UWUA Health and Welfare Fund

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: 01/01/2021 – 12/31/2021**

Coverage for: Participant, Spouse, Family | **Plan Type:** PPO

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.uwuabenefits.org or call 1-800-920-8116. 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 call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$250** per person / **$500** per family (in-network) **$250** per person / **$500** per family (out-of-network)	Generally, you must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Services that require a copayment or are covered in full are not subject to the deductible. See below for these services. If you have other family members on the plan, costs for each family member are subject to the individual deductible maximum until the amount of deductible expenses paid by all family members meets the overall family deductible. Check your plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care, office visits and prescription drugs are covered before you meet your deductible. However, office visit services and prescription drugs are subject to a copayment.	This 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. Check your plan documents or call the number on the back of your ID card for a list of preventive care benefits.
Are there other deductibles for specific services?	There are no other deductibles.	See the chart starting on page 2 for other cost sharing that may apply for services this plan covers.
What is the out-of-pocket limit for this plan?	There is not an out-of-pocket limit for this plan. However, there are annual coinsurance maximums as follows: In-network **- $1,000** per person / **$2,000** per family; Out-of-network - **$2,000** per person / **$4,000** per family	The annual deductible and coinsurance maximums are applicable each calendar year. If you have other family members in this plan, each family member must meet the individual deductible and coinsurance maximum until the overall family deductible and coinsurance limit has been met. Prescription drug and medical copayments **do not** apply to these annual maximums. Private duty nursing coinsurance amounts do not apply to these maximums.
What is not included in the out-of-pocket limit?	There is not an out-of-pocket maximum for this plan.	

Will you pay less if you use a network provider?	Yes. For a list of **in-network** providers see www.bcbsm.com or call 1-877-790-2583 or the number on the back of your ID card.	This plan uses a PPO provider network. You will pay less if you use a provider in the plan's PPO network. You will pay more if you use an out-of-network provider, and you may receive a bill from a provider for the difference between the provider's charge and what this plan pays (balance billing) if you use a non-participating provider. Your network provider might use an out-of-network provider for some services (such as lab work) and some non-participating providers may not be covered. Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without a referral. Note: A referral for an out-of-network provider is required to avoid additional out-of-pocket expenses.

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 copayment	20% coinsurance after deductible	Covered: Deductible, Copayment and Coinsurance does not apply to accidental or medical emergencies. Non-participating providers may balance bill.
	Specialist visit	$20 copayment	20% coinsurance after deductible	Non-participating providers may balance bill.
	Preventive care/screening/ immunization	Covered: Deductible, Copayment and coinsurance does not apply	Not covered	You may have to pay cost sharing for services that are not considered preventive care. See your plan documents or call the number on the back of your ID card for a list of preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	20% coinsurance after deductible	Non-participating providers may balance bill.
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	20% coinsurance after deductible	May require preauthorization. Non-participating providers 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/drug lists**	Generic drugs	$10 copayment for 30-day supply; $20 copayment for 90-day mail order or 90-day retail supply	In-network copayment plus an additional 25% of the approved amount; deductible does not apply	Preauthorization, step therapy and/or quantity limits may apply to select drugs. A ninety-day (90-day) supply for prescription drugs is not covered when using an out-of-network pharmacy. Specialty drugs are limited to a 30-day supply whether retail or mail order.
	Formulary Preferred brand drugs	$40 copayment for 30-day supply; $80 copayment for 90-day mail order or 90-day retail supply	In-network copayment plus an additional 25% of the approved amount; deductible does not apply	
	Non-preferred brand drugs	$40 copayment for 30-day supply; $80 copayment for 90-day mail order or 90-day retail supply	In-network copayment plus an additional 25% of the approved amount; deductible does not apply	
	Specialty drugs	Specialty drugs can be generic, preferred or non-preferred; copayments apply as noted above for in-network or out-of-network prescriptions.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	20% coinsurance after deductible	Non-participating facilities are not covered.
	Physician/surgeon fees	10% coinsurance after deductible	20% coinsurance after deductible	Non-participating providers may balance bill.

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 need immediate medical attention	Emergency room care	$50 copayment per visit; deductible does not apply	$50 copayment per visit; deductible does not apply	Copayment is waived if you are admitted or for an accidental injury.
	Emergency medical transportation	10% coinsurance after deductible	10% coinsurance after deductible	Mileage limits may apply. Non-participating providers may balance bill.
	Urgent care	$20 copayment	20% coinsurance after deductible	Covered: Deductible, Copayment and Coinsurance does not apply to accidental or medical emergencies. Non-participating providers may balance bill.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	20% coinsurance after deductible	Preauthorization may be required. Non-emergency services must be rendered in a participating hospital.
	Physician/surgeon fees	10% coinsurance after deductible	20% coinsurance after deductible	Non-participating providers may balance bill.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance after deductible	20% coinsurance after deductible	Your cost share may be different for services performed in an office setting. Non-participating physicians may balance bill. Non-participating mental health/substance abuse facilities/clinics are not covered.
	Inpatient services	10% coinsurance after deductible	20% coinsurance after deductible	Preauthorization is required. Non-participating facilities are not covered.
If you are pregnant	Office visits	Pre and Post Natal Care Covered: Deductible, Copayment and Coinsurance does not apply	20% coinsurance after deductible	Non-participating providers may balance bill.
	Childbirth/delivery professional services	10% coinsurance after deductible	20% coinsurance after deductible	Non-participating providers may balance bill.
	Childbirth/delivery facility services	10% coinsurance after deductible	20% coinsurance after deductible	Non-participating facilities are not covered.

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 need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	10% coinsurance after deductible	Preauthorization is required. Must be provided by a participating home health care agency.
	Rehabilitation services	10% coinsurance after deductible	20% coinsurance after deductible	Physical, Speech and Occupational Therapy is limited to a combined (in-network/out-of-network) maximum of 60 visits per individual, per calendar year. Non-participating facilities/clinics are not covered.
	Habilitation services	10% coinsurance after deductible	20% coinsurance after deductible	Physical, Speech and Occupational Therapy is limited to a combined (in-network/out-of-network) maximum of 60 visits per individual, per calendar year. Non-participating facilities/clinics are not covered.
	Skilled nursing care	10% coinsurance after deductible	10% coinsurance after deductible	Preauthorization is required. Limited to a maximum of 120 days per individual per calendar year. Non-participating facilities are not covered.
	Durable medical equipment	10% coinsurance after deductible	10% coinsurance after deductible	Non-participating providers may balance bill.
	Hospice services	Covered: Deductible, Copayment and Coinsurance does not apply	Covered: Deductible, Copayment and Coinsurance does not apply	Must be provided through a participating hospice provider.
If your child needs dental or eye care	Eye exam and Glasses	$20 copayment for exam; $20 copayment for lenses/frames	Member responsible for difference between approved amount and provider's charge	Eye exams and prescription glasses are covered once. Frame allowance applies. Miscellaneous copayments may apply for additional services.
	Dental check-up	Covered: Deductible, Copayment and Coinsurance does not apply for preventive services only		Non-participating providers may balance bill. Two visits per calendar year for exams and cleanings; bitewing x-rays limited to once per calendar year; full mouth x-rays limited to each three years. Other limitations may apply.

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.)

- Cosmetic surgery (not medically necessary)
- Infertility treatment
- Acupuncture (if prescribed for rehabilitation)
- Long-term care
- Hearing aids
- Routine foot care (not medically necessary)
- Weight loss programs

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

- Allergy testing and therapy
- Bariatric surgery (medical necessity)
- Routine dental care (Adult)
- Orthodontic (to age 19)
- Routine eye care (Adult)
- Prescription contraceptive devices, injections and medications

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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. 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 Fund Office at 1-800-920-8116.

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 1-800-920-8116.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-920-8116.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-920-8116.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-920-8116.]

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 *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	**$20,000**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,250**

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 *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	**$3,000**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$160
Coinsurance	$235
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$645**

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

The plan's overall deductible	$250
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	**$4,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$175
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$425**