MICHIGAN TROWEL TRADES HEALTH & WELFARE FUND
Benefits and Eligibility at a Glance
Effective January 1, 2015

	In-Network	Out-of-Network
Deductible, Co pays and Dollar Maximums		
Deductible – per calendar year	$1,000 for one member, $2,000 for the family each calendar year	$2,000 for one member, $4,000 for the family each calendar year
Fixed dollar co-pays	$40 co-payment for office visits & chiropractic visits $150 co-pay for emergency room visits	$150 co-pay for emergency room visits
Co-insurance- (It is calculated as a percent of the allowed amount and is your share of the costs of a covered service. Co-insurance begins after a member has met their annual deductible)	50% of approved amount for mental health care, substance abuse and private duty nursing 20% of approved amount for most other covered services	50% of approved amount for mental health care, substance abuse and private duty nursing 40% of approved amount for most other covered services
Annual co-insurance dollar maximums	$1,000 for one member, $2,000 for two or more members each calendar year	$3,000 for one member, $6,000 for two or more members each calendar year
Lifetime dollar maximum	None	
Preventive Services		
Health Maintenance Exam – includes chest X-ray, EKG, cholesterol screening and select lab procedures	100%, one per calendar year (no deductible or co-pay)	Not covered
Gynecological Exam	100%, one per calendar year (no deductible or co-pay)	Not covered
Pap Smear Screening – laboratory and pathology services	100%, one per calendar year (no deductible or co-pay)	Not covered
Well-Baby and Child Care	100% (no deductible or co-pay) • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	100% (no deductible or co-pay)	Not covered
Fecal occult blood screening	100%, one per calendar year (no deductible or co-pay)	Not Covered
Flexible sigmoidoscopy exam	100%, one per calendar year (no deductible or co-pay)	Not Covered
Prostate specific antigen (PSA) screening	100%, one per calendar year (no deductible or co-pay)	Not Covered

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Preventive Services		
Colonoscopy	100% one per calendar year (no deductible or co-pay)	60% after out-of-network deductible
Routine Mammography Screening	100% one per calendar year (no deductible or co-pay)	60% after out-of-network deductible
Physician Office Services		
Office Visits	$40 co-payment per office visit	60% after out-of-network deductible
Outpatient and home medical care visits – must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office Consultations – must be medically necessary	$40 co-payment per office visit	60% after out-of-network deductible
Urgent Care Visits – must be medically necessary	$40 co-payment per office visit	60% after out-of-network deductible
Emergency Medical Care		
Hospital Emergency Room	$150 co pay per visit (co-pay waived if admitted or for an accidental injury)	$150 co-pay per visit (co-pay waived if admitted or for an accidental injury)
Ambulance Services – medically necessary	80% after in-network deductible	80% after in-network deductible
Diagnostic Services		
Laboratory and Pathology Services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic Tests and X-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic Radiology	80% after in-network deductible	60% after out-of-network deductible
Maternity Services Provided by a Physician		
Prenatal and Postnatal Care	100% (no deductible or co-pay)	60% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Delivery and Nursery Care	80% after in-network deductible	60% after out-of-network deductible
	Includes covered services provided by a certified nurse midwife	
Hospital Care		
Semiprivate Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	80% after in-network deductible	60% after out-of-network deductible
Note: Non-emergency services must be rendered in a **participating** hospital	Unlimited days	
Inpatient Consultations	80% after deductible	60% after out-of-network deductible
Chemotherapy	80% after deductible	60% after out-of-network deductible

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Alternatives to Hospital Care		
Skilled nursing care – must be in a participating skilled nursing facility.	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice Care	100% (no deductible or co-pay)	100% (no deductible or co-pay)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods-**provided through a participating hospice program only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management).	
Home infusion therapy - must be medically necessary and given by participating home infusion therapy providers.	80% after in-network deductible	80% after in-network deductible
Home Health Care - must be medically necessary and given by participating home health care agency.	80% after in-network deductible	80% after in-network deductible
Surgical Services		
Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations – limited to three presurgical consultations for each surgical diagnosis	100% (no deductible or co-pay)	60% after out-of-network deductible
Voluntary Sterilization	80% after in-network deductible	60% after out-of-network deductible
Human Organ Transplants		
Specified Organ Transplants – **in designated facilities only**, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or co-pay)	100% (no deductible or co-pay)- in designated facilities **only**
Bone Marrow – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504); specific criteria applies	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Kidney, Cornea and Skin	80% after in-network deductible	60% after out-of-network deductible

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Mental Health Care and Substance Abuse Treatment		
Inpatient Mental Health Care and Substance abuse treatment	80% after in-network deductible	60% after out-of-network deductible
	Limited to a maximum of 60 days per member per calendar year	
Outpatient Mental Health Care - • Facility and Clinic	80% after in-network deductible	60% after in-network deductible, in participating facilities **only**
• Physician's Office	80% (no deductible)	60% after out-of-network deductible
Limited to a maximum of 50 visits per calendar year with a lifetime maximum of 120 visits per member		
Outpatient Substance Abuse Treatment – in approved facilities **only**	80% after in-network deductible	60% after out-of-network deductible (in-network cost sharing will apply if there is no PPO network)
Other Services		
Outpatient Diabetes Management Program (ODMP)	80% after in-network deductible for diabetes medical supplies 100% (no deductible or co-pay) for diabetes self-management training	60% after out-of-network deductible
Allergy Testing and Therapy	100% (no deductible or co-pay)	60% after out-of-network deductible
Chiropractic Spinal Manipulation treatment and osteopathic manipulation treatment – limited to combined maximum of 24 visits (PPO network and non-network providers combined) per member, per calendar year	$40 co-pay per office visit	60% after out-of-network deductible
Outpatient Physical, Speech and Occupational Therapy- limited to a combined maximum of 60 visits per member, per calendar year	80% after in-network deductible	60% after out-of-network deductible
Durable Medical Equipment	80% after in-network deductible	80% after in-network deductible
Prosthetic and Orthotic Appliances	80% after in-network deductible	80% after in-network deductible
Private Duty Nursing	50% after in-network deductible	50% after in-network deductible

PPO In-Network - Providers who have contracted with BCBSM's PPO program are termed "participating" or "in-network" providers. In other words, these providers are part of the PPO network. If you use the services of a PPO network provider, you will be responsible only for applicable deductibles and co-payments for approved services.

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- **PPO Out-of-Network –** Providers who have not contracted with BCBSM's PPO program are considered "Out-of-Network" providers if you choose an "Out-of-Network" provider for services, additional co-payments will be required, **plus any amount charged by the provider greater than BCBSM's payment if the provider is also not part of BCBSM's Traditional Network. Please note that these balances could be substantial.** If a PPO provider "refers" you out-of-network to a BCBSM Traditional participating provider, you will not be liable for additional copayments or cost above Cubism's approved payment. **However, if you are referred to a provider who does not participate in BCBSM's Traditional or PPO Network, you will be responsible for additional co-payments plus costs greater than BCBSM's payment.**

	Network Pharmacy	Non-Network Pharmacy
Prescription Drug Coverage – the Fund does not cover prescriptions filled at Sam's Club or Wal-mart		
Tier 1 - Generic prescription Drugs	$15 co-pay	$15 co-pay plus 25% of the BCBSM approved amount for the drug
Tier 2 – Preferred brand prescription drugs	$30 co-pay	$30 co-pay plus 25% of the BCBSM approved amount for the drug
Tier 3 – Non-preferred brand drugs	$60 co-pay	$60 co-pay plus 25% of the BCBSM approved amount for the drug
Disposable Needles and Syringes – dispensed with insulin	Covered – 100% less plan co-pay for insulin	Covered – 75% less plan co-pay for insulin
Mail order (home deliver) prescription drugs	**Co pay for up to a 30 day supply:** $15 co-pay for Tier 1 (generic) drugs $30 co-pay for Tier 2 (formulary) brand) drugs $60 co-pay for Tier 3 (non-formulary brand) drugs **Co pay for a 31-90 day supply:** $30 co-pay for Tier 1 (generic) drugs $60 co-pay for Tier 2 (formulary) brand) drugs $120 co-pay for Tier 3 (non-formulary brand) drugs	Not covered
Dental Coverage	Preventive Services covered at 100% when services are provided through a Dental Network of America (DNOA) provider. Oral exams, teeth cleaning, fluoride treatment and a set of bitewing x-rays (up to 4) – 2 times per year	

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Vision Coverage Co pays - • $5 co-pay per exam • $7.50 co-pay for corrective lenses and frames or medically necessary contact lenses **Benefit Period:** All vision benefits are covered once every 12 consecutive months. During any 12-month period, benefits are payable for either eyeglasses or contact lenses, not both. **Participating Vision Provider:** Benefits are covered at 100% of approved amount less co-pay. **Nonparticipating Vision Provider:** If you receive services from a nonparticipating provider, you will be reimbursed 75% of approved amount less $5 co-pay for vision exam and a predetermined amount for all other benefits. You are responsible for any difference between your vision provider's charge and the approved amount.	**Exams –** Covers visual testing by an optometrist or ophthalmologist, including history, testing sharpness of vision, internal and external exam of the eyes, and testing for glaucoma (when necessary). **Corrective lenses –** Covers prescribed glass or plastic lenses less than 65 mm in diameter. Tinted lenses are covered when prescribed for medical reasons. **Contact lenses –**Covers glass or plastic lenses. If contact lenses are selected, but not medically necessary, your plan will pay a maximum of $35. You are responsible for any difference between this amount and the provider's charge. **Frames –**Covers standard plastic, metal or wire eyeglass frame, up to the approved amount.
Other Fund Information	
Retiree Coverage	**Non- Medicare** – The same as the Active Participants **Medicare** - The Supplemental Program for retirees with Medicare (or eligible for Medicare) is provided through Blue Care Network
Eligibility	**Initial:** 345 hours within three (3) consecutive months or less, skip one month for bookkeeping, eligible the 1st day of the following month for three (3) months. *Initial eligibility must be re-satisfied if a participant remains ineligible for more than 12 consecutive months.* **Continuing:** 345 hours within three (3) consecutive months or less, skip one month for bookkeeping, eligible the 1st day of the following month for three (3) months. **Annual:** 1,380 hours within twelve (12) consecutive months, skip one month for bookkeeping, eligible for the 14th, 15th and 16th months. **Short Hours:** a participant can remit a short hour self-payment based upon the current hourly contribution rate up to a maximum of 15 hours per month or 45 hours per quarter.

** Benefits and Eligibility are reviewed annually and subject to change at any time.