible/coinsurance /copayment does not apply)	Covered (deductible/coinsurance/ copayment does not apply)	Covered through a participating hospice program only.
If your child needs dental or eye care	Children's eye exam	Discounts available through VSP	Discounts available through VSP	----------none----------
	Children's glasses			----------none----------
	Children's dental check-up	0% coinsurance for preventive services subject to $1,000 per person annual limit.		Non-participating 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
- 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 (medical necessity)
- Chiropractic Care
- Routine Dental care (Adult)
- Routine Eye 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 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 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. You may also contact the Department of Laborer Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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.]

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	$20,000

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$3,800
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$4,800

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	$3,000

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$40
Coinsurance	$392
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,432

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	$4,000

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$250

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