Iron Workers' Health Fund of Eastern Michigan

Summary of Benefits and Coverage

Annual Notices

Iron Workers' Local No. 25 Fringe Benefit Funds
P.O. Box 99219
Troy, MI 48099-9219
Phone: (248) 347-3100 • Toll Free: (800) 572-8553 • Fax: (248) 813-9898
Website: www.iw25fringe.org

April 2023

Dear Participant:

Enclosed please find your Summary of Benefits and Coverage (SBC), other Annual Notices, and a Summary of Material Modification from the Iron Workers' Health Fund of Eastern Michigan (Fund). Please keep this information with your Summary Plan Description.

SUMMARY OF BENEFITS AND COVERAGE

The SBC is provided annually and is intended to help you understand your health care coverage provided by the Fund. The SBC includes three parts:

- Benefits and Coverage Information
- Coverage Examples
- An internet address for obtaining a Uniform Glossary.

Benefits and Coverage Information

This section includes a chart that lists various features of the Fund's medical plan coverage. It also provides information about coverage for different services, such as office visits, prescription drugs, and emergency room services.

Coverage Examples:

The coverage examples on the last page of the SBC show how the Fund might cover medical care for three specific scenarios. These examples show what the Fund would pay and what the patient would pay based on a common set of assumptions. It is important to note that these are examples only and should not be used to estimate your actual costs.

Uniform Glossary:

The SBC explains how to access or request a glossary with definitions for common health insurance and medical terms, such as copayment and deductible.

If you have any questions regarding the content of the SBC, or your coverage in general, please contact the Fund Office at (800) 572-8553 or (248) 347-3100.

NOTICES

Notice of Changes:

It is the responsibility of the Participant to notify the Fund Office within the time frame set forth below of any of the following changes: Marriage, New Babies, Adoptions and Legal Guardianship – within 31 days of the date the Participant acquires a new Dependent family member. If a Dependent is not timely enrolled he/she will not be able to enroll until the next open enrollment period, which is from April 1-30.

In addition, it is the Participant's responsibility to immediately notify the Fund Office of the following changes: Change of Address, Deaths, Divorce, or obtaining Other Coverage.

As a reminder, failure to inform the Fund Office of a divorce or other event which makes a dependent ineligible for coverage is considered a fraud on the Fund and could result in a rescission of coverage and liability for medical claims paid by the Fund.

It is also important to update your current Beneficiary Designation and to make sure it reflects the Beneficiary that you wish to receive benefits in the event of your death. It is a good idea to take a moment and call the Benefit Office to find out who your designated Beneficiary is or request a form to update.

The Trustees have contracted with Guardian Life Insurance Company to provide the fully insured Death Benefit in the amount of $100,000 and an accidental Death and Dismemberment benefit in the amount of $100,000 provided for Active Participants effective April 1, 2023.

Notice of the Privacy Policy and Procedures of the Fund:

The Notice of Privacy Practices summarizes your health care consumer rights and your right to be notified of the ways in which the Plan uses or discloses protected health information including, the Plan's obligations to notify you no later than 60 days after discovery of a disclosure of unsecured protected health information that poses a significant risk of financial, reputational or other harm to you. The Notice also details your right to request restrictions or limitations on the medical information the Plan uses or discloses about you for treatment, payment or health care operations including restriction requests to a health care plan for the purposes of payment or health care operations where the protected health information pertains solely to a health care item or service that has been paid out-of-pocket and in full. If you would like to obtain a written copy of the Notice or you have any questions regarding this Notice, please contact the Fund Office.

The Women's Health and Cancer Rights Act of 1998 Annual Notice:

The Fund, as required by the Women's Health and Cancer Rights Act of 1998 (WHRCA), provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. Not only is this notice being published to comply with the 1998 Omnibus Appropriations Bill, but it is very important that you understand that these benefits are available through your Health Fund.

Newborns' and Mothers' Health Protection Act 1996 Notice:

The Newborns' and Mothers' Health Protection Act of 1996 (Newborns' Act) requires group health plans that offer maternity hospital benefits for mothers and newborns to pay for at least a 48-hour hospital stay for the mother and newborn following childbirth (or, in the case of cesarean section, a 96-hour hospital stay), unless the attending provider, in consultation with the mother, decides to discharge earlier.

Covid-19 Public Health Emergency:

The federal government recently announced its intent to end the COVID-19 Public Health Emergency on May 11, 2023. COVID-19 vaccines have been added to the Affordable Care Act's list of preventive benefits. As a result, the Health Fund must continue to provide 100% coverage in-network for COVID-19 vaccine administration after the end of the Public Health Emergency.

COVID-19 diagnostic testing administered by a health care provider, a testing facility or a lab will be subject to your normal copays and deductibles. This includes applicable charges if you use an out-of-network provider. Previously, these tests were covered at 100% both in and out of network. Once the Public Health Emergency ends, if you use a non-participating provider, lab tests will not be covered. Exclusions include testing for employment, travel and/or school purposes, proctored tests (taken while supervised virtually and verified).

Coverage for over-the-counter tests will no longer be required or available, whether the kit is purchased in stores or online. COVID-19 treatments will be covered and subject to normal copayments and deductibles as they are today.

Dental Benefits:

Effective January 1, 2023, Golden Dental Plan was acquired by DENCAP Dental Plans. If you are currently enrolled in the Golden Dental Plan you are automatically enrolled in the DENCAP Dental Plan. There will be no change to your current benefit plan design and there will be an expanded dental network that will soon be available to members.

Summary of Material Modification:

This Summary of Material Modifications ("SMM") is to advise you that effective **September 1, 2022**, the 8th Amendment to the Iron Workers' Health Fund of Eastern Michigan was implemented. The 8th Amendment covers Article 2, Section 2.11 Termination of Coverage provisions of the Plan

If you have any questions regarding the information provided in this notice, please contact the Fund Office at (800) 572-8553 or (248) 347-3100.

Board of Trustees,
Iron Workers Health Fund of Eastern Michigan

Enclosure

Iron Workers' Local No. 25 Fringe Benefit Funds
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April 2023

To: All Participants of the Iron Workers' Health Fund of Eastern Michigan

From: Board of Trustees of the Iron Workers' Health Fund of Eastern Michigan

Please read this Notice carefully as it contains important information regarding your Plan.

PLAN CHANGE – TERMINATION OF COVERAGE

Effective September 1, 2022, the Board of Trustees implemented the 8th Amendment to the Iron Workers' Health Fund of Eastern Michigan modifying Section 2.11 of the Plan as follows:

2.11 Termination of Coverage

The coverage for benefits provided by this Plan shall terminate the earlier of:

(a) On the date the Plan is terminated; or

(b) On the date the Covered Person ceases to be eligible for coverage under the terms of the Plan or;

(c) Upon written notification from the Union, on the first date a covered Participant works for a noncontributing employer in the iron working industry. As of that date such individual will not be entitled to continue coverage by way of Bank or self-payments and will be offered COBRA continuation coverage only; or

(d) Upon written notification from the Union, on the date a covered Participant first works for an employer who is not in the iron working industry if such individual is not available for work for a contributing Employer. Such individual will not be entitled to continue coverage by way of Bank or self-payments and will be offered COBRA continuation coverage only.

Notwithstanding sub-paragraph (d) above, upon application by such a Participant, the Trustees will approve work for a covered Participant who is not available for work for a contributing employer if he/she is not working in the iron working industry or for an employer who competes directly or indirectly with contributing Employers. In such case, the covered Participant's Bank will be frozen for 90 days. Such an affected Participant will not be able to self-pay and will be offered COBRA coverage. Within such 90 days, the affected Participant's Bank will be reinstated upon cessation of work for such noncontributing employer if the Participant immediately becomes available for work for a contributing employer. After 90 days, if the Participant does not cease such employment and become available for work for a contributing Employer, his/her Bank will terminate.

If you have any questions, please call the Fund Office at (800) 572-8553 or (248) 347-3100. Please keep this Notice with your Summary Plan Description (SPD).

The Summary of Benefits and Coverage (SBC) 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 and costs, you can get the complete terms in the policy or plan document at the Fund Office of the Iron Workers Health Fund of Eastern Michigan Benefit Plan, P.O. Box 99219, Troy, MI 48099-9219 or by calling (800) 572-8553.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**In-Network: $250** Individual / **$500** Couple or Family **Out-of-Network: $500** Individual/ **$1,000** Couple or Family	Generally, you must pay all the costs from **providers** up to the **deductible** amount before this plan begins to pay. If you have other family members on the policy, the overall family **deductible** must be met before the plan begins to pay. Check your policy or plan document to see when the **deductible** starts over. See chart on page 2 for how much you pay for covered services after you meet the **deductible**. Out-of-network amounts also apply toward in-network deductible. In-network amounts do not apply toward out-of-network deductible.
Are there services covered before you meet your deductible?	**Yes.** Preventive care services are covered before you meet your deductible.	You will have to meet the deductible before the plan pays for any services. As required by law, certain services are covered 100%, i.e. no deductible. These are primarily preventive care services.
Are there deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services, but see Common Medical Event chart on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	**OOP: Medical In-Network $2,250** Individual /**$4,500** Couple or Family; **Medical Out-of-Network $12,700** Individual/ **$25,400** Couple or Family; **Rx: $4,900** Individual / **$9,800** Couple or Family	The **OOP** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. By law, the Overall OOP for deductibles, co-payments, and co-insurance on in-network essential benefits is: Medical 2022: $8,700 Individual/ $17,400 Couple or Family Medical 2023: $9,100 Individual/ $18,200 Couple or Family In-network coinsurance amounts do not count toward the out-of-network coinsurance maximum. Out-of-network coinsurance amounts do count toward the in-network coinsurance maximum.
What is not included in the out–of–pocket limit?	Self-payments, balance-billed charges, and services 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. Please see page 7 under Contact Information for the toll-free number to call to obtain a list of participating **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 a non-participating 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 in-network provider may use an out-of-network provider for some services. See the chart starting on page 2 for how this plan pays different kinds of **providers**. For additional information see Contacts on page 7.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission (referral) from this plan.

Self-payments. The Fund requires monthly self-payments by participants to participate in the Fund. The monthly self-payment for this Option1 is $418 for single; $586 for 2 person; and $615 for family. Group Number 0070040310000 – Non-Medicare

Questions: Call the Fund Office (800) 572-8553, the number on your BCBSM ID card, or go to www.bcbsm.com. If you aren't clear about any of the terms used in this form, call the Fund Office or see the Glossary at http://www.dol.gov/ebsa/healthreform. See pg. 7 for additional contact information.

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
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay	20% co-insurance after deductible.	---none---
	Specialist visit	$20 co-pay; no co-pay for chiropractor visit; 10% co-insurance after deductible-xray during visit.	20% co-insurance after deductible.	Chiropractor: 26 visits per member per calendar year for spinal manipulations. Out-of-network or for services other than spinal manipulation deductible/co-insurance apply.
	Preventive care/screening/ immunization	No Charge	20% co-insurance after deductible	Wellness exam subject to annual visit limitation. Routine preventive care generally limited to annually; subsequent related care subject to deductible and percent copay. Well-baby/Well-child care visits; 8 visits, birth to 12 months; 6 visits, 13 months to 35 months; 2 visits, 36 months to 47 months You may have to pay for services that aren't preventative. Ask your provider if the services you need are preventative. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance after deductible	20% co-insurance after deductible.	---none---
	Imaging (CT/PET scans, MRIs)	10% co-insurance after deductible	20% co-insurance after deductible.	May require preauthorization.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition For more information about **prescription drug coverage** contact the Fund or OptumRx.	Generic drugs	Retail - $10 co-pay Mail - $20 co-pay (90 day supply)	Retail - $10 co-pay Mail - $20 co-pay (90 day supply)	Does not cover prescriptions filled at Sam's Club or Walmart. Generic women's contraceptives covered without copay; formulary brand name contraceptives covered without copay if suitable generic unavailable.
	Formulary brand-name (preferred brand) drugs	Retail - $15 co-pay Mail - $30 co-pay (90 day)	Retail - $15 co-pay Mail - $30 co-pay (90 day)	Does not cover prescriptions filled at Sam's Club or Walmart. For information visit: www.OptumRx.com or call: 1-866-328-2005
	Nonformulary brand-name (non-preferred brand) drugs	Retail - $30 co-pay Mail - $60 co-pay (90 day)	Retail - $30 co-pay Mail - $60 co-pay (90 day)	Does not cover prescriptions filled at Sam's Club or Walmart.
	Specialty drugs	Retail - $30 co-pay Mail - $60 co-pay (90 day)	Retail - $30 co-pay Mail - $60 co-pay (90 day)	Must be obtained from OptumRx Specialty Pharmacy. See pg. 7 for contact information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance after deductible	20% co-insurance after deductible	---none---
	Physician/surgeon fees	10% co-insurance after deductible	20% co-insurance after deductible	---none---
If you need immediate medical attention	Emergency room services	10% co-insurance after deductible	10% co-insurance after deductible	---none---
	Emergency medical transportation	10% co-insurance after deductible	10% co-insurance after deductible	---none---
	Urgent care	$20 co-pay; 10% co-insurance after deductible on any services rendered such as x-ray, etc.	$20 co-pay; 20% co-insurance after deductible	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance after deductible	20% co-insurance after deductible	Preauthorization is required.

Questions: Call the Fund Office (800) 572-8553, the number on your BCBSM ID card, or go to www.bcbsm.com. If you aren't clear about any of the terms used in this form, call the Fund Office or see the Glossary at http://www.dol.gov/ebsa/healthreform. See pg. 7 for additional contact information.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider	Non-Participating Provider	
	Physician/surgeon fee	10% co-insurance after deductible	20% co-insurance after deductible	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health/ Substance Abuse outpatient services	10% co-insurance after deductible	10% co-insurance after deductible (mental health and behavioral health) 20% co-insurance after deductible (substance abuse)	Your cost share may be different for services provided in an office setting. Outpatient substance abuse disorder treatment covered at approved facilities only.
	Mental/Behavioral health/ Substance Abuse inpatient services	10% co-insurance after deductible	20% co-insurance after deductible	Preauthorization is required.
If you are pregnant	Office Visits	Pre-natal: covered 100% Post-natal: 10% co-insurance after deductible	20% co-insurance after deductible	Pre-natal care only, covered for dependent children.
	Childbirth/delivery professional services	10% co-insurance after deductible	20% co-insurance after deductible	Pre-natal care only, covered for dependent children.
	Childbirth/delivery facility services	10% co-insurance after deductible	20% co-insurance after deductible	Pre-natal care only, covered for dependent children.
If you need help recovering or have other special health needs	Home health care	10% co-insurance after deductible	10% co-insurance after deductible	Must be medically necessary and provided by a participating home health care agency.
	Rehabilitation services	10% co-insurance after deductible	20% co-insurance after deductible	Services at nonparticipating outpatient physical therapy facilities are not covered.
	Habilitation services	20% co-insurance, after deductible for ABA	20% co-insurance, after deductible for ABA	Applied behavioral analysis (ABA) treatment for Autism – subject to preauthorization
	Skilled nursing care	20% co-insurance after deductible	20% co-insurance after deductible	Must be in a participating skilled nursing facility and preauthorization is required.
	Durable medical equipment	10% co-insurance after deductible	10% co-insurance after deductible	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider	Non-Participating Provider	
	Hospice service	No Charge	No Charge	Subject to pre-hospice counseling. Hospice coverage for four 90-day periods provided. After reaching certain dollar maximum, member transitions into individual case management. Physician certification required.
If you or your child needs dental or eye care	Eye exam Safety Glasses or Contacts – Eye Exam	$5 co-pay None – see limitation below.	Reimbursement up to $50 less $5 co-pay that applies to all charges (member responsible for any difference)	Blue Vision benefits are provided by Vision Service Plan (VSP) Once per covered person per calendar year.
	Glasses Lenses Frames Safety Glasses Contact Lenses – Medically necessary Contact Lenses – Elective	100% In-Network $130 allowance Covered up to 100% of Approved Amount Lenses and Frames Covered up to 100% of Approved Amount $150 Allowance for Exam & Contact Lenses	Reimburse up to approved amount Reimburse up to $45 for frames. Not covered. Reimbursement up to $210 per pair. $105 Allowance for Exam & Contact Lenses	Prescription glasses or contact lenses, not both. One pair of lenses, with or without frames, per calendar year. One frame per calendar year. One per member per calendar year. Applicable to Medically Necessary or Elective Contacts: Allowance for prescription glasses or contact lenses, not both, Participant pays balance after Approved Amount. 15% off 1x per year eye exam for medically necessary elective contacts.
	Dental check-up (oral exam)	No Charge	Covered at Delta Dental's approved PPO Dentist Schedule.	Delta Dental: Frequency limitations; $1,200 annual maximum, N/A children up to age 18. DENCAP Dental (formerly Golden Dental) see benefit guide.

To see examples of how this plan might cover costs for a sample medical situation, see the examples on page 8.

Questions: Call the Fund Office (800) 572-8553, the number on your BCBSM ID card, or go to www.bcbsm.com. If you aren't clear about any of the terms used in this form, call the Fund Office or see the Glossary at http://www.dol.gov/ebsa/healthreform. See pg. 7 for additional contact information.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy/plan document for other excluded services.)		
Long-term care Routine foot care	Infertility treatment	Weight loss programs
Cosmetic surgery	Expenses arising from motor vehicle or motorcycle accidents	Expenses incurred due to an on-the-job injury

Other Covered Services (This isn't a complete list. Check your policy/plan document for other covered services/your costs for these services.)

Bariatric surgery	Chiropractic care	Hearing aids
Non-emergency care when traveling outside the United States - see http://provider.bcbs.com	Private-duty nursing	Acupuncture treatment
Routine eye care		Dental care

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or co-insurance, or benefits not otherwise covered.

Contact Information (If you need additional information, please contact the Fund Office at 1-800-572-8553 or Customer Service as listed below).

For Medical and Vision (for a list of participating providers go to www.bcbsm.com and view the list of Participating Traditional/PPO Providers):
BCBSM, Customer Service, P.O. Box 2888, Detroit, Michigan 48231 | Toll-free (877) 790-2583

For Prescription Drugs:
OptumRx, 1-866-328-2005, P.O. Box 29044, Hot Springs, AR 71903-9044
OptumRx Specialty Pharmacy, 1-866-218-5445

For Dental Benefits:

For individuals enrolled in the Delta Dental Plan, contact Delta Dental at P.O. Box 9085, Farmington Hills, MI 48333 | Toll-free (800) 482-8915
For individuals enrolled in the DENCAP Dental Plan (formerly Golden Dental), contact DENCAP Dental Plan at 45 E. Milwaukee, Detroit, MI 48202 | Toll-free (800) 451-5918 | For a list of participating dentists, please contact the dental program that you are enrolled in at the related toll-free number.

Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a self-payment which may be significantly higher than the self-payment you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the Fund Office at 1-800-572-8553. 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. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-696-6775 or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Fund Office at 1-800-572-8553 or Blue Cross Blue Shield of Michigan by calling 1-877-790-2583. For grievances and appeals regarding prescription drug or dental coverage, see the contact information listed above.
Or, you can contact Michigan Office of Financial and Insurance Regulation at **www.michigan.gov/ofir** or 1-877-999-6442. For group health coverage subject to ERISA, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Does this Coverage Provide Minimum Essential Coverage?
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.
This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
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.
Not Applicable

---------- To see examples of how this plan might cover costs for a sample medical situation, see the next page. ----------

Questions: Call the Fund Office (800) 572-8553, the number on your BCBSM ID card, or go to www.bcbsm.com. If you aren't clear about any of the terms used in this form, call the Fund Office or see the Glossary at http://www.dol.gov/ebsa/healthreform. See pg. 7 for additional contact information.

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 *[cost sharing]*	100%
■ Hospital (facility) *[cost sharing after deductible]*	10%
■ Other *[cost sharing after deductible]*	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)* (12/9 months)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$11,380**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$10
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,320**

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 *[cost sharing after deductible]*	10%
■ Hospital (facility) *[cost sharing after deductible]*	10%
■ Other *[cost sharing after deductible]*	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)* (12/ per year)
Diagnostic tests *(blood work)*
Prescription drugs (12 months at $10 copay)
Durable medical equipment *(glucose meter)*

Total Example Cost	**$4,830**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments – Primary Care/Rx	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$770**

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

■ The plan's overall deductible	$250
■ Specialist *[cost sharing after deductible]*	10%
■ Hospital (facility) *[cost sharing after deductible]*	10%
■ Other *[cost sharing after deductible]*	10%

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	**$2,280**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$70
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$520**

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

IRON WORKERS' LOCAL NO. 25
FRINGE BENEFIT FUNDS
P.O. BOX 99219
TROY, MI 48099-9219

Important Fund Information