
 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.ua190benefits.org or call 1-888-390-7473 (PIPE). 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.healthcare.gov/sbc-glossary/ or call 1-888-390-7473 (PIPE) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$250 per individual, and \$500 per family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Preventive care/screening/immunizations/presurgical consultations are not subject to those services. This means that those services are provided once per year, free of charge to you.
Are there services covered before you meet your deductible ?	Yes: Preventive care, screening, immunizations, presurgical consultations	The plan covers some items and services even if you haven't yet met the deductible amount. 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 ?	\$7,150 for single coverage, and \$14,300 for two-person or family coverage	The out-of-pocket limit is the most you could pay in a year for covered services
What is not included in the out-of-pocket limit ?	The out-of-pocket limit doesn't include amounts paid for premiums, balance-billing charges, prescription medicines, and services not covered by the plan	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 1-800-810-BLUE for list of network providers	This plan uses a provider network . You could pay less if you use a provider in the plan's network . In-network providers have agreed to accept Blue Cross Blue Shield of Michigan's (BCBSM) approved amount. Out-of-network providers may balance-bill you for amounts in excess of BCBSM's approved amount. 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	\$30	\$30	None
	Specialist visit	\$30	\$30	None
	Preventive care/screening/immunization	\$0	\$0	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	Preventive tests are 100% covered
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	Complex radiology such as CAT, MRI and PET scans must be performed in participating facilities
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at 1-888-390-7473	Generic drugs	\$0 up to \$1440	\$0 up to \$1440	After you receive \$1440 in prescription drug coverage, you pay 100% of coverage; amounts you pay for prescription medicines do not count towards the annual out-of-pocket limit; certain medications limited
	Preferred brand drugs	\$0 up to \$1440	\$0 up to \$1440	After you receive \$1440 in prescription drug coverage, you pay 100% of coverage; amounts you pay for prescription medicines do not count towards the annual out-of-pocket limit ; certain medications limited
	Non-preferred brand drugs	\$0 up to \$1440	\$0 up to \$1440	After you receive \$1440 in prescription drug coverage, you pay 100% of coverage; amounts you pay for prescription medicines do not count towards the annual out-of-pocket limit ; certain medications limited
	Specialty drugs	\$0 up to \$1440	\$0 up to \$1440	Specialty drugs are only covered if you obtain pre-authorization for them. After you receive \$1440 in prescription drug coverage, you pay 100% of coverage;

[* For more information about limitations and exceptions, see the plan or policy document at www.ua190benefits.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)	
				amounts you pay for prescription medicines do not count towards the annual <u>out-of-pocket limit</u> ; certain medications limited
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	None
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	\$100	\$100	Waived if treatment is for accidental injury or patient is admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	Ambulance services must be medically necessary
	Urgent care	\$30	\$30	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Non-emergency services must be rendered in a participating hospital. If you go to a non-participating hospital, facility or alternative to hospital care provider, you will need to pay most of the charges yourself.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	Outpatient substance use disorder treatment is provided in approved facilities only. Services for substance use disorder must be approved before they will be covered.
	Inpatient services	20% coinsurance	20% coinsurance	Services for substance use disorder must be approved before they will be covered.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Must be medically necessary
	Rehabilitation services	20% coinsurance	20% coinsurance	Services provided in a freestanding outpatient physical therapy facility are covered only when the facility is a participating facility
	Habilitation services	20% coinsurance	20% coinsurance	None
	Skilled nursing care	20% coinsurance	20% coinsurance	Participating providers only; 100 days

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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)	
				maximum
	Durable medical equipment	20% coinsurance	20% coinsurance	None
	Hospice services	20% coinsurance	20% coinsurance	Participating providers only
If your child needs dental or eye care	Children's eye exam	Total cost charged by provider	Total cost charged by provider	May be reimbursed by Miscellaneous Account up to \$1800 limit or Individual HRA Account
	Children's glasses	Total cost charged by provider	Total cost charged by provider	May be reimbursed by Miscellaneous Account up to \$1800 limit or Individual HRA Account
	Children's dental check-up	50% coinsurance	50% coinsurance	Annual \$800 limit per person if over age 19

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](#).)

- Accupuncture
- Chiropractic care over 38 visits
- Cosmetic Surgery
- Hearing Aids over 36-month limit
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S., absent prior approval from the UA Local 190 Health and Welfare Plan Joint Board of Trustees
- Routine eye care (Adult)
- Routine foot care
- Services to treat an injury or condition that is a direct or indirect result of a motor vehicle accident
- Services to treat work-related injuries covered by workers' compensation laws
- Skilled nursing over 100 days
- Weight loss programs (except under Miscellaneous Account or IHRA)

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

- Bariatric surgery (only in accordance with strict guidelines imposed by Blue Cross Blue Shield of Michigan)
- Chiropractic care (38 visits/year)
- Dental care (adult)
- Hearing aids (\$5,000 every 36 months) (you may be able to obtain a discount on hearing aids by calling the TruHearing program at 1-844-237-1422)
- Private-duty nursing (10% coinsurance)
- The plan is integrated with a Miscellaneous Account that can be used to pay certain qualifying medical expenses that are not otherwise covered by the plan. The Miscellaneous Account has an annual limit of \$1,800 and re-sets each year. The plan also is integrated with the Individual HRA Plan, which provides a reimbursement account funded by hourly employer contributions that can be used to pay certain qualifying medical expenses that are not otherwise covered by the plan. The Individual HRA is limited to the balance in the account at any point in time. Unused Individual HRA amounts carry over from year to year. The Plan is integrated with a Prescription Medicine Account that can be used to pay for covered prescriptions. Certain prescriptions require preauthorization to be covered. The Prescription Medicine Account has an annual limit of \$1,440, subject to Plan coverage of covered prescription medications after you have reached the out-of-pocket limit referenced on page 1, and re-sets each year. Note that costs for prescription medications will not count towards the out-of-pocket limit.

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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or www.dol.gov/ebsa/healthreform. 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 Administrative Manager TIC International Corporation, Attention: James Schreiber, 1-888-390-7473. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www/dol.gov/ebsa/healthreform.

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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

-----*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](#) [*cost sharing*] 20%
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 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	\$7540
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$1408
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is *	\$1908

*These numbers assume Peg has family coverage

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](#) [*cost sharing*] \$0
- Hospital (facility) [*cost sharing*] 0%
- Other [*cost sharing*] 0%

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	\$5400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$
The total Joe would pay is **	\$500

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist](#) [*cost sharing*] 20%
- Hospital (facility) [*cost sharing*] 0%
- Other [*cost sharing*] 20%
(Durable Medical Equipment)

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	\$3000
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$100
Coinsurance	\$480
<i>What isn't covered</i>	
Limits or exclusions	
The total Mia would pay is ***	\$1080

** Note: These numbers assume Joe has family coverage. These numbers assume that Joe is participating in the Outpatient Diabetes Management Program. If you have diabetes and do not participate in the Outpatient Diabetes Management Program, your costs may be higher. For more information on the Outpatient Diabetes Management Program, please contact 1-888-390-7473 (PIPE)


*** Note: These numbers assume Mia has family coverage. These numbers assume that Mia is not admitted to the hospital. If she is admitted to the hospital, the \$100 copayment (for emergency room visit) is waived. Also, if Mia needs follow-up office visits, there is a \$30 copayment for each office visit.

 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.ua190benefits.org or call 1-888-390-7473 (PIPE). 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.healthcare.gov/sbc-glossary/ or call 1-888-390-7473 (PIPE) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$ 100 per contract	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. Preventive care/screening/immunizations/presurgical consultations are not subject to those services. This means that those services are provided once per year, free of charge to you.
Are there services covered before you meet your <u>deductible</u> ?	Yes: Preventive care, screening, immunizations, presurgical consultations	The <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at: https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No	You do not have to meet <u>deductibles</u> for specific services.

What is the out-of-pocket limit for this plan ?	\$7,150 for single coverage, and \$14,300 for two-person or family coverage	The out-of-pocket limit is the most you could pay in a year for covered services
What is not included in the out-of-pocket limit ?	The out-of-pocket limit doesn't include amounts paid for premiums, balance-billing charges, prescription medicines, and services not covered by the plan	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 1-800-810-BLUE for list of network providers	This plan uses a provider network . You could pay less if you use a provider in the plan's network . In-network providers have agreed to accept Blue Cross Blue Shield of Michigan's (BCBSM) approved amount. Out-of-network providers may balance-bill you for amounts in excess of BCBSM's approved amount. 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	20% coinsurance	20% coinsurance	None
	Specialist visit	20% coinsurance	20% coinsurance	None
	Preventive care/screening/immunization	\$0	\$0	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

[* For more information about limitations and exceptions, see the plan or policy document at www.ua190benefits.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 test	Diagnostic test (x-ray, blood work)	\$0	\$0	Preventive tests are 100% covered
	Imaging (CT/PET scans, MRIs)	\$0	\$0	Complex radiology such as CAT, MRI and PET scans must be performed in participating facilities
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at 1-888-390-7473	Generic drugs	\$0 up to \$1440	\$0 up to \$1440	After you receive \$1440 in prescription drug coverage, you pay 100% of coverage; amounts you pay for prescription medicines do not count towards the annual out-of-pocket limit; certain medications limited
	Preferred brand drugs	\$0 up to \$1440	\$0 up to \$1440	After you receive \$1440 in prescription drug coverage, you pay 100% of coverage; amounts you pay for prescription medicines do not count towards the annual <u>out-of-pocket limit</u> ; certain medications limited
	Non-preferred brand drugs	\$0 up to \$1440	\$0 up to \$1440	After you receive \$1440 in prescription drug coverage, you pay 100% of coverage; amounts you pay for prescription medicines do not count towards the annual <u>out-of-pocket limit</u> ; certain medications limited
	Specialty drugs	\$0 up to \$1440	\$0 up to \$1440	Specialty drugs are only covered if you obtain pre-authorization for them. After you receive \$1440 in prescription drug coverage, you pay 100% of coverage; amounts you pay for prescription medicines do not count towards the annual <u>out-of-pocket limit</u> ; certain medications limited
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$0	\$0	None
	Physician/surgeon fees	\$0	\$0	None
If you need immediate medical attention	Emergency room care	\$50	\$50	Waived if treatment is for accidental injury or patient is admitted
	Emergency medical transportation	\$0	\$0	Ambulance services must be medically necessary
	Urgent care	20% coinsurance	20% coinsurance	None

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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)	\$0	\$0	Non-emergency services must be rendered in a participating hospital. If you go to a non-participating hospital, facility or alternative to hospital care provider, you will need to pay most of the charges yourself.
	Physician/surgeon fees	\$0	\$0	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0	\$0	Outpatient substance use disorder treatment is provided in approved facilities only. Services for substance use disorder must be approved before they will be covered.
	Inpatient services	\$0	\$0	Services for substance use disorder must be approved before they will be covered.
If you are pregnant	Office visits	\$0	\$0	None
	Childbirth/delivery professional services	\$0	\$0	None
	Childbirth/delivery facility services	\$0	\$0	None
If you need help recovering or have other special health needs	Home health care	\$0	\$0	Must be medically necessary
	Rehabilitation services	\$0	\$0	Services provided in a freestanding outpatient physical therapy facility are covered only when the facility is a participating facility
	Habilitation services	\$0	\$0	None
	Skilled nursing care	20% coinsurance	20% coinsurance	Participating providers only; 100 days maximum
	Durable medical equipment	10% coinsurance	10% coinsurance	None
	Hospice services	\$0	\$0	Participating providers only
If your child needs dental or eye care	Children's eye exam	Total cost charged by provider	Total cost charged by provider	May be reimbursed by Miscellaneous Account up to \$1800 limit or Individual HRA Account
	Children's glasses	Total cost charged by provider	Total cost charged by provider	May be reimbursed by Miscellaneous Account up to \$1800 limit or Individual HRA Account
	Children's dental check-up	50% coinsurance	50% coinsurance	Annual \$800 limit per person if over age 19

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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](#).)

- Accupuncture
- Chiropractic care over 38 visits
- Cosmetic Surgery
- Hearing Aids over 36-month limit
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S., absent prior approval from the UA Local 190 Health and Welfare Plan Joint Board of Trustees
- Routine eye care (Adult)
- Routine foot care
- Services to treat an injury or condition that is a direct or indirect result of a motor vehicle accident
- Services to treat work-related injuries covered by workers' compensation laws
- Skilled nursing over 100 days
- Weight loss programs (except under Miscellaneous Account or IHRA)

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

- Bariatric surgery (only in accordance with strict guidelines imposed by Blue Cross Blue Shield of Michigan)
- Chiropractic care (38 visits/year)
- Dental care (adult)
- Hearing aids (\$5,000 every 36 months) (you may be able to obtain a discount on hearing aids by calling the TruHearing program at 1-844-237-1422)
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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 [insert telephone number].]

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[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

-----*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](#) \$100
- [Specialist](#) [cost sharing] 0%
- Hospital (facility) [cost sharing] 0%
- Other [cost sharing] 0%

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	\$7540
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$100

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist](#) [cost sharing] \$0
- Hospital (facility) [cost sharing] 0%
- Other [cost sharing] 0%

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	\$5400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$
The total Joe would pay is *	\$100

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist](#) [cost sharing] 20%
- Hospital (facility) [cost sharing] 0%
- Other [[cost sharing](#)] 0%
(Durable Medical Equipment)

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	\$3000
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments **	\$50
Coinsurance	10% for durable medical equipment
<i>What isn't covered</i>	
Limits or exclusions	\$
The total Mia would pay is **	\$150 + 10% of durable medical equipment

* Note: These numbers assume that Joe is participating in the Outpatient Diabetes Management Program. If you have diabetes and do not participate in the Outpatient Diabetes Management Program, your costs may be higher. For more information on the Outpatient Diabetes Management Program, please contact 1-888-390-7473 (PIPE)

** Note: These numbers assume that Mia is not admitted to the hospital. If she is admitted to the hospital, the \$50 copayment (for emergency room visit) is waived. Also, if Mia needs follow-up office visits, there is a 20% copayment for each office visit.