This is a Summary of Benefits and Coverage (SBC) document. 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 the Plan Office at 1-800-572-8975 or BCBSM at 1-877-790-2583. 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 1-866-444-EBSA (3272) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For participating providers $250/individual or $500/family* For non-participating providers $500/individual or $1,000/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 and primary 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 do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For participating providers $1,000 individual / $2,000/family; For non-participating providers $2,000 individual / $4,000 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?	Contributions, fixed dollar copays, self-payments, balance-billed charges 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.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.

**Medical Plan benefits run on a calendar year (January through December).

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)
(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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	$25 co-pay / visit	40% co-insurance	Out-of-network must be medically necessary
	Specialist visit	$25 co-pay / visit	40% co-insurance	Out-of-network must be medically necessary
	Preventive care/screening/ immunization	No charge	Not covered	Most services are not covered out-of-network; One routine physical per calendar year. 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.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	Approved BCBSM provider
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	May require prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic drugs	$8 co-pay for 1 month $10 co-pay for 3 months $8 co-pay for mail order 3 month supply	In-network co-pay plus the difference between the charged amount and approved amount	All Drugs: Subject to Plan formulary and other Plan limitations or exclusions. Contact CVS Caremark at 1-800-841-5550 or the Plan Office at 1-800-572-8975 for more information. Day supply limit on certain specialty medications. Prior authorization required for certain medications. Limitations for compounds and certain drugs. **Note:** Filling scripts using mail-order provides the best co-pay value.
	Preferred brand drugs	$20 co-pay for 1 month $30 co-pay for 3 months $25 co-pay for mail order 3 month supply		
	Non-preferred brand drugs	$35 co-pay for 1 month $50 co-pay for 3 months $40 co-pay for mail order 3 month supply		
	Specialty drugs	Available at the co-pay specified above	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	Approved BCBSM provider
	Physician/surgeon fees	20% co-insurance	40% co-insurance	Approved BCBSM provider
If you need immediate medical attention	Emergency room care	$250 co-pay / visit	$250 co-pay / visit	Co-pay waived if admitted or for an accidental injury
	Emergency medical transportation	20% co-insurance	20% co-insurance	Must be medically necessary
	Urgent care	$25 co-pay / visit	40% co-insurance	Out-of-network must be medically necessary

* For more information about limitations and exceptions, see the plan or policy document at www.oe324.org or www.iuoe324fringe.org.

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 have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Unlimited days
	Physician/surgeon fees	20% co-insurance	40% co-insurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance	40% co-insurance	Out-of-network – Participating facilities only Mental health and substance abuse procedures that are the equivalent of an office visit and billed as such may be subject to the fixed dollar office visit copay (currently $25).
	Inpatient services	20% co-insurance	40% co-insurance	
If you are pregnant	Office visits	No charge	40% co-insurance	Approved BCBSM provider. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Depending on the type of services, cost sharing may apply. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% co-insurance	40% co-insurance	
	Childbirth/delivery facility services	20% co-insurance	40% co-insurance	
If you need help recovering or have other special health needs	Home health care	20% co-insurance	20% co-insurance	Must be medically necessary; Participating providers only.
	Rehabilitation services	20% co-insurance	40% co-insurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	20% co-insurance	20% co-insurance	Applied Behavioral Analysis (ABA), Physical, Speech and Occupational Therapy; ABA treatment for Autism – when rendered by an approved board certified analyst – is covered through age 18, subject to preauthorization; Must use BCBSM approved provider.
	Skilled nursing care	20% co-insurance	20% co-insurance	Must be in participating facility; Limited to 120 days per calendar year; May require authorization.
	Durable medical equipment	20% co-insurance	20% co-insurance	Approved BCBSM provider
	Hospice services	No charge	No charge	Limited to a dollar maximum adjusted periodically; Participating hospital programs only.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	No charge	Not covered	Diagnostic / preventive covered 100% with Delta Dental Premier or PPO provider.

* For more information about limitations and exceptions, see the plan or policy document at www.oe324.org or www.iuoe324fringe.org.

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	• Long-term care	• Routine foot care
• Cosmetic surgery	• Routine eye care (Adult)	• Weight loss programs
• Infertility treatment		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.
• 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 Health Care Plan Office 1-800-572-8975 or the U.S. Department of Labor, Employee Benefits Security Administration 1-866-444-3272 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: Operating Engineers' Local 324 Health Care Plan at 1-800-572-8975.

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 1-877-790-2583.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-790-2583.

Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-877-790-2583.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-790-2583.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.oe324.org or www.iuoe324fringe.org.

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	$250
Specialist copayment	$25
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	$250
Copayments	$80
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,390**

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

The plan's overall deductible	$250
Specialist copayment	$25
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	$250
Copayments	$800
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,210**

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

The plan's overall deductible	$250
Specialist copayment	$25
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	$250
Copayments	$80
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$630**

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

OPERATING ENGINEERS LOCAL 324 HEALTH CARE PLAN NOTICE OF NONDISCRIMINATION

Operating Engineers Local 324 Health Care Plan ("the Health Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, call the Health Plan at (248) 836-2760 or Toll Free (800) 572-8975 and ask for assistance.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and 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 or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/oJfice/file/index.html.

ATTENTION: FOR FREE LANGUAGE ASSISTANCE CALL 1 (800) 572-8975

Language	Message About Language Assistance
Español Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (800) 572-8975.
繁體中文 Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 (800) 572-8975.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1 (800) 572-8975.
Tiếng Việt Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (800) 572-8975.
한국어 Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1 (800) 572-8975 번으로 전화해 주십시오.
لعربية Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1 (800) 572-8975
ᐊᓂᔑᓇᐯᒧᐎᓐ Assyrian	ܐܝܬ ܠܟ ܒܠܫܢܐ ܕܐܣܘܪܝܐ، ܐܢ ܐܢܬ ܡܬܟܠܡ ܠܫܢܐ ܐܣܘܪܝܐ، ܫܝܠܘܬ ܥܕܪܐ ܠܫܘܢܝ ܒܠܫ ܕܡܬܐ ܠܟ ܒܠܐ ܡܫܠܡ. ܐܬܨܠ ܒ 1 (800) 572-8975
Shqip Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1 (800) 572-8975
日本語 Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1 (800) 572-8975まで、お電話にてご連絡ください。
বাংলা Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1 (800) 572-8975
Tagalog Filipino	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (800) 572-8975.
Русский Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1 (800) 572-8975.
Polski Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1 (800) 572-8975
Srpsko-hrvatski Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1 (800) 572-8975.
Italiano Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1 (800) 572-8975