SHEET METAL WORKERS' LOCAL 292

ACTIVE ELIGIBLE HEALTH FUND PARTICIPANTS

PRESCRIPTION DRUG BENEFIT CHANGE

AND

SUMMARY OF BENEFITS AND COVERAGE

SHEET METAL WORKERS' LOCAL 292
FRINGE BENEFIT FUNDS
P.O. Box 189
Troy, MI 48099-0189
(248) 641-4992 (888) 646-6565

March 2021

TO: All Active Eligible Participants in the Sheet Metal Workers Local No. 292 Health Fund

RE: Prescription Drug Benefit Change and Summary of Benefits and Coverage (SBC)

The following notices are being distributed due to your enrollment in the new prescription drug benefit program with Blue Cross Blue Shield.

***SMART – Important Information About Your Prescription Drug Benefits*:** The enclosed notice details the changes made to the prescription drug coverage effective January 1, 2021. This notice describes the new prescription drug coverage in detail and provides examples of how the new plan works.

***Summary of Benefits and Coverage (SBC)*:** The SBC provides a general description of the Plan's benefits and associated costs. The SBC has been updated to include coverage under the new prescription drug plan.

If you have any questions, please contact the Fund Office at (248) 641-4992.

Sincerely,

Board of Trustees
Sheet Metal Workers Local No. 292 Health Fund

Enclosures

SHEET METAL | AIR | RAIL | TRANSPORTATION

Important Information About Your Prescription Drug Benefits

The Board of Trustees of the Sheet Metal Workers Local 292 Health Fund (the Fund) introduced a new prescription drug benefits program effective January 1, 2021. **The new program is administered by Blue Cross Blue Shield of Michigan (replacing EnvisionRx)**. Since Blue Cross Blue Shield of Michigan already administered our Simply Blue PPO Medical Plan in 2020, your medical and prescription drugs have be integrated and coordinated for the 2021 Plan year, which should make it easier for you and lead to better care.

The new prescription drug program covers the same medications and services, provides access to the same pharmacies, but it is structured differently. We have put together this notice to explain how the new program works.

You should have received a new ID card around January 1, 2021, from Blue Cross Blue Shield of Michigan that you will use for both your medical and prescription drug coverage.

Please review this notice carefully. It describes the new program, what changed, and what stayed the same. If you have any questions about the changes or your benefits in general, please call the Benefit Office.

Introducing Your New Blue Cross Blue Shield of Michigan Prescription Drug Benefits

The Trustees made these changes to help you save money and to save money for the Fund so we can continue providing you and your dependents comprehensive, affordable coverage.

The new prescription drug program looks a little different, but it is designed to work better for you and the Fund. The 2020 Plan was one-size-fits-all, with a 30% coinsurance for all covered medications. The new prescription drug benefits program has five tiers of covered medications, with different copays or coinsurance rates for each.

The chart below shows the new plan design. Later in this notice, we have some examples and tips to show you how it can save you money.

	2020 Rx Benefits (Self-Funded Rx)		Current Rx Benefits (Effective January 1, 2021)	
Rx Copays	**Retail or Mail**		**Retail or Mail** (Up to 30-day supply)	**Retail or Mail** (31- to 90-day supply)
Tier 1 (Generic medications)	30% coinsurance		$15 copay	$30 copay
Tier 2 (Preferred brand medications)	30% coinsurance		$50 copay	$100 copay
Tier 3 (Non-preferred brand medications)	30% coinsurance		Greater of $70 copay or 50% coinsurance (up to a max of $100)	Greater of $140 copay or 50% coinsurance (up to a max of $200)
Tier 4 (Generic or preferred brand specialty medications)	Not available		20% coinsurance (up to a max of $200)	Not available
Tier 5 (Non-preferred brand specialty medications)	Not available		25% coinsurance (up to a max of $300)	Not available
Out-of-Pocket Maximum	Separate Medical Out-of-Pocket Max: $4,000 single $8,000 family	Separate Rx Out-of-Pocket Max: $3,900 single $7,800 family	Combined Medical and/or Rx Out-of-Pocket Max: $6,850 single $13,700 family	

How the New Prescription Drug Benefit Works – Some Examples

Example 1

You are currently taking a covered generic prescription medication that costs $100 for a 30-day fill. Your 2020 coinsurance was 30% of the cost, or $30. In 2021, under the new program, your copay is $15.

Example 2

You are currently taking a covered generic maintenance medication that costs $500 for a 90-day fill. Your 2020 coinsurance was 30% of the cost, or $150. In 2021, under the new program, your copay is $30.

Example 3

You are currently taking a covered non-preferred brand name medication that costs $1,000 for a 30-day fill. Your 2020 coinsurance was 30% of the cost, or $300. In 2021, under the new program, your copay is $100.

What Are Tiers? Who Decides What Tier My Medication Is On?

Prescription drug programs cover some drugs, but not others. The list of covered drugs is called a formulary. That list is set by the prescription drug program administrator. Starting January 1, 2021, our formulary is set by Blue Cross Blue Shield of Michigan. The overall list is very similar to our list of covered medications in 2020. However, it is divided into five groups or tiers. The tiers are based on the type or usage of the medication. The tiers are determined by the:

- Cost of the drug and how it compares to other drugs for the same treatment.
- Drug availability.
- Clinical effectiveness and connection to standard of care and other cost factors.

Blue Cross Blue Shield of Michigan has set up five tiers of covered medications.

- **Tier 1** drugs have the lowest co-payment and are generic versions of brand name drugs.
- **Tier 2** drugs have a medium co-payment and are brand name drugs that are usually more affordable.
- **Tier 3** drugs have a higher copay or coinsurance rate and are brand-name drugs that have a generic version available.
- **Tier 4** drugs are generic or preferred brand specialty drugs and are typically used to cover serious illness.
- **Tier 5** drugs are non-preferred brand specialty medications.

We encourage you to review the formulary with your doctor and/or pharmacist. Take a look at what tiers your current medications are in and ask about the tiers when you get a prescription for a new medication. If your medication is not in tier 1 or 2, ask your doctor or pharmacist if there are any alternative medications in those tiers that could work for you. Quite often there are alternative drugs in those tiers that are just as effective and cost less.

Network Pharmacies

The list of pharmacies that are considered to be in-network are the same in 2021. If you were using a network pharmacy in 2020, it should be in the network under the new program. These days, it is hard to find an out-of-network pharmacy. If you do go to an out-of-network pharmacy, you will pay the amounts listed in the chart on the first page PLUS an additional 25% of the approved amount, so it will cost you a lot more. Check on the **bcbsm.com** website to make sure your pharmacy is in-network or ask your pharmacist.

What's the Deal with the Combined Out-of-Pocket Maximum?

Under the new plan design, there is a combined out-of-pocket maximum for your medical and prescription drug benefits. Because both benefit programs are administered by Blue Cross Blue Shield of Michigan, they can easily be integrated and tracked. Under the 2020 benefits, you had one out-of-pocket maximum for medical expenses that were administered by Blue Cross Blue Shield of Michigan and a separate out-of-pocket maximum for prescription drug expenses that were administered by EnvisionRx.

Remember that the out-of-pocket maximum is the most you will have to pay for covered services in a Plan year. After you spend this amount on deductibles, copays, and coinsurance for in-network care and services, the Plan pays 100% of the costs of covered benefits.

How the Combined Out-of-Pocket Maximum Works – An Example

Example: You have an individual deductible of $3,000, $30 copays for office visits, coinsurance of 20% for most services, copays or coinsurance for prescriptions, and an out-of-pocket maximum ($4,000 medical max and $3,900 prescription max in 2020; $6,850 combined max in 2021). During the year, the following happens:

- You fall awkwardly and break a finger. You go to the emergency room and are treated and released.
  - Cost: $10,000
- You fill 3 prescriptions for generic medications.
  - 2020 Cost: $90 (each prescription costs $100, so the 30% coinsurance for each is $30)
  - 2021 Cost: $45 ($15 coinsurance for each)
- You go to the doctor and/or urgent care five times during the year.
  - Cost: $30 copay per visit for a total cost of $150.
- You fill 4 prescriptions for preferred brand name medications.
  - 2020 Cost: $180 (each prescription costs $200, so the 30% coinsurance for each is $60)
  - 2021 Cost: $150 ($50 coinsurance for each)

For the sake of this example, let's say that these events happen in the order listed.

Here's how it worked in 2020:

- First, let's add up your medical expenses. For the emergency room, you first pay your $3,000 deductible. Then you pay 20% of the remaining cost. Since there is $7,000 remaining, 20% comes to $1,400. Your medical out-of-pocket maximum is $4,000, so you only need to pay $1,000 of the $1,400. At that point, the Plan begins paying 100% of your covered expenses. That means your other doctor and urgent care visits are also covered 100% by the Plan.
- Now, let's look at your prescription drug expenses. Your total comes to $270 (well below the annual prescription drug out-of-pocket maximum).
- For the year, you spend $4,270 for your medical and prescription drug expenses, and you reach the medical out-of-pocket maximum, but you do not meet the prescription drug out-of-pocket maximum.

Here's how it works in 2021:

- For the emergency room, you first pay your $3,000 deductible. Then, you pay 20% of the remaining cost. Since there is $7,000 remaining, 20% comes to $1,400. Your ER total comes to $4,400.
- Your prescription total is $195 for the year.
- Your doctor visits are $150 for the year.
- Your total medical and prescription drug expenses for the year comes to $4,745 (under the combined out-of-pocket maximum of $6,850).

90-Day Retail Prescription Program

Blue Cross Blue Shield of Michigan offers a 90-Day Retail Prescription Program that can save you money on prescriptions that you take on an ongoing basis. You can get up to a 90-day supply of your maintenance medications at a retail pharmacy for a reduced cost.

To use this benefit, ask your doctor to write a new prescription for an 84- to 90-day supply. Take the prescription to your local pharmacy to be filled. Under the new copay structure, your copay for a 90-day prescription will be the same as filling two 30-day prescriptions. **You're basically getting 30 days' of your medication for free!** The cost is the same as ordering your 90-day prescriptions through the mail-order pharmacy.

Ask your pharmacist if he or she participates in the program before having your prescription filled.

Use the Blue Cross Blue Shield of Michigan Website

You can find a lot of helpful information, forms and tools regarding your prescription drug coverage on the Blue Cross Blue Shield of Michigan website (**bcbsm.com**). Log in (or register for an account if you have not already done so) and then you can see the formulary, find forms, ask questions, find out procedures for prior approval or step therapy (if needed), find a pharmacy, and much more.

Helpful Contact Information

Benefit Office: BeneSys

Address:	P.O. Box 189, Troy, MI 48099-0189
Phone:	(248) 641-4992
Website:	https://www.ourbenefitoffice.com/SheetMetal292/Benefits/Home.aspx

Blue Cross Blue Shield of Michigan

Phone:	(877) 790-2583
Website:	www.bcbsm.com

Blue Cross Blue Shield of Michigan

A nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

SHEET METAL WORKERS LOCAL NO. 292 HEALTH FUND

Simply Blue PPO℠ LG **Coverage for:** Individual/Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call the number on the back of your BCBSM ID card. 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 https://www.healthcare.gov/sbc-glossary or call the number on the back of your BCBSM ID card to request a copy.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$3,000 Individual/ $6,000 Family	$6,000 Individual/ $12,000 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. Preventive care services 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? (May include a coinsurance maximum)	$6,850 Individual/ $13,700 Family	$13,700 Individual/ $27,400 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See (http://www.bcbsm.com) or call the number on the back of your BCBSM ID card for a list of network providers.		This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.		You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/office visit; deductible does not apply	40% coinsurance	None
	Specialist visit	$30 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/ screening/ immunization	No Charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	May require preauthorization

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/druglists	Generic or select prescribed over-the-counter drugs	$15 copay for retail 30-day supply; $30 copay for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not covered out of network. Select diabetic supplies and devices may be covered under the prescription drug program.
	Preferred brand-name drugs	$50 copay for retail 30-day supply; $100 copay for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
	Nonpreferred brand-name drugs	$70 copay or 50% coinsurance of the approved amount (whichever is greater), but no more than $100 copay for retail 30-day supply; $140 or 50% coinsurance of the approved amount (whichever is greater), but no more than $200 copay for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
	Generic and preferred brand-name specialty drugs	20% coinsurance of the approved amount, but no more than $200 copay for retail or mail order 30-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	Preauthorization is required. Specialty drugs limited to a 15 or 30-day supply. Pharmacy Specialty drugs obtained from other than an Exclusive Specialty Pharmacy Network provider will not be covered.
	Nonpreferred brand-name specialty drugs	25% coinsurance of the approved amount, but no more than $300 copay for retail or mail order 30-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$150 copay/visit; deductible does not apply	$150 copay/visit; deductible does not apply	Copay waived if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	Mileage limits apply
	Urgent care	$30 copay/visit; deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required
	Physician/surgeon fee	20% coinsurance	40% coinsurance	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	20% coinsurance	20% coinsurance for mental health; 40% coinsurance for substance use disorder	None
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	Prenatal: No Charge; deductible does not apply Postnatal: 20% coinsurance	Prenatal: 40% coinsurance Postnatal: 40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services cost share may apply. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Physician certification required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 30 visits per member, per calendar year.
	Habilitation services	20% coinsurance for Applied Behavioral Analysis; 20% coinsurance for Physical, Speech and Occupational Therapy	20% coinsurance for Applied Behavioral Analysis; 40% coinsurance for Physical, Speech and Occupational Therapy	Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization.
	Skilled nursing care	20% coinsurance	20% coinsurance	Preauthorization is required. Limited to 120 days per member per calendar year
	Durable medical equipment	20% coinsurance	40% coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge; deductible does not apply	No Charge; deductible does not apply	Physician certification required. Visit limits apply.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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 treatment	• Hearing aids	• Routine eye care (Adult)
• Cosmetic surgery	• Infertility treatment	• Routine foot care
• Dental care (Adult)	• Long term 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	• Coverage provided outside the United States. See http://provider.bcbs.com	• Private duty nursing
• Chiropractic care	• Non-emergency care when traveling outside the U.S.	

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 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling the number on the back of your BCBSM ID card. 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 Blue Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or http://www.michigan.gov/difs or difs-HICAP@michigan.gov

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 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. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: See Addendum

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	$3,000
■ 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:

Cost Sharing	
Deductibles	$3,000
Copayments	$10
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,470**

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

■ The plan's overall deductible	$3,000
■ 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:

Cost Sharing	
Deductibles	$900
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,920**

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

■ The plan's overall deductible	$3,000
■ Specialist copayment	$30
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies)*
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

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 coinsurance, or benefits not otherwise covered.

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

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

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

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

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

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

ئەگەر ئێوە، یان کەسێک کە ئێوە یارمەتی دەدەن، پێویستی بە یارمەتی هەیە، مافی ئەوەتان هەیە یارمەتی و زانیاری پێویست بە زمانەکەی خۆتان وەربگرن بەبێ هیچ تێچوونێک. بۆ قسەکردن لەگەڵ وەرگێڕ، پەیوەندی بە ژمارەی خزمەتگوزاری بەکارهێنەرانەوە بکەن کە لەسەر کارتەکەتان، یان لە 877-469-2583 TTY:711 ئەگەر ئێستا ئەندام نیت.

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

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

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

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

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

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

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

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

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

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

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

Important disclosure

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

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

SHEET METAL WORKERS' LOCAL 292
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Important Fund Information