BAC OF MICHIGAN
HEALTH AND WELFARE FUND

Summary of Benefits and Coverage

BAC of Michigan Health and Welfare Fund: BCBSM

Coverage for: Eligible Participants & Dependents | 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, visit www.BACLocal2Benefits.org or by phone at 248-828-6000. 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.healthcare.gov/sbc-glossary or call 1-800-318-2596 to request a copy.*

Important Questions			***Why This Matters:***
	In-Network	***Out-Of-Network***	
What is the overall deductible?	*$250/ Individual or $750/ family*	*$250/ Individual or $750/ family*	*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.*	*Yes.*	*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 specific deductibles.*	*No. There are no other specific deductibles.*	*You don't have to meet deductibles for specific services.*
What is the out-of-pocket limit for this plan?	*Coinsurance maximum for medical benefits: $1,000 individual / $2,000 family; "True" OOP max: $7,900 Individual / $15,800 Family*	*Coinsurance maximum for medical benefits: $3,000 individual / $6,000 family; "True" OOP max: $15,800 Individual/ $31,600 Family*	*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*
What is not included in the out-of-pocket limit?	*"True" OOP max: premiums, balance-billing, and health care this plan doesn't cover. Coinsurance max for medical benefits: fixed dollar and private duty nursing Copayments, deductibles, premiums, balance-billing charges, and health care this plan doesn't cover.*		*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 website 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*	*$25 copay/office visit*	*Not Covered*	*Deductible does not apply.*
	Specialist visit	*$25 copay/office visit*	*Not Covered*	
	Preventive care/screening/ immunization	*No charge*	*Not Covered*	
If you have a test	*Diagnostic test (x-ray, blood work)*	*20% coinsurance after deductible*	*40% coinsurance after deductible*	*None*
	Imaging (CT/PET scans, MRIs)	*20% coinsurance after deductible*	*40% coinsurance after 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 drugs to treat your illness or condition More information about prescription-drug-coverage **prescription drug coverage** is available at www.bcbsm.com/druglists (800) 437-3803	Generic drugs	$5 copay/retail No charge/mail order	25% of the approved amount, after the $5 copayment	Prescription Drug Benefits are available only for Active Participants, COBRA Participants, and non-bargaining unit Participants. **Non-Medicare Eligible Retirees and their Dependents are not eligible for Prescription Drug Benefits.** Prior authorization is required for specialty drugs; dispensing of specialty drugs must be through a retail pharmacy that participates in the BCBS Preferred Rx Pharmacy program. Mail orders must use the designated Specialty Drug Vendor. Initial fill of Select Controlled Substance drugs are limited to a 5-day supply. (Additional refills for these medications will be limited to no more than a 30-day supply) A 90-day supply of Maintenance medications is covered using mail order or at a Smart90 retail pharmacy ONLY. To locate one, log in at www.express-scripts.com and click Find a Pharmacy in the menu under Prescriptions. Smart90 network pharmacies will be noted in your search results. Or call Express Scripts at (800) 918-8011. If you obtain your 90-day supply of maintenance medications from any other provider, you may be responsible for the total cost.
	Preferred brand drugs	30% coinsurance for retail or mail order	25% of the approved amount, after the 30% copayment	
	Non-preferred brand drugs	30% coinsurance- for retail or mail order	25% of the approved amount, after the 30% copayment	
	Specialty drugs	Generics: $5 copay/retail No charge/mail order Brands: 30% coinsurance for retail or mail order	25% of the approved amount, after the 30% copayment	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	None
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	$250 copay/visit; then 20% coinsurance after deductible	$250 copay/visit; then 40% coinsurance after deductible	Co-pay waived if from a covered accident, patient admission or undergoes surgery in the course of the Emergency room visit.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Ground transportation 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)	
	Urgent care	$50 copay/visit, then 20% coinsurance after deductible	$50 copay/visit, then 40% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required. If emergent admission, please contact BCBSM at (800) 572-3413.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Service must be performed by a licensed Psychiatrist (M.D. or D.O.) or certified licensed psychologist (Ph.D., Ed.D or M.A.) or social worker or other professional counselor licensed as a Licensed Professional counselor in the State of Michigan.
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required. If emergent admission. Please contact BCBSM (800) 762-2382
If you are pregnant	Office visits	No charge	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). For participants' dependent daughters, only one pregnancy per daughter is covered. Charges on behalf of the child of a dependent daughter 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	

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 deductible	40% coinsurance after deductible	
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Physical therapy limited to 25 visits per calendar year, per occurrence. Occupational Therapy and/or Speech Therapy benefits are payable only if the treatment follows Hospital confinement for an accident (except for accidents that are work or auto/vehicular related), or stroke, cancer or heart-related problem, or is the result of diagnoses of Childhood Apraxia of Speech (CAS) or Autism Spectrum Disorder (ASD). *See SMM for additional information. Occupational Therapy and/or Speech Therapy to treat ASD is subject to the Adaptive Behavior Treatment hour limitation. The Fund does not cover Occupational or Speech Therapies under any other circumstances.
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	None
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	None
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	The Fund covers rental or purchase (whichever is most economical and the Fund's option) with prescription and physician's statement of medical necessity.
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	Covered only if prognosis of six months or less of life; and the concurrent opinion of the attending physician and hospice that the care and treatment to be provided will not exceed the cost of any other alternative treatment.

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 hearing care	Audiometric exam	No charge after deductible and coinsurance	Not Covered	Coverage for Active members only. Coverage only provided once every 12 months. Member may be responsible for the difference in cost between the approved amount of a hearing aid and the charge of the hearing aid.
	Hearing aid evaluation	No charge after deductible and coinsurance	Not Covered	
	Hearing aid conformity test	No charge after deductible and coinsurance	Not Covered	
	Hearing aid	$500	Not Covered	
If you need dental or eye care	Eye exam	Covered under a separate plan.		Dental and vision coverage is provided under a separate plan. Please call Delta Dental at 1-800-524-0149 or visit www.deltadental.com for Dental. 1-800-877-7195 or visit www.vsp.com for Vision (Reference BCBSM ID Number).
	Glasses			
	Dental checkup			

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 (if prescribed for rehabilitation purposes) • Cosmetic Surgery • Automobile or motor vehicle accident • Infertility Treatment	• Long Term Care • Non-emergency care when traveling outside the U.S. • Private Duty Nursing	• Treatment for TMJ (covered under Dental Only) • Work related injury
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery • Organ transplants	• Chiropractic Care • Autism Spectrum Disorders (Minor)	• Routine eye care (Adult) • Routine Foot Care

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 866-444-3272 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: The Fund Office at 248-828-6000or www.BACLocal2Benefits.org. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa/healthreform.*

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.

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	$250
■ Specialist copayment	$25
■ 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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$20
Coinsurance	$1000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,330**

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

The plan's overall deductible	$250
■ Specialist copayment	$25
■ 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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$1,379
Coinsurance	$199
What isn't covered	
Limits or exclusions	$255
The total Joe would pay is	**$2,083**

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

The plan's overall deductible	$250
■ Specialist copayment	$25
■ 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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$50
Coinsurance	$291
What isn't covered	
Limits or exclusions	$37
The total Mia would pay is	**$628**

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

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