

# **MICHIGAN GLASS and GLAZING INDUSTRY FRINGE BENEFIT FUNDS**

## **Summary of Benefits and Coverage**

# MICHIGAN GLASS and GLAZING INDUSTRY FRINGE BENEFIT FUNDS

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Dear Member,

The Board of Trustees of the Michigan Glass & Glazing Industry Welfare Insurance Fund are pleased to announce that, effective January 1<sup>st</sup>, 2026, Union Blue has been engaged to process claims for hospital, medical, surgical and prescription benefits. This is a Blue Cross Blue Shield product offering through CareFirst BCBS and their partner, Highmark BCBS. The Union Blue proposal, negotiated International Union, offered the Health Fund significant savings to the Fund's administrative fees over the next 5 years without changing the current Preferred Provider Organization Network in place. **There are no changes to your health care benefits provided by the Fund. The prescription drug provider will change from OptumRx to ESI, however, this change will not affect your current level of benefits.**

**Beginning on November 1<sup>st</sup>, 2025, members can contact Highmark BCBS at 844-945-5520** to ask questions and get information on the medical and pharmacy coverage and programs, The Board of Trustees wants to make sure that your experience and this provider change is seamless for you and your families. Some of the things you can ask about when you call are:

- ✓ Medical Claims and Benefits
- ✓ PPO Network
- ✓ Member Customer Service
- ✓ Eligibility
- ✓ Utilization Management – for Inpatient and Outpatient Services for Union Blue
- ✓ Care Management – which includes Transition of Care
- ✓ Pharmacy Program – mirrors your current in place today
- ✓ Member Portal
- ✓ Diabetes Management
- ✓ Mental Well-Being

**Towards the middle of December 2025, you will be receiving your new member ID cards so please be on the lookout for these and make sure and replace the cards you are using today with the new cards. Effective 1/1/2026 you must begin using your new ID cards and make sure your providers note the changes in their records. This will be important in making sure your claims are sent to the right place with proper member identification information.**

Best and Warm Regards,

Michigan Glass & Glazing Industry Welfare Fund

Enclosure:

Summary of Benefits and Coverage

CareFirst Union Blue Benefits at a Glance

**Michigan Glass & Glazing Welfare Fund (Michigan Glaziers)**

(group #s 109332-00/01/02/70)

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network	Out-of-Network
<b>General Provisions</b>		
<b>Effective Date</b>	1/1/2026	
<b>Benefit Period</b> (1)	Calendar Year	
<b>Deductible</b> (per benefit period)		
Individual	\$1,000	\$2,000
Family	\$2,000	\$4,000
<b>Plan Pays</b> – payment based on the plan allowance	80% after deductible	60% after deductible
<b>Out-of-Pocket Limit</b> (Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	\$2,500	\$5,000
Family	\$5,000	\$10,000
<b>Total Maximum Out-of-Pocket</b> (Includes deductible, coinsurance, copayments, prescription cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$8,700	N/A
Family	\$17,400	N/A
<b>Office/Clinic/Urgent Care Visits</b>		
<b>Retail Clinic Visits &amp; Virtual Visits</b>	100% after \$30 copayment	60% after deductible
<b>Primary Care Provider (PCP) Office Visits &amp; Virtual Visits</b>	100% after \$30 copayment	60% after deductible
<b>Specialist Office Visits &amp; Virtual Visits</b>	100% after \$30 copayment	60% after deductible
Virtual Visit Provider Originating Site Fee	80% after deductible	60% after deductible
<b>Urgent Care Center Visits</b>	100% after \$30 copayment - copayment does not apply to Urgent Care Center Visits prescribed for the treatment of Mental Health or Substance Abuse	60% after deductible
<b>Telemedicine Services</b> (3)	100% after \$30 copayment	Not Covered
<b>Preventive Care</b> (4)		
<b>Routine Adult</b>		
Physical exams	100% (deductible does not apply)	60% after deductible
Adult immunizations	100% (deductible does not apply)	60% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	60% (deductible does not apply)
Breast Cancer Screenings	100% (deductible does not apply)	60% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)	60% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	60% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
<b>Routine Pediatric</b>		
Physical exams	100% (deductible does not apply)	60% after deductible
Pediatric immunizations	100% (deductible does not apply)	60% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
<b>Emergency Services</b>		
<b>Emergency Room Services</b> (5)	100% after \$150 copayment (waived if admitted)	
<b>Ambulance – Emergency</b>	80% after network deductible	
<b>Ambulance – Non-Emergency</b> (6)	80% after deductible	60% after deductible
<b>Hospital and Medical/Surgical Expenses (including maternity)</b> (5)		
<b>Hospital Inpatient</b>	80% after deductible	60% after deductible
<b>Hospital Outpatient</b>	80% after deductible	60% after deductible
<b>Pre-Surgical Consultations</b>	100% (deductible does not apply)	60% after deductible
<b>Outpatient Surgery</b> (facility)	80% after deductible	60% after deductible
<b>Surgical Services</b> (professional)	80% after deductible	60% after deductible
<b>Maternity</b> (non-preventive professional services) including dependent daughter	100% (deductible does not apply)	60% after deductible


<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Medical Care</b> (including inpatient visits and consultations)	80% after deductible	60% after deductible
<b>Therapy Services</b>		
<b>Physical Medicine, Occupational Therapy &amp; Speech Therapy</b>	80% after deductible	60% after deductible
	<b>Benefit Limit:</b> 30 combined visits per benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
<b>Infusion Therapy</b>	80% after network deductible	
<b>Respiratory Therapy</b>	80% after deductible	60% after deductible
<b>Spinal Manipulations</b>	100% after \$30 copayment	60% after deductible
	<b>Benefit Limit:</b> 12 visits per benefit period	
<b>Other Therapy Services</b> (Cardiac Rehab, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	60% after deductible
<b>Mental Health/Substance Abuse</b>		
<b>Inpatient Mental Health Services</b>	80% after deductible	60% after deductible
<b>Inpatient Detoxification/Rehabilitation</b>	80% after deductible	60% after deductible
<b>Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits</b>	80% after deductible	60% after deductible
<b>Outpatient Substance Abuse</b>	80% after deductible	60% after deductible
<b>Other Services</b>		
<b>Allergy Extracts and Injections</b>	80% after deductible	60% after deductible
<b>Autism Spectrum Disorder Applied Behavior Analysis</b> (7)	80% after deductible	60% after deductible
<b>Assisted Fertilization Procedures</b>	Not Covered	Not Covered
<b>Dental Services Related to Accidental Injury</b>	Not Covered	Not Covered
<b>Diabetes Treatment</b> Equipment and Supplies Diabetes Education Program	80% after deductible	60% after deductible
	80% after deductible	60% after deductible
<b>Diagnostic Services</b>  Advanced Imaging (MRI, CAT, PET scan, etc.) Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing) Mammograms (medically necessary)	80% after deductible	60% after deductible
	80% after deductible	60% after deductible
	100% (deductible does not apply)	60% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	80% after network deductible	
<b>Home Health Care</b>	80% after network deductible	
	<b>Benefit Limit:</b> Unlimited visits per benefit period, aggregate with Visiting Nurse	
<b>Hospice</b>	100% (deductible does not apply)	
<b>Infertility Counseling, Testing and Treatment</b> (8)	80% after deductible	60% after deductible
<b>Private Duty Nursing</b>	70% after deductible	50% after deductible
	<b>Benefit Limit:</b> unlimited hours per benefit period	
<b>Skilled Nursing Facility Care</b>	80% after network deductible	
	<b>Benefit Limit:</b> 120 days per benefit period	
<b>Blue Distinction Specialty Care*</b> <i>For Transplants and Bariatric Surgery</i>  @ Blue Distinction Centers + (BDC+)	100% (deductible does not apply)	Not applicable
	@ Non-BDC+	60% after deductible
<b>Precertification/Authorization Requirements</b> (9)	Yes	

Prescription Drugs <sup>(10)</sup>	
<b>Prescription Drug Deductible</b> Individual Family	none none
<b>Prescription Drug Program <sup>(10)</sup></b> SensibleRx Choice Defined by the National Plus Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.  Your plan uses Comprehensive Formulary with an Incentive Benefit Design  <b>Select Specialty Drugs are Limited to a 31-Day Supply</b>  <b>Rx for Health Diabetes: \$5 retail/\$10 Mail Order</b> (applies to insulin, needles, syringes and other diabetic drugs)  <b>Rx for Health Asthma: \$5 retail/\$10 Mail Order</b> <b>Rx for Health Hypertension: \$5 retail/\$10 Mail Order</b>	<p style="text-align: center;"><b>With the Smart90 CVS Network, after two fills at a retail pharmacy that is not CVS you must choose between a 90-day supply through CVS retail pharmacy stores or through Express Scripts Mail Order Pharmacy.</b></p> <p style="text-align: center;"><b>Retail Drugs (31-day Supply)</b>            Generic \$10 copayment            Formulary Brand \$30 copayment            Non-Formulary Brand \$50 copayment</p> <p style="text-align: center;"><b>Maintenance Drugs through Mail Order (1-90-day Supply)</b>            Generic \$20 copayment            Formulary Brand \$75 copayment            Non-Formulary Brand \$125 copayment</p>

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Benefits and/or benefit administration may be provided by or through the following entity, which is an independent licensee of the Blue Cross Blue Shield Association: CareFirst BlueCross BlueShield which is the business name of First Care, Inc.



Important Questions		Answers		Why This Matters:
		In-Network	Out-of-Network	
<p> 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, <a href="http://www.allmyhealth.com">www.allmyhealth.com</a> or call 1-844-945-5520. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <a href="http://www.HealthCare.gov/sbc-glossary/">www.HealthCare.gov/sbc-glossary/</a> or call 1-844-945-5520 to request a copy.</p>				
What is the overall deductible?	\$1,000 individual/\$2,000 family	\$2,000 individual/\$4,000 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. Office visits, preventive care services, emergency room care, urgent care, professional maternity services, hospice services, and prescription drug benefits are covered before you meet your network deductible.  Copayments and coinsurance amounts don't count toward the network 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .	
Are there other deductibles for specific services?	No.	No	You don't have to meet deductibles for specific services.	
What is the out-of-pocket limit for this plan?	Coinsurance max for medical benefits: \$2,500 Individual / \$5,000 Family  Medical OOP max: \$8,700 Individual / \$17,400 Family	Coinsurance max for medical benefits: \$5,000 Individual / \$10,000 Family  Medical OOP max: N/A	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.	

<p><b>What is not included in the <u>out-of-pocket limit</u>?</b></p>	<p><u>Network</u>: <u>Premiums</u>, <u>balance-billed charges</u>, and <u>health care this plan doesn't cover</u> do not apply to your total maximum <u>out-of-pocket</u>.</p> <p><u>Out-of-network</u>: <u>Copayments</u>, <u>deductible</u>, <u>premiums</u>, <u>balance-billed charges</u>, <u>prescription drug expenses</u>, and <u>health care this plan doesn't cover</u>.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p><b>Will you pay less if you use a <u>network provider</u>?</b></p>	<p>Yes. See <a href="http://www.allmyhealth.com">www.allmyhealth.com</a> or call 1-844-945-5520 for a list of <u>network providers</u>.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider in the plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>).</p> <p>Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p><b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b></p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>

 All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's office</u> or <u>clinic</u>	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	---none---
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	---none---
	Other practitioner office visit	\$30 co-pay for Chiropractic and osteopathic manipulative therapy	60% co-insurance after deductible Chiropractic and osteopathic manipulative therapy	Limited to a <b>combined</b> maximum of 12 visits per member per calendar year

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)	
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply.	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.  Please refer to your <u>preventive</u> schedule for additional information.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification may be required.
	<u>Imaging</u> (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available at <a href="http://www.allmyhealth.com">www.allmyhealth.com</a> .	Generic drugs	\$10 <u>copay</u> /prescription (retail) \$20 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	Up to 31-day supply retail pharmacy. Up to 90-day supply maintenance <u>prescription drugs</u> through mail order.  <u>Specialty Drugs</u> are limited to a 31-day Supply.
	<u>Formulary Brand drugs</u>	\$30 <u>copay</u> /prescription (retail) \$75 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	
	<u>Non-Formulary Brand drugs</u>	\$50 <u>copay</u> /prescription (retail) \$125 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification may be required.
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$150 <u>copay</u> /visit <u>Deductible</u> does not apply.	\$150 <u>copay</u> /visit <u>Deductible</u> does not apply.	<u>Copay</u> waived if admitted as an inpatient.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of-network: Subject to <u>network deductible</u> .

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)	
	<u>Urgent care</u>	\$30 <u>copay/visit</u> <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	The <u>Copayment</u> , if any, does not apply to Urgent Care Services prescribed for the treatment of Mental Health or Substance Abuse.
If you have a hospital stay	Facility fees (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification may be required.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification may be required.
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	No charge	40% <u>coinsurance</u>	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
				<u>Network</u> : The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health <u>Preventive Schedule</u> for additional information.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Out-of-network</u> : Subject to <u>network deductible</u> . Precertification may be required.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Combined network</u> and <u>out-of-network</u> : 30 combined physical medicine, occupational therapy, and speech therapy visits per benefit period. Limit does not apply to therapy services when prescribed for the treatment of mental health or substance abuse disorder. Precertification may be required.

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)	
	<u>Habilitation services</u>	20% co-insurance after deductible for Applied Behavioral Analysis; 20% co-insurance after deductible for Physical, Occupational, Speech therapy	40% co-insurance after deductible for Applied Behavioral Analysis; 40% co-insurance after deductible for Physical, Speech, Occupational therapy	Prior authorization is required for applied behavior analysis (ABA). Services rendered by an approved licensed behavior analyst (LBA) will apply the In-network cost-sharing.
	<u>Skilled nursing care</u>	20% coinsurance	20% coinsurance	Combined <u>network</u> and <u>out-of-network</u> : 120 days per benefit period. Out-of- <u>network</u> : Subject to <u>network deductible</u> . Precertification may be required.
	<u>Durable medical equipment</u>	20% coinsurance	20% coinsurance	Out-of- <u>network</u> : Subject to <u>network deductible</u> . Precertification may be required.
	<u>Hospice services</u>	No charge Deductible does not apply.	No charge Deductible does not apply.	Precertification may be required.
	Children's eye exam	Ophthalmologist - \$75 Optometrist - \$65	Ophthalmologist - \$75 Optometrist - \$65	Once every 12 months
If your child needs dental or eye care	Children's glasses	The Plan pays up to the following limits – Single lenses: \$110; Bifocal lenses: \$130; Trifocal lenses: \$140; Progressives: \$150; Contact lenses: \$140; Frames: \$120	The Plan pays up to the following limits – Single lenses: \$110; Bifocal lenses: \$130; Trifocal lenses: \$140; Progressives: \$150; Contact lenses: \$140; Frames: \$120	Lenses: once every 12 months Frames: once every 24 months
	Children's dental check-up	No Charge	Coverage limited to amount paid to an in-network provider for the same service, and you are responsible for any additional amount charged.	Twice per calendar year

## **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
- Hearing aids
- Routine eye care (Adult)
- Cosmetic surgery
- 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
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See [www.bcbsglobalcare.com](http://www.bcbsglobalcare.com)
- Chiropractic care
- 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's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit <http://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:

- CareFirst Blue Cross Blue Shield at 1-844-945-5520.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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 \$1,000
- Specialist copayment \$30
- 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:**

<u>Cost Sharing</u>	
Deductibles	\$1,000
Copayments	\$10
Coinsurance	\$2,300
<b>What isn't covered</b>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,370</b>

**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 \$30
- 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:**

<u>Cost Sharing</u>	
Deductibles	\$900
Copayments	\$800
Coinsurance	\$0
<b>What isn't covered</b>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,720</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,000
- Specialist copayment \$30
- 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:**

<u>Cost Sharing</u>	
Deductibles	\$1,000
Copayments	\$200
Coinsurance	\$200
<b>What isn't covered</b>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,400</b>

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-844-945-5520.

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

### Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with:

Civil Rights Coordinator  
 P.O. Box 22492  
 Pittsburgh, PA 15222  
 Phone: 1-866-286-8295 (TTY: 711), Fax: 412-544-2475  
 Email: [CivilRightsCoordinator@highmarkhealth.org](mailto:CivilRightsCoordinator@highmarkhealth.org)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](http://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone at:

U.S. Department of Health and Human Services  
 200 Independence Avenue, SW  
 Room 509F, HHH Building  
 Washington, D.C. 20201  
 Phone: 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at [hhs.gov/ocr/office/file/index.html](http://hhs.gov/ocr/office/file/index.html).

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**ATTENTION:** If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge. Call the number on the back of your ID card (TTY: 711) for help.

**ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711) si necesita ayuda.

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TTY: 711).

**ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nimewo ki sou do Kat ID w lan (TTY: 711) pou jwenn èd.

**ВНИМАНИЕ:** Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи). Для получения помощи позвоните по номеру, указанному на обратной стороне вашей идентификационной карты (TTY: 711).

**ATTENZIONE:** se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili. Per assistenza, chiami il numero riportato sul retro della Sua tessera di identificazione (TTY: 711).

**ATTENTION :** si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711) pour obtenir de l'aide.

**ÀKÍYÈSÍ:** Tí ó bá nsọ èdè Yorùbá, àwọn iṣẹ ìtumọ ati ògbufọ èdè wà ní àrọwọtọ lófìfẹ́ fún ọ. Àwọn iṣẹ ìtọjú ati ìrànlọwọ tó yẹ (bí títẹ́wé nla, gbigbọ ohùn, ati iwé afọjú) lati pèsè iwífúnni ní àwọn ọna ìrááyè sí wà pẹlu lófìfẹ́. Pẹ nọmba tó wà lẹhin kaádi ìdánimọ rẹ (TTY: 711) fún ìrànlọwọ.

**אכטונג:** אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערזעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזוויי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל. רופט דעם נומער אויף די אנדערע זייט פון אייער אידענטיטעט קארטל (TTY: 711) פאר הילף.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجانًا. تتوفر أيضًا الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقات يمكن الوصول إليها من دون أي تكلفة. اتصل على الرقم المدون على ظهر بطاقة هويتك (TTY: 711) للحصول على المساعدة.

**注意：**如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字、音频和盲文），以便您获取无障碍格式的信息。如需帮助，请拨打您的ID卡背面的号码（听障人士专用号码：711）。

**ध्यान आपशी:** જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિ:શુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઓડિયો અને બ્રેલ) પણ નિ:શુલ્ક ઉપલબ્ધ છે. મદદ માટે તમારા આઈડી કાર્ડની પાછળ આપેલા નંબર (TTY: 711) પર કોલ કરો.

**CHÚ Ý:** Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711) để được trợ giúp.

**ध्यान दिनुहोस्:** यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई नि:शुल्क भाषा अनुवाद र दोभासे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि नि:शुल्क उपलब्ध छन्। मद्दतको लागि तपाईंको ID कार्डको पछाडिको नम्बरमा कल गर्नुहोस् (TTY: 711)।

**कृपया ध्यान दें:** यदि आप हिंदीभाषा बोलते हैं, तो आपके लिए मुफ्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एकसेस करने योग्य फॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी नि:शुल्क उपलब्ध हैं। सहायता के लिए अपने पहचान कार्ड के पीछे लिखे नंबर (TTY: 711) पर कॉल करें।

**주의:** 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용할 수 있습니다. 도움이 필요하시면 ID 카드 뒷면에 있는 번호로 전화하십시오(TTY: 711).

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