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FRINGE BENEFIT FUNDS
P.O. BOX 159
TROY, MICHIGAN 48099-0159
(248) 641-4988 (866) 646-8919

Dear Active Participants and Pre-Medicare Retirees:

Enclosed please find revised Summary of Benefits and Coverage for the 2024 Plan Year, which updates the maximum out-of-pocket limits for 2024 and language relating to the new Opt-Out Plan that became effective 1-1-2024.

Please review carefully and retain your records.

If you have any questions, please contact the Fund Office.

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 1-248-641-4988. 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 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: F: **$500**/person; **$1,000**/family S: **$1,000**/person; **$2,000**/family B: **$1,500**/person; **$3,000**/family Out-of-Network: F: **$1,000**/person; **$2,000**/family S: **$2,000**/person; **$4,000**/family B: **$5,000**/person; $**10,000**/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. In-network preventative 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 preventative services without cost sharing and before you meet your deductible. See a list of covered preventative services at https://www.healthcare.gov/coverage/ preventative-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?	In-Network: F: **$1,000**/person; **$2,000**/family S: **$2,500**/person; **$5,000**/family B: **$5,350**/person; **$10,700**/family By Law the Overall OOP for copayments, deductibles, and co-insurance on in-network essential benefits for 2024 is: $9,450 Individual/ $18,900 Family Out-of-Network : F: **$2,000**/person; **$4,000**/family S: **$5,000**/person; **$10,000**/family B: **$10,000**/person; $**20,000**/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?	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. See www.hap.org or call 1-866-766-4661 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	F: $20 copay/visit S: $25 copay/visit B: $25 copay/visit	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	Deductible does not apply to in-network visits
	Specialist visit	F: $20 copay/visit S: $25 copay/visit B: $50 copay/visit	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	Deductible does not apply to in-network visits
	Preventive care/screening/ immunization	F/S/B: No charge	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	You may have to pay for services that are not 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)	F: 10% coinsurance S: 20% coinsurance B: 30% coinsurance	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	———— None ————
	Imaging (CT/PET scans, MRIs)	F: 10% coinsurance S: 20% coinsurance B: 30% coinsurance	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	———— None ————
If you need drugs to treat your illness or condition More information about **prescription**	Generic drugs (Tier 1)	Retail (34-day supply): F/S/B: 25% coinsurance, copay $15-$75 Retail (90-day supply) F/S/B: 25% coinsurance, copay $35-$175	Retail (34-day supply): F/S/B: 25% coinsurance, copay $15-$75 Retail (90-day supply) F/S/B: 25% coinsurance, copay $35-$175	For all drug tiers, copay amounts are minimum and maximum limits. Drugs which cost over $400 are subject to coupon program, call 866-680-4859.

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)	
drug coverage is available at www.costcohealthsolutions.com	Preferred brand drugs (Tier 2)	Retail (34 day supply): F/S/B: 25% coinsurance, copay $15-$75 Mail Order (90 day supply) F/S/B: 25% coinsurance, copay $35-$175	Retail (34 day supply): F/S/B: 25% coinsurance, copay $15-$75	Unless your physician prescribes otherwise, if you receive a brand drug when a generic equivalent is available, you must pay the copay and the cost difference between generic and brand name drug. Must use Costco Mail Order for all specialty drugs and are limited to a 30-day supply. Mail order pharmacy may be contacted at (800) 607-6861. Some drugs require preauthorization. A list of these drugs can be found at www.costcohealthsolutions.com Wal-Mart and Sam's Club retail pharmacies excluded; you are unable to fill at these pharmacies. Out-of-Network claims must be submitted manually (paper claim).
	Non-preferred brand drugs (Tier 3)	Retail (34 day supply): F/S/B: 25% coinsurance, copay $15-$75 Mail Order (90 day supply) F/S/B: 25% coinsurance, copay $35-$175	Retail (34 day supply): F/S/B: 25% coinsurance, copay $15-$75	
	Specialty drugs (Tier 4)	F/S/B: 25% coinsurance, copay $100-$200	No coverage.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	F: 10% coinsurance S: 20% coinsurance B: 30% coinsurance	F:20% coinsurance S: 30% coinsurance B:40% coinsurance	———— None ————
	Physician/surgeon fees	F: 10% coinsurance S: 20% coinsurance B: 30% coinsurance	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	———— None ————
If you need immediate medical attention	Emergency room care	F: $250 copay/visit S: $350 copay/visit B: $450 copay/visit	F: $250 copay/visit S: $350 copay/visit B: $450 copay/visit	Copay waived if accidental injury or admitted. For cost of related diagnostic tests, see p. 2 for applicable coinsurance and UCR after deductible is satisfied.
	Emergency medical transportation	F: 10% coinsurance S: 20% coinsurance B: 30% coinsurance	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	Coverage is for ground ambulances; benefit limited to 2 trips/confinement. Air Ambulance covered only when Medically Necessary.
	Urgent care	F: $20 copay/visit S: $25 copay/visit B: $25 copay/visit	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	Deductible does not apply to in-network visits
If you have a hospital stay	Facility fee (e.g., hospital room)	F: 10% coinsurance S: 20% coinsurance	F: 20% coinsurance S: 30% coinsurance	Benefit is limited to a semi-private room; preauthorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		B: 30% coinsurance	B: 40% coinsurance	
	Physician/surgeon fees	F: 10% coinsurance S: 20% coinsurance B: 30% coinsurance	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	———— None ————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	F: 10% coinsurance S: 20% coinsurance B: 30% coinsurance	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	———— None ————
	Inpatient services	F: 10% coinsurance S: 20% coinsurance B: 30% coinsurance	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	Preauthorization required.
If you are pregnant	Office visits	F: 10% coinsurance S: 20% coinsurance B: 30% coinsurance	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	Cost sharing does not apply for preventative services.
	Childbirth/delivery professional services	F: 10% coinsurance S: 20% coinsurance B: 30% coinsurance	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	No coverage for a Dependent child (i.e., benefit is only available for a Participant (i.e., an active employee, pensioner, surviving spouse) and his or her spouse.)
	Childbirth/delivery facility services	F: 10% coinsurance S: 20% coinsurance B: 30% coinsurance	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	No coverage for a Dependent child (i.e., benefit is only available for a Participant (i.e., an active employee, pensioner, surviving spouse) and his or her spouse.)
If you need help recovering or have other special health needs	Home health care	F: 10% coinsurance S: 20% coinsurance B: 30% coinsurance	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	Preauthorization required.
	Rehabilitation services	F: 10% coinsurance S: 20% coinsurance B: 30% coinsurance	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	———— None ————
	Habilitation services	F: 10% coinsurance S: 20% coinsurance B: 30% coinsurance	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	———— None ————
	Skilled nursing care	F: 10% coinsurance S: 20% coinsurance B: 30% coinsurance	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	Preauthorization required.
	Durable medical equipment	F: 10% coinsurance S: 20% coinsurance B: 30% coinsurance	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	———— None ————

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)	
	Hospice services	F: 10% coinsurance S: 20% coinsurance B: 30% coinsurance	F: 20% coinsurance S: 30% coinsurance B: 40% coinsurance	Preauthorization required.
If your child needs dental or eye care	Children's eye exam	VSP Discount Program: Included under Options Full, Standard, Basic and Opt Out Plan	VSP Discount Program: Included under Options Full, Standard, Basic, and Opt Out Plan	VSP Discount Program details set forth in VSP brochures and summaries. Contact information: vsp.com or 248-350-2082 SVS Vision Discount Card provided for Opt-Out Participants
	Children's glasses	VSP Discount Program: Included under Options Full, Standard, Basic and Opt Out Plan	VSP Discount Program: Included under Options Full, Standard, Basic and Opt Out Plan	VSP Discount Program details set forth in VSP brochures and summaries. Contact information: vsp.com or 248-350-2082. SVS Vision Discount Card provided for Opt-Out Participants.
	Children's dental check-up	No coverage.	No coverage.	Dental coverage is only available under the Opt Out Plan.

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
- Cosmetic Surgery (with limited exceptions)
- Dental Care (Adults)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the United States
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

Bariatric surgery, Chiropractic Care, Hearing Aids, Private Duty Nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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 on how 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.

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.

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

The plan's overall deductible	$500
Specialist copayment	$0
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$500
Copayments	$10
Coinsurance	$1000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,560**

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

The plan's overall deductible	$500
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$500
Copayments	$1200
Coinsurance	$40
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

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

The plan's overall deductible	$500
Specialist copayment	$20
Hospital (facility) copayment	$0*
Other coinsurance	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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$50
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$650**

The plan would be responsible for the other costs of these EXAMPLE covered services. * Copay waived for accidental injury or if admitted.