LABORERS' METROPOLITIAN DETROIT HEALTH CARE FUND

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Coverage Period: 10/01/2018 – 09/30/2019
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.metrodetroitlaborers.org or call 1-800-228-0048. 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?	$0 Individual/$0 Family for in-network and out-of-network services	See the chart starting on Page 2 for how much you pay for covered services. As noted there is no deductible.
Are there services covered before you meet your deductible?	Yes. There is no deductible required for services to be covered.	You don't have any deductibles for services, but see the chart starting on page 2 for other costs for services this plan covers.
Are there other deductibles for specific services?	No	There are no deductibles.
What is the out-of-pocket limit for this plan?	Out-of-pocket (TROOP) In-network Limit: $6,600 Individual/$13,200 Family Out-of-network Limit: $6,600 Individual/$13,200 Family Note: Within the out-of-pocket limit above there is a $1,000 coinsurance family maximum in-network and a $1,000 family coinsurance maximum out-of-network. (Copayments noted throughout do not apply to the coinsurance maximum noted above.)	The out-of-pocket limit (also called TROOP) 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.	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.

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	20% coinsurance	30% coinsurance	Non-participating providers may balance bill
	Specialist visit	20% coinsurance	30% coinsurance	Non-participating providers may balance bill
	Preventive care/screening/ immunization	Covered (no coinsurance/ copayment)	30% coinsurance	You may have to pay in-network cost sharing for services that are not preventive. See a list of covered preventive services at https://www.healthcare/gov/coverage/ preventive-care-benefits Non-participating providers may balance bill
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	Non-participating providers may balance bill
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	Preauthorization may be required for select imaging tests. 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/pharmacy	Generic drugs (Tier 1)	$20 copayment for 30-day supply; $40 copayment for 84-90 day supply	In-network copayment plus an additional 25% coinsurance based on BCBSM approved amount	Step therapy and/or prior authorization may apply.
	Preferred brand drugs (Tier 2)	$60 copayment for 30-day supply; $120 copayment for 84-90 day supply	In-network copayment plus an additional 25% coinsurance based on BCBSM approved amount	
	Non-preferred brand drugs (Tier 3)	$100 copayment for 30-day supply; $200 copayment for 84-90 day retail supply	In-network copayment plus an additional 25% coinsurance based on BCBSM approved amount	
	Generic and preferred brand-name specialty drugs – (Tier 4)	20% copayment with a maximum of $200 for a 30-day supply; 84-90 day supply not covered	In-network copayment plus an additional 25% coinsurance based on BCBSM approved amount	Step Therapy and/or prior authorization may apply
	Non-preferred brand-name specialty drugs – (Tier 5)	25% copayment with a maximum of $300 for a 30-day supply; 84-90 day supply not covered	In-network copayment plus an additional 25% coinsurance based on BCBSM approved amount	Step therapy and/or prior authorization may apply
	Lifestyle Drugs	Not Covered	Not Covered	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	20% coinsurance	Services must be rendered in a participating ambulatory surgery center.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	Non-participating providers may balance bill
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Non-participating providers may balance bill
	Emergency medical transportation	20% coinsurance	20% coinsurance	Non-participating providers may balance bill
	Urgent care	20% coinsurance	30% coinsurance	Non-participating providers may balance bill
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Non-emergency services must be rendered in a participating hospital.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	Non-participating providers may balance bill
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	Must be performed in an approved facility Non-participating providers may balance bill
	Inpatient services	20% coinsurance	30% coinsurance	Must be performed in an approved facility Non-participating providers may balance bill
If you are pregnant	Office visits	Prenatal care covered (no coinsurance) 20% coinsurance for postnatal care.	30% coinsurance	Non-participating providers may balance bill
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	Non-participating providers may balance bill
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	Non-participating facilities are not covered
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Must be provided by a participating home health care agency
	Rehabilitation services	20% coinsurance	30% coinsurance	Services at non-participating outpatient physical therapy facilities are not covered.
	Habilitation services	20% coinsurance	30% coinsurance	
	Skilled nursing care	20% coinsurance	20% coinsurance	Must be in a participating skilled nursing facility.
	Durable medical equipment	20% coinsurance	20% coinsurance	Non-participating providers may balance bill
	Hospice services	0% coinsurance	0% coinsurance	Provided through a participating hospice program only.

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 your child needs dental or eye care	Eye exam	Covered (no copayment) for exams, lenses and medically necessary contact lenses; $250 frame allowance; $250 elective contact lens allowance; $60 copayment for fit and follow-up for contact lens	Member responsible for difference between BCBSM approved amount and provider's charge for eye exam, lens and frames and contact lens. Eye exam reimbursed up to $45; frames reimbursed up to $70; medically necessary contact lens reimbursed up to $210; elective contact lens reimbursed up to $105.	Eye exams, lenses and frames and/or contact lenses covered once every calendar year. Benefits are reduced if using a non-participating provider. Prior authorization required for medically necessary contact lens coverage. Must use VSP provider for progressive lens to be covered.
	Glasses			
	Dental check-up	0% co-insurance for preventive services only		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
- Long Term Care
- Routine Foot Care (not medically necessary)
- 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
- Hearing aids
- Routine Dental care (Adult)
- Routine Eye care (Adult)
- Autism Spectrum Disorder
- 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.metrodetroitlaborers.org or 1-800-228-0048. 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 1-800-228-0048.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-228-0048.]
[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-228-0048.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-228-0048.]
———————————*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	$0
Specialist coinsurance	20%
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	$0
Copayments	$0
Coinsurance	$3,600
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$1,000

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist coinsurance	20%
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	$0
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$560

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

The plan's overall deductible	$0
Specialist coinsurance	20%
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	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$800

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ئەگەر تۆ، یان کەسێک کە تۆ یارمەتی دەدەیت، پێویستی بە یارمەتی هەیە، مافی ئەوەت هەیە بە بێ هیچ تێچوونێک یارمەتی و زانیاری پێویست بە زمانەکەت وەربگریت. بۆ قسەکردن لەگەڵ وەرگێڕ، پەیوەندی بە ژمارەی خزمەتگوزاری بەکارهێنەران بکە کە لەسەر کارتەکەت هەیە، یان 877-469-2583 TTY:711، ئەگەر ئەندام نیت.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号 (メンバーでない方は 877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.