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 http://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?	$9,200 for single coverage and $18,400 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 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; see www.davisvision.com or call (877) 923-2847, 9772; see www.DeltaDentalMI.com or call 1-800-524-0149 for lists	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), Delta Dental's and Davis Vision's approved amount. Out-of-network providers may balance-bill you for amounts in excess of BCBSM's, Delta Dental's or Davis Vision'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	No	You can see the specialist you choose without a referral.

Important Questions	Answers	Why This Matters:
see a specialist?		

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	$30 copayment and deductible apply to office visits, online visits, office consultations, office visit-equivalent mental health and substance use disorder treatment services, retail health center services and urgent care visits. Substance use disorder must be pre-authorized. Outpatient substance use disorder treatment is only covered in an approved facility. No copayment applies for mental health online visits through Teledoc.
	Specialist visit	$30	$30	$30 copayment and deductible apply to office visits, online visits, office consultations, office visit-equivalent mental health and substance use disorder treatment services, retail health center services and urgent care visits. Substance use disorder must be pre-authorized. Outpatient substance use disorder treatment is only covered in an approved facility. No copayment applies for mental health online visits through Teledoc.
	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

[* For more information about limitations and exceptions, see the plan or policy document at www.ua190benefits.org.

				participating facilities
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com by signing into the member portal or using the mobile app to obtain pharmacy lists	Generic drugs	$0 up to $2000	$0 up to $2000	After you receive $2000 in prescription drug coverage, you pay 100% of coverage; certain medications limited
	Preferred brand drugs	$0 up to $2000	$0 up to $2000	After you receive $2000 in prescription drug coverage, you pay 100% of coverage; certain medications limited
	Non-preferred brand drugs	$0 up to $2000	$0 up to $2000	After you receive $2000 in prescription drug coverage, you pay 100% of coverage; certain medications limited
	Specialty drugs	$0 up to $2000	$0 up to $2000	Specialty drugs are only covered if you obtain pre-authorization for them. After you receive $2000 in prescription drug coverage, you pay 100% of coverage; 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	Ambulence 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	$30	$30	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.

[* For more information about limitations and exceptions, see the plan or policy document at www.ua190benefits.org.

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 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	$0	Total cost charged by provider over $40	100% of the approved amount for an eye exam is covered for in-network services through Davis Vision; for out-of-network services, Davis Vision reimburses up to $40 for an eye exam; May be reimbursed via Individual HRA Account with manual submission of prescription vision expenses that are not covered by Davis Vision including an "Explanation of Benefits" from Davis Vision and completed Individual HRA application; May not be reimbursed through Miscellaneous Account
	Children's glasses	80% of amount over $250 allowance for frames from provider that are not in Davis Vision collection	$140 for frames; amount over $30 for single vision standard plastic lenses; amount over $50 for bifocal standard plastic lenses; amount over $70 for trifocal standard plastic lenses	100% of the approved amount for an eye exam, lenses (either contact lenses or lenses for a glasses frame) and frame every 12 months, with full coverage for fashion, designer or premier level frame from Davis Vision collection, or $250 for any frame from the provider, plus 20% of the balance over $250 in-network; single vision, bifocal, or trifocal standard plastic lenses, or lenticular lenses are covered at no cost once every 12 months in-network; May be reimbursed via

				Individual HRA Account with manual submission of prescription vision expenses that are not covered by Davis Vision, including an "Explanation of Benefits" from Davis Vision and completed Individual HRA application; May not be reimbursed via Miscellaneous Account
	Children's dental check-up	$0	Any amount over 100% of the Delta Dental Nonparticipating Dentist Fee for Class I services	Class 1 benefits that are covered are paid at 100% of the approved amount in-network; no annual limit applies to pediatric dental services (excluding pediatric orthodontic services)

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 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 (subject to annual maximum of $1,500 per covered adult; Class 1 benefits do not count against this annual maximum)
- Vision care (for in-network services, 100% of Approved Amount for eye exam, lenses (either contact lenses or lenses for a glasses frame) and frame every 12 months, with full coverage for fashion, designer or premier level frame from Davis Vision collection, or $250 for any frame from the provider, plus 20% of the balance over $250 in-network; if you choose contact lenses, disposable contact lenses are covered at $350 every 12 months, with 5% off the balance over $350; if you choose glasses, single vision, bifocal, or trifocal standard plastic lenses, or lenticular lenses are covered at no cost in-network)
- 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

[* For more information about limitations and exceptions, see the plan or policy document at www.ua190benefits.org.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
$1,000 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 $2,000, 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 filled without presenting your BCBSM card 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: 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 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: call 1-888-390-7473 (PIPE) or call Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) go to www.do.gov/ebsa/healthreform.

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 [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, kwiijigo 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:

[* For more information about limitations and exceptions, see the plan or policy document at www.ua190benefits.org.

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$2540
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3040**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
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%**

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	$500
Copayments	$100
Coinsurance	$560
What isn't covered	
Limits or exclusions	$1160
The total Mia would pay is	**$1160**

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

**** Note: These numbers assume that 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 that 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.**