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, go to www.milaborerfunds.org or call 1-877-645-2267. 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 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 / individual or $0 / family for in-network and out-of-network services.	See the chart starting on Page 2 for how much you pay for covered services. As noted there is **no** deductible.
Are there services covered before you meet your deductible?	Yes. There is no deductible required for services to be covered.	You don't have any deductibles for services, but see the chart starting on page 2 for other costs for services this plan covers.
Are there other deductibles for specific services?	No.	There are no deductibles.
What is the out-of-pocket limit for this plan?	$8,550 / Individual or $17,100 / Family in-network. Out-of-network cost sharing has no limit and does not count towards limit.	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. **Note:** Within the out-of-pocket limit above there is a $1,200 coinsurance family maximum for in-network. Copayments noted throughout do not apply to the coinsurance maximum noted here.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, pharmacy penalties, health care this plan doesn't cover and certain other amounts.	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.bcbsm.com or call 1-877-790-2583 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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/office visit	$20 copay/office visit plus 30% coinsurance	Tele-health visits are $10 copay. Out-of-network providers may balance bill.
	Specialist visit	$20 copay/visit	$20 copay/visit plus 30% coinsurance	Out-of-network providers may balance bill.
	Preventive care/screening/ immunization	No charge	30% coinsurance	You may have to pay in-network cost sharing for services that are not preventive. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits. Out-of-network providers may balance bill.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	Preauthorization may be required for select imaging tests. Out-of-network providers may balance bill.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.bcbsm.com/pharmacy** For more information about the Coupon Program contact the Fund Office.	Generic drugs (Tier 1)	$15 copay 1-30 days; $30 copay 84-90 days	In-network copay **plus** 25% coinsurance based on BCBSM approved amount.	Step therapy, quantity limits and/or prior authorization may apply. Out-of-network pharmacy 31-90 day supply **not covered**. **Prescription Drug Manufacturer Coupon Assistance Program is mandatory for Participants with prescription drugs (including Specialty drugs) that cost $400 or more and a manufacturer's coupon is available.** Health Plan Advocate, the program administrator, will contact the Participant. If a Manufacturer Coupon is not used, the Participant's cost sharing is 50% of the cost of the prescription drug.
	Preferred brand drugs (Tier 2)	$50 copay 1-30 days; $100 copay 84-90 days	In-network copay **plus** 25% coinsurance based on BCBSM approved amount.	
	Non-preferred brand drugs (Tier 3)	50% of the approved amount with a minimum of $80 copay and a maximum of $100 for 1-30-days; 50% with a minimum of $160 copay and a maximum of $200 for 84-90 days	In-network copay **plus** 25% coinsurance based on BCBSM approved amount.	

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Generic and preferred brand-name specialty drugs (Tier 4)	20% of the approved amount but no more than $200 copay for 1-30-days	In-network copay **plus** 25% coinsurance based on BCBSM approved amount.	Step therapy, quantity limits and/or prior authorization may apply. **31-90 day supply not covered for specialty drugs** in or out-of-network.
	Non-preferred brand-name specialty drugs (Tier 5)	25% of the approved amount but no more than $300 copay for 1-30-days	In-network copay **plus** 25% coinsurance based on BCBSM approved amount.	
	Lifestyle drugs	Not Covered	Not Covered	Examples of lifestyle drugs are fertility, impotence, weight loss, etc.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	Services must be rendered in a participating ambulatory surgery center.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	Out-of-network providers may balance bill.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network providers may balance bill.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$20 copay/visit	$20 copay/office visit plus 30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Non-emergency services must be rendered in a participating hospital.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	Out-of-network providers may balance bill.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	Must be performed in an approved facility. Out-of-network providers may balance bill.
	Inpatient services	20% coinsurance	30% coinsurance	Must be performed in an approved facility. Non-participating facilities are **not covered**.
If you are pregnant	Office visits	Prenatal no charge; $20 copay/visit for postnatal.	30% coinsurance	Out-of-network providers may balance bill.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	Out-of-network providers may balance bill.
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	Non-participating facilities are not covered.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Must be provided by a participating home health care agency.
	Rehabilitation services	20% coinsurance	30% coinsurance	Services at non-participating outpatient physical therapy facilities are not covered.
	Habilitation services	20% coinsurance	30% coinsurance	
	Skilled nursing care	20% coinsurance	20% coinsurance	Must be in a participating skilled nursing facility
	Durable medical equipment	20% coinsurance	20% coinsurance	Out-of-network providers may balance bill.
	Hospice services	0% coinsurance	0% coinsurance	Provided through a participating hospice program only.
If your child needs dental or eye care	Children's eye exam	$10 copay	$10 copay	Coverage limited to one exam per year. Out-of-network providers may balance bill.
	Children's glasses	$10 copay frames and lenses; $200 allowance for frames. Additional costs for progressive lenses.	$10 copay, provider can bill for the difference between the BCBSM approved amount and the provider's charge.	Coverage limited to one pair of glasses per 24 month period. Out-of-network providers may balance bill.
	Children's dental check-up	20% coinsurance for Class I (preventive).	20% coinsurance for Class I (preventive).	Class II (basic) & III (major) services covered 50% coinsurance; $3,000 annual family max. Non-participating dentists may balance bill.

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
- Infertility treatment
- Hearing aids
- Long-term care
- Routine foot care
- Weight loss programs

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

- Bariatric surgery (medical necessity)
- Chiropractic care
- Routine dental care (Adult)
- Routine eye care (Adult)
- Care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor, Employee Benefits Security Administration 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families. 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: www.milaborerfunds.org or 1-877-645-2267. You may also contact the Department of Laborer Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families.

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 1-877-645-2267.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-645-2267.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-877-645-2267.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-645-2267.

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	$0
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 Services0
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$30
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,290**

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

The plan's overall deductible	$0
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*	$0
Copayments	$1,500
Coinsurance	$20
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,540**

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$50
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

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