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, contact our Member Services Department at 1-800-572-7687. 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.mctwf.org or call 1-800-572-7687 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 Individual/$1,500 family network providers. $1,000 Individual/$3,000 family non-network providers.	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care/screening and primary, specialist, emergency room, or urgent care provider services as long as you use a network provider.	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?	For network providers, $2,500 Individual/$5,000 family for most medical services. For non-network providers, $5,000 Individual/$10,000 family for most medical services.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, non-network coinsurance expenses.	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.mctwf.org or call 1-800-572-7687	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)	Non-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	$25 copay/visit	40% coinsurance	None
	Specialist visit	$50 copay/visit	40% coinsurance	
	Preventive care	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
	Screening	No charge	40% coinsurance	
	Immunization	No charge	40% coinsurance	
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	Preauthorization required, otherwise not covered
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.caremark.com**	Generic drugs	$10 copay/prescription for up to 34 days supply (retail & mail order), $20 copay for 35-60 days' supply (retail & mail order), $30 copay for 61-90 days' supply (retail) and $20 copay 61-90 days' supply (mail order).	Difference between the charges and the allowed amount plus the applicable network copay.	Preauthorization required as follows, otherwise not covered: Coverage of non-formulary brand drugs, compound drugs exceeding a specified dollar limit, and drugs within the following therapeutic categories: Acne, Anti-Obesity, ADHD/Narcolepsy (age 20 and above), Anabolic Steroids, Oral Anti-fungal, SSRI (brand name only), Proton Pump Inhibitors (brand or generic treatment greater than 90 days per one year period). Erectile dysfunction tablets, influenza treatment and preventions, smoking cessation and other limitations *see section 6.8 in SPD.
	Preferred brand drugs	$20 copay/prescription for up to 34 days supply (retail & mail order), $40 copay for 35-60 days' supply (retail & mail order), $60 copay for 61-90 days' supply (retail) and $45 copay 61-90 days' supply (mail order).		
	Non-preferred brand drugs	$35 copay/prescription for up to 34 days supply (retail & mail order), $70 copay for 35-60 days' supply (retail & mail order), $105 copay for 61-90 days' supply (retail) and $80 copay 61-90 days' supply (mail order).		
	Specialty drugs	$20 copay/prescription for up to 34 days supply (retail & mail order), $40 copay for 35-60 days' supply (retail & mail order), $60 copay for 61-90 days' supply (retail) and $45 copay 61-90 days' supply (mail order).		Prior authorization required, other-wise not covered. Certain specialty drugs may be deemed as non-preferred brand drugs and may be subject to the corresponding copay structure.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician fees	20% coinsurance	40% coinsurance	
	Surgeon fees	20% coinsurance	40% coinsurance	

* For more information about limitations and exceptions, see your Summary Plan Description (SPD) or Schedule of Benefits (SOB) at www.mctwf.org

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$125 copay/visit	$125 copay/visit	Copay waived if admitted. *see section 6.8 in SPD for limitations.
	Emergency medical transportation	20% coinsurance	20% coinsurance	*see section 3.15 in SPD for limitations.
	Urgent care	$55 copay/visit	40% coinsurance	None
If you have a hospital stay	Facility fee(e.g. hospital room)	20% coinsurance	40% coinsurance	Prior authorization required, otherwise not covered.
	Physician fees	20% coinsurance	40% coinsurance	
	Surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services.	Outpatient services	$20 copay/visit	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Prior authorization required, otherwise not covered.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help re-covering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Prior authorization required, otherwise not covered.
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	20% coinsurance	Prior authorization required, otherwise not covered. *see your SOB for limitations.
	Durable medical equipment	20% coinsurance	20% coinsurance	Prior authorization generally required for purchases and repairs only, otherwise not covered.
	Hospice services	20% coinsurance	20% coinsurance	Prior authorization required, otherwise not covered.

* For more information about limitations and exceptions, see your Summary Plan Description (SPD) or Schedule of Benefits (SOB) at www.mctwf.org

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	Any Charge over $50	Limited to one exam year.
	Children's glasses	Basic Lenses - No charge	Lenses - any charge over $50 for single, $60 for bifocal, $70 for trifocal and $70 for lenticular	Limited to one vision correction option/year.
		Frames - any charge over $150	Frames - any charge over $75	
	Children's dental check-up	No charge	Any charge over the allowed amount	Limited to 2 oral examinations and cleanings/ year.

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
- Long-term care
- Routine foot care (except in presence of certain systemic conditions)

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

- Bariatric surgery
- Chiropractic care up to 24 spinal manipulations per person annually. One mechanical traction per day only with spinal manipulation expenses. One "new patient" office visit every 36 months and one "established patient" office visit annually, per chiropractor.
- Dental care (Adult) up to annual per person maximum of $1,500 DNoA Preferred.
- Hearing aids up to $1,500 per person, per aid every 2 years.
- Non-emergency care when traveling outside the U.S. Contact 1-800-810-2583.
- Private-duty nursing limited to 24 hrs. per day for 5 days lifetime, 16 hrs. per day for 45 days lifetime and 8 hrs. per day for 900 days lifetime.
- Routine eye care (Adult) limited to one exam and one vision correction option per calendar year.

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-EBSA (3272). 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 plan at 1-800-572-7687. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Michigan Office of Financial and Insurance Regulations at 1-877-999-6442.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-572-7687.

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** **$500**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **20%**
- **Other copayment/coinsurance** **$25/20%**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$40
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,100**

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** **$50**
- **Hospital (facility) copayment** **20%**
- **Other copayment/coinsurance** **$25/20%**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$870
Coinsurance	$373
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,598**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **20%**
- **Other copayment/coinsurance** **$25/$125/20%**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$275
Coinsurance	$215
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$790**

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