PIPEFITTERS LOCAL 636
FRINGE BENEFIT FUNDS
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MCA DETROIT

Important Changes Coming to Your Health Plan

Dear Pipefitters Local 636 Insurance Fund Participant,

Beginning January 1, 2027, your Pipefitters Local 636 Insurance Plan Coverage will end with Blue Cross Blue Shield of Michigan and your medical coverage will be provided under a new three-tier provider network with Nomi Health and Health Alliance Plan (formerly known as HAP). Nomi Health will be your Tier 1 Network and will provide your lowest-cost option for covered care; Health Alliance Plan will be your Tier 2 Network and will provide you with broader network coverage at traditional cost-sharing.

Please read this guide before you make your open enrollment choices.

How Your New Coverage Works

Your out of pocket cost will depend on which provider you see:

- **Tier 1: Nomi Health Network (your lowest cost).**
  - **$0 Out-of-Pocket Costs:** Get care that you need with **NO** non-emergent copays, coinsurance, or deductibles when using the Nomi Network. This includes everything from routine check-ups and lab work to surgeries and physical therapy. For urgent and emergency care services, your traditional copay will apply.
  - **Thousands of Top Providers:** Nomi Health Network includes Henry Ford Health, University of Michigan Health (Ann Arbor, Lansing, and West Michigan), Bronson Healthcare, MSU Health, ProMedica, Trinity Health Alliance of Michigan, and many more.
  - **Comprehensive Services:** From routine check-ups to specialized treatments, Nomi Health covers all your healthcare needs.
  - **Refer to your plan materials and SBCs for complete benefit details.**

Nomi Health

- **Tier 2: Health Alliance Plan (Your broader in-network option.)**
    - You will have access to HAP Health Alliance Plan PPO providers in Michigan and First Health Complementary Network providers outside Michigan, subject to your plan's traditional in-network cost sharing.
        - **For Michigan members:** Health Alliance Plan PPO providers.



        - **For members outside Michigan:** First Health Complementary Network providers.



- **Tier 3: Out-of-network (generally your highest cost option).**
    - You will generally pay the highest out-of-pocket costs when using providers outside the Nomi, Health Alliance Plan PPO and First Health Complementary Networks. In addition to deductibles and coinsurance, an out-of-network provider may bill you for amounts above the plan's allowed amount.

Please see the attached SBCs for the full and standard plans for a summary of benefits and cost-sharing effective January 1, 2027.

Why Tiers Matter

For the greatest savings, first check whether your provider participates in the Tier 1 Nomi Health Network.

If your provider does not participate in Tier 1, or you prefer a broader network, check your Tier 2 options: Health Alliance Plan PPO for Michigan members and First Health Complementary Network for members outside Michigan.

Choosing a participating Tier 1 or Tier 2 provider can help you avoid the higher costs associated with out-of-network care.

How to Find a Provider

- **Tier 1, Nomi Health Network:** Go to nomi.health/me and enter Group # 10001062in the Group ID field.



- **Tier 2, Michigan (Health Alliance Plan):** Go to www.hap.org and search for Health Alliance Plan PPO providers.

- **Tier 2, outside Michigan (First Health Complementary Network):** Go to www.firsthealthcomplementary.com or call (800) 226-5116.

Provider participation can change. Before scheduling non-emergency services, confirm that your provider participates in the appropriate network.

What You Need to Do Before Open Enrollment

- **Check your current doctors.** Find out whether they participate in your Tier 1 or applicable Tier 2 network before making your enrollment choices.
- **Review your benefits.** Read this guide and the Fund's open enrollment materials to understand your coverage and costs.
- **Continue using your current ID card for your current coverage.** Follow the instructions provided with your new card about when to begin using it.
- **Watch your mail.** Your new ID card and a follow-up letter will arrive before January 1, 2027.

Questions?

For benefit or enrollment questions: Contact Pipefitters Local 636 Insurance Fund member services at (248) 641- 4936 or (888) 646-8920, or **www.pipefitters636fringe.org.**

- **For provider search:** Go to nomi.health/me and enter Group #10001062 in the Group ID field or www.hap.org and search for Health Alliance Plan PPO providers. **For First Health Complementary Network provider questions:** Go to www.firsthealthcomplementary.com or call (800) 226-5116.

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, call 1-248-641-4936. 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	Answers			Why This Matters:
What is the overall deductible?	Tier 1 – NOMI Network: **$0** / person; **$0** / family	Tier 2 – Health Alliance Plan (HAP) Network: **$300** / person; **$600** / family	Out-of-Network **$600** / person; **$1,200** / 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 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. All services rendered by Tier 1 Nomi providers are covered before you meet your deductible. In addition, Tier 2 in-network preventive services, in-network office visits, chiropractic care, and prescription benefits are covered before you meet your 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.			You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Tier 1 – NOMI Network: ACA limit / person; ACA limit / family	Tier 2 – Health Alliance Plan (HAP) Network: **$2,500** / person; **$5,000** / family	Out-of-Network **$5,000** / person; **$10,000** / family	The ACA Overall OOP (ACA limit) for out-of-pocket expenses (e.g., copayment, coinsurance, and deductible) for in-network essential health benefits for 2027 is: $12,000 for individual coverage and $24,000 for family coverage. 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?	Self-payments, premiums, balance-billing charges, penalties for failure to obtain pre-authorization for services, 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. You pay the least if you use a provider in the **Nomi** (Tier 1) network. You will pay more if you use a provider in the **Health Alliance Plan** (Tier 2) network. See www.nomihealth.com or www.hap.org for a list of Tier 1 and Tier 2 network providers.			You pay the least if you use a provider in the **Nomi** network. You will pay more if you use a provider in the **Health Alliance Plan** 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)	
		Tier 1 – NOMI	Tier 2 - HAP		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	$20 copay / visit	30% coinsurance	Deductible does not apply to in-network visits
	Specialist visit	No charge	$20 copay / visit	30% coinsurance	Deductible does not apply to in-network visits
	Preventive care / screening / immunization	No charge	No charge	Not Covered.	You may have to pay for services that are not preventive services. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	30% coinsurance	Preauthorization may be required.
	Imaging (CT / PET scans, MRIs)	No charge	20% coinsurance	30% coinsurance	Preauthorization may be required.
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.express-scripts.com**	Generic drugs (Tier 1)	Retail & Mail Order (1-34 day supply): $10 copay Retail & Mail Order (35-90 day supply): $20 copay		Not Covered.	Drugs which cost over $400 are subject to coupon program, call 866-680-4859. Unless your physician prescribes otherwise, if you receive a brand (Tier 2 or 3) drug when a generic (Tier 1) equivalent is available, you must pay the copay and the cost difference between generic and brand name drug. Must use Accredo Specialty Pharmacy for all specialty drugs, which are limited to a 30-day supply. Mail order pharmacy may be contacted at (800) 803-2523. Some drugs require preauthorization. A list of these drugs can be found at www.express-scripts.com. Wal-Mart and Sam's Club retail pharmacies excluded; you are unable to fill at these pharmacies.
	Preferred brand drugs (Tier 2)	Retail & Mail Order (1-34 day supply): $40 copay Mail Order (35-90 day supply): $80 copay		Not Covered.	
	Non-preferred brand drugs (Tier 3)	Retail & Mail Order (1-34 day supply): $80 copay Mail Order (35-90 day supply): $160 copay		Not Covered.	
	Specialty drugs (Tier 4)	Limited to 30-day supply only: $150 copay		Not Covered.	

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)	
		Tier 1 – NOMI	Tier 2 - HAP		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	30% coinsurance	Preauthorization may be required for certain procedures.
	Physician / surgeon fees	No charge	20% coinsurance	30% coinsurance	Preauthorization may be required for certain procedures.
If you need immediate medical attention	Emergency room care	$150 copay / visit	$150 copay / visit	$150 copay / visit	Copay waived if care is due to an accidental injury or if Covered Person is admitted. For the cost of related diagnostic tests, see p. 2 for applicable coinsurance amount, subject to the deductible.
	Emergency medical transportation	No charge (if available)	20% coinsurance	30% coinsurance	Coverage applies to ground ambulances; benefit limited to two trips per confinement. Air ambulance covered only when medically necessary
	Urgent care	$20 copay / visit	$20 copay / visit	30% coinsurance	Deductible does not apply to in-network visits.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	30% coinsurance	Benefit is limited to a semi-private room; preauthorization is required.
	Physician / surgeon fees	No charge	20% coinsurance	30% coinsurance	Preauthorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	20% coinsurance	30% coinsurance	——————————— None ———————————
	Inpatient services	No charge	20% coinsurance	30% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	No charge	20% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services
	Childbirth/delivery professional services	No charge	20% coinsurance	30% coinsurance	Separate cost-sharing applies for Mother and Newborn.
	Childbirth/delivery facility services	No charge	20% coinsurance	30% coinsurance	Separate cost-sharing applies for Mother and Newborn.

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)	
		Tier 1 – NOMI	Tier 2 - HAP		
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	30% coinsurance	Preauthorization is required.
	Rehabilitation services	No charge	20% coinsurance	30% coinsurance	Limited to combined rehabilitation therapies maximum of 90 visits per member per year.
	Habilitation services	Not Covered		Not Covered.	For coverage related to treatment of mental health conditions and substance use disorders contact Fund Office.
	Skilled nursing care	No charge	20% coinsurance	30% coinsurance	Preauthorization is required. Limited to a maximum of 120 days per member per calendar year.
	Durable medical equipment	No charge	20% coinsurance	30% coinsurance	Durable Medical Equipment over $500 requires preauthorization
	Hospice services	No charge	No charge	No charge	Preauthorization is required
If your child needs dental or eye care	Children's eye exam & Children's glasses	$10 Exam copay $25 Materials copay Lenses covered in full after copay Necessary contact lenses covered in full after copay $130 frames / elective contact lenses allowance		Single vision lenses up to $30 allowance. Frames up to $70 allowance. Necessary contact lenses up to $210	Fully Insured Vision Benefits via Delta Vision. Call Fund Office for more information/brochures. Prescription glasses or contact lenses, not both. One pair of lenses every 12 months. One frame every 24 months.
	Children's dental check-up	Delta Dental: No charge, once every 6 months DENCAP: No charge, once every 6 months		Not Covered	Delta Dental: maximum benefit $2,000 per covered adult; no max for children to age 18. A lifetime orthodontic benefit of $2,000 to age 19 is available. DENCAP: maximum benefit $1,500 per year per covered person; lifetime limit orthodontics $1,200 for adults and $1,800 for children.

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	• Long Term Care	• Routine foot care
• Cosmetic Surgery (with limited exceptions)	• Non-emergency care when traveling outside the United States	• Infertility Treatment
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Chiropractic Care	• Cologuard cancer screening
• Private Duty Nursing	• Hearing Aids (TruHearing must be used for coverage)	

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. 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 by calling the number on the back of your ID card. Or, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

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.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 216-267-3344 or 888-424-7488 .]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 216-267-3344 or 888-424-7488.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 216-267-3344 or 888-424-7488 .]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 216-267-3344 or 888-424-7488 .]

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

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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 under the Full Plan using the Health Alliance Plan (Tier 2) Network. If you use the Nomi (Tier 1) network, you may be able to reduce your costs. For more information about the plan's network tiers, please contact the Fund Office.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$300
■ Specialist copayment	$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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$20
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,580**

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

■ The plan's overall deductible	$300
■ Specialist copayment	$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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$900
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	$300
■ Specialist copayment	$20
■ Hospital (facility) *[copayment*	$0*
■ 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:

Cost Sharing	
Deductibles	$300
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1000**

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

For more information about limitations and exceptions, call 1-248-641-4949 or 1-888-868-6411 to request a copy of the plan.

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, call 1-248-641-4936. 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	Answers			Why This Matters:
What is the overall deductible?	Tier 1 – NOMI Network: **$0** / person; **$0** / family	Tier 2 – Health Alliance Plan (HAP) Network: **$1,000** / person; **$2,000** / family	Out-of-Network: **$2,000** / person; **$4,000** / 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 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. All services rendered by Tier 1 Nomi providers are covered before you meet your deductible. In addition, Tier 2 in-network preventive services, in-network office visits, chiropractic care, and prescription benefits are covered before you meet your 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.			You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Tier 1 – NOMI Network: ACA limit / person; ACA limit / family	Tier 2 – Health Alliance Plan (HAP) Network: **$5,000** / person; **$10,000** / family	Out-of-Network: **$10,000** / person; **$20,000** / family	The ACA Overall OOP (ACA limit) for out-of-pocket expenses (e.g., copayment, coinsurance, and deductible) for in-network essential health benefits for 2027 is: $12,000 for individual coverage and $24,000 for family coverage. 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?	Self-payments, premiums, balance-billing charges, penalties for failure to obtain pre-authorization for services, 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. You pay the least if you use a provider in the **Nomi** (Tier 1) network. You will pay more if you use a provider in the **Health Alliance Plan** (Tier 2) network. See www.nomihealth.com or www.hap.org for a list of Tier 1 and Tier 2 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)	
		Tier 1 – NOMI	Tier 2 – HAP		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	$25 copay / visit	40% coinsurance	Deductible does not apply to in-network visits
	Specialist visit	No charge	$50 copay / visit	40% coinsurance	Deductible does not apply to in-network visits
	Preventive care / screening / immunization	No charge	No charge	Not Covered.	You may have to pay for services that are not preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	40% coinsurance	Preauthorization may be required.
	Imaging (CT / PET scans, MRIs)	No charge	30% coinsurance	40% coinsurance	Preauthorization may be required.
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.express-scripts.com**	Generic drugs (Tier 1)	Retail & Mail Order (1-34 day supply): $10 copay Retail & Mail Order (35-90 day supply) $20 copay		Not covered.	Drugs which cost over $400 are subject to coupon program, call 866-680-4859. Unless your physician prescribes otherwise, if you receive a brand (Tier 2 or 3) drug when a generic (Tier 1) equivalent is available, you must pay the copay and the cost difference between generic and brand name drug. Must use Accredo Specialty Pharmacy for all specialty drugs, which are limited to a 30-day supply. Mail order pharmacy may be contacted at (800) 803-2523. Some drugs require preauthorization. A list of these drugs can be found at www.express-scripts.com. Wal-Mart and Sam's Club retail pharmacies excluded; you are unable to fill at these pharmacies.
	Preferred brand drugs (Tier 2)	Retail & Mail Order (1-34 day supply): $40 copay Mail Order (35-90 day supply) $80 copay		Not covered.	
	Non-preferred brand drugs (Tier 3)	Retail & Mail Order (1-34 day supply): $80 copay Mail Order (35-90 day supply) $160 copay		Not covered.	
	Specialty drugs (Tier 4)	**Limited to 30-day supply only**. $150 copay		Not covered.	

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)	
		Tier 1 – NOMI	Tier 2 – HAP		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	40% coinsurance	Preauthorization may be required for certain procedures.
	Physician/surgeon fees	No charge	30% coinsurance	40% coinsurance	Preauthorization may be required for certain procedures.
If you need immediate medical attention	Emergency room care	$150 copay / visit	$150 copay / visit	$150 copay / visit	Copay waived if care is due to an accidental injury or if Covered Person is admitted. For the cost of related diagnostic tests, see p. 2 for applicable coinsurance amount, subject to the deductible.
	Emergency medical transportation	No charge (if available)	30% coinsurance	40% coinsurance	Coverage is for ground ambulances; benefit limited to two trips per confinement. Air ambulance covered only when medically necessary.
	Urgent care	$25 copay / visit	$25 copay / visit	40% coinsurance	Deductible does not apply to in-network visits.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	40% coinsurance	Benefit is limited to a semi-private room; Preauthorization is required.
	Physician/surgeon fees	No charge	30% coinsurance	40% coinsurance	Preauthorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	30% coinsurance	40% coinsurance	——————— None ———————
	Inpatient services	No charge	30% coinsurance	40% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	No charge	30% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services
	Childbirth/delivery professional services	No charge	30% coinsurance	40% coinsurance	Separate cost-sharing applies for Mother and Newborn.
	Childbirth/delivery facility services	No charge	30% coinsurance	40% coinsurance	Separate cost-sharing applies for Mother and Newborn.

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)	
		Tier 1 – NOMI	Tier 2 – HAP		
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	40% coinsurance	Preauthorization is required
	Rehabilitation services	No charge	30% coinsurance	40% coinsurance	Limited to combined rehabilitation therapies maximum of 90 visits per member per year.
	Habilitation services	Not Covered		Not Covered	For coverage related to treatment of mental health conditions and substance use disorders, contact Fund Office.
	Skilled nursing care	No charge	30% coinsurance	40% coinsurance	Preauthorization is required. Limited to a maximum of 120 days per member per calendar year.
	Durable medical equipment	No charge	30% coinsurance	40% coinsurance	Durable Medical Equipment over $500 requires preauthorization
	Hospice services	No charge	No charge	No charge	Preauthorization is required
If your child needs dental or eye care	Children's eye exam & Children's glasses	$10 Exam copay $25 Materials copay Lenses covered in full after copay Necessary contact lenses covered in full after copay $130 frames / elective contact lenses allowance		Single vision lenses up to $30 allowance. Frames up to $70 allowance. Necessary contact lenses up to $210	Fully Insured Vision Benefits via Delta Vision. Call Fund Office for more information/brochures. Prescription glasses or contact lenses, not both. One pair of lenses every 12 months. One frame every 24 months.
	Children's dental check-up	Delta Dental: No charge, once every 6 months DENCAP: No charge, once every 6 months		Not Covered	Delta Dental: maximum benefit $2,000 per covered adult; no max for children to age 18. A lifetime orthodontic benefit of $2,000 to age 19 is available. DENCAP: maximum benefit $1,500 per year per covered person; lifetime limit orthodontics $1,200 for adults and $1,800 for children.

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	• Long Term Care	• Routine foot care
• Cosmetic Surgery (with limited exceptions)	• Non-emergency care when traveling outside the United States	• Infertility Treatment
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Chiropractic Care	• Cologuard cancer screening
• Private Duty Nursing	• Hearing Aids (TruHearing must be used for coverage)	

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: 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 1-877-267-2323 x 61565 or www.cciio.cms.gov. 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 by calling the number on the back of your ID card. For group health coverage subject to ERISA, you may also contact Employee Benefits Security Administration at 1-866-444-EBSA (3272).

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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al216-267-3344 or 888-424-7488.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 216-267-3344 or 888-424-7488.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 216-267-3344 or 888-424-7488.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 216-267-3344 or 888-424-7488.]

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

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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 under the Full Plan using the Health Alliance Plan (Tier 2) Network. If you use the Nomi (Tier 1) network, you may be able to reduce your costs. For more information about the plan's network tiers, please contact the Fund Office.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1000
Specialist *copayment*	$50
Hospital (facility) *coinsurance*	30%
Other *coinsurance*	30%

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:

Cost Sharing	
Deductibles	$1000
Copayments	$50
Coinsurance	$3,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,610**

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

The plan's overall deductible	$1000
Specialist *copayment*	$50
Hospital (facility) *coinsurance*	30%
Other *coinsurance*	30%

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:

Cost Sharing	
Deductibles	$900
Copayments	$1000
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,120**

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

The plan's overall deductible	$1000
Specialist *copayment*	$50
Hospital (facility) copayment	$0*
Other coinsurance	30%

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:

Cost Sharing	
Deductibles	$1000
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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

For more information about limitations and exceptions, call 1-248-641-4949 or 1-888-868-6411 to request a copy of the plan.