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.ualocal370benefits.org or call 1-888-797-5862. 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 1-855-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $250 / individual or $500 / family; for out-of-network providers $1,000 / individual or $2,000 / family per calendar year.	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 prescription drugs 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 don't have to meet deductibles for specific services
What is the out-of-pocket limit for this plan?	For network providers $1,000 individual / $2,000 family; for out-of-network 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. The overall in-network OOP for deductibles, copayments and coinsurance is $6,350 / individual; $12,700 / couple or family.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, deductibles 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 1-800-810-2583 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.

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 copay/office visit	40% coinsurance	Out-of-Network may balance bill.
	Specialist visit	$20 copay/visit	40% coinsurance	Out-of-Network may balance bill.
	Preventive care/screening/ immunization	No charge	Not covered	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	40% coinsurance	Out-of-Network may balance bill.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Out-of-Network may balance bill.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/pharmacy	Generic drugs (Tier 1)	Retail: $10 copay for 30 day supply Mail Order: $20 copay for 90 day supply	$10 copay plus an additional 25% of BCBSM approved amount for the drug.	Mandatory Generic Program effective August 1, 2018. If you choose a brand name drug, the Fund will only cover the cost of the generic drug less your applicable co-pay. **Prior-authorization and step-therapy required or the prescription may not be covered.** For information on women's contraceptive coverage, contact the Fund Office. Mail order drugs are not covered out-of-network. Specialty drugs can be generic, preferred or non-preferred drugs. Contact BCBSM/AllianceRx at 866-515-1355 for a list of specialty drugs.
	Preferred brand drugs (Tier 2)	Retail: $30 copay for 30 day supply Mail Order: $60 copay for 90 day supply	$30 copay plus an additional 25% of BCBSM approved amount for the drug	
	Non-preferred brand drugs (Tier 3)	Retail: $60 copay for 30 day supply Mail Order: $120 copay for 90 day supply	$60 copay plus an additional 25% of BCBSM approved amount for the drug	
	Specialty drugs (Tier 4)	Copay will vary based on drug class		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Out-of-Network may balance bill.

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)	
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Out-of-Network may balance bill.
If you need immediate medical attention	Emergency room care	$100 copay	$100 copay	Out-of-Network may balance bill; copay waived if admitted or for an accidental injury.
	Emergency medical transportation	Ground: 20% coinsurance Air: 20% of lesser of billed charges or the Qualifying Payment Amount, after deductible.	Ground: 20% coinsurance Air: In-network deductible and in-network out-of-pocket maximum apply and this co-insurance and deductible to be counted towards in-network out-of-pocket maximum.	Out-of-Network may balance bill; must be medically necessary.
	Urgent care	$20 copay/visit	40% coinsurance	Out-of-Network may balance bill.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Unlimited stay; must be pre-certified. Not pre-certified - $500 penalty; semi-private room. Non-emergency services must be rendered in a participating hospital.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Out-of-Network may balance bill.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Must be in approved facilities only. In-Network cost sharing if there is no PPO Network. Out-of-Network may balance bill.
	Inpatient services	20% coinsurance	40% coinsurance	Unlimited day; out-of-Network may balance bill.
	Online visits	$20 copay / visit	40% coinsurance	
If you are pregnant	Office visits	No charge	40% coinsurance	Out-of-Network may balance bill.

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)	
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Certain prenatal services may be covered under the preventive care benefit on page 2.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Out-of-Network may balance bill. Must be medically necessary and provided and billed by a participating home health care agency.
	Rehabilitation services	20% coinsurance	40% coinsurance	Out-of-Network may balance bill. Physical, occupational and speech therapy is limited to a combined maximum of 60 visits per individual per calendar year.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	20% coinsurance	Out-of-Network may balance bill. Must be in a participating skilled nursing facility. Limited to a maximum of 120 days per individual per calendar year.
	Durable medical equipment	20% coinsurance	20% coinsurance	Out-of-Network may balance bill.
	Hospice services	No charge	No charge	Provided through a participating hospice program only; contact BCBSM for additional information.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	50% coinsurance for preventative services; once every 6 months.	50% coinsurance for preventative services; once every 6 months.	$1,000 maximum benefit per individual per calendar year. Out-of-Network may balance bill. Active employees only. Participants have the right to opt out.

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 (if prescribed for rehabilitation purposes)
- Cosmetic surgery (not medically necessary)
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Hearing Aids
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Autism spectrum disorders • Bariatric surgery (medically necessary) • Chiropractic care	• Non-emergency care when traveling outside the U.S. • Online visits	• Private-duty nursing • Routine dental care (Adult)

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, Employee Benefit Security Administration 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: Flint Plumbing and Pipefitting Industry Health Care Fund at 1-888-797-5862.

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 1-888-797-5862.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-797-5862.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-797-5862.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-797-5862.

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	$250
Specialist copayment	$20
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	$10
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,320**

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	$20
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*	$240
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,160**

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

The plan's overall deductible	$250
Specialist copayment	$20
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	$50
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

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