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. 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 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$100** per contract	Generally, you must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. 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 services**, screening, immunizations, and presurgical consultations 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?	There are no other specific **deductibles**.	You don't have to meet specific **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers, **$9,200** individual / **$18,400** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services from in-network providers. This limit helps you plan for health care expenses. Balance-billed charges by out-of-network **providers** do not count toward the **out-of-pocket limit**. The **out-of-pocket limit** includes medical care and **prescription drugs**.
What is not included in the out-of-pocket limit?	Premiums, self-payments, balance billed charges, out-of-network services, and health care this plan does not cover.	Even though you may be required to 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, www.davisvision.com, www.deltadentalmi.com, or call 1-800-810-2583, 1-877-923-2847, or 1-800-524-0149 for lists of participating 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 the **network's** approved amount. If you use an out-of-network **provider**, the **plan** will only pay up to the **network's** approved amount for those services, and you will be responsible for the balance. Be aware that your **network provider** may 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 don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.

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 after deductible	20% of approved amount plus remainder of total charges	20% coinsurance applies 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	20% coinsurance after deductible	20% of approved amount plus remainder of total charges	20% coinsurance applies 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	No charge	N/A	Benefits covered at 100% in-network. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Remainder of total charges after approved amount	None
	Imaging (CT/PET scans, MRIs)	No charge	Remainder of total charges after approved amount	Complex radiology scans must be performed in participating facility.

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 $2,000	$0 up to $2,000	After you receive $2000 in prescription drug coverage, you pay 100% of coverage; certain medications limited
	Preferred brand drugs	$0 up to $2,000	$0 up to $2,000	
	Non-preferred brand drugs	$0 up to $2,000	$0 up to $2,000	
	Specialty drugs	$0 up to $2,000	$0 up to $2,000	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)	No charge	Remainder of total charges after approved amount	None
	Physician/surgeon fees	No charge	Remainder of total charges after approved amount	None
If you need immediate medical attention	**Emergency room care**	$50 copay/visit	$50 copay/visit	Copay is waived for accidental injury or if patient is admitted.
	Emergency medical transportation	No charge	Remainder of total charges after approved amount	Ambulance services must be medical necessary.
	Urgent care	20% coinsurance after deductible	20% of approved amount plus remainder of total charges	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Remainder of total charges after approved amount	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	No charge	Remainder of total charges after approved amount	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Remainder of total charges after approved amount	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	No charge	Remainder of total charges after approved amount	Services for substance use disorder must be approved before they will be covered.
If you are pregnant	Office visits	No charge	Remainder of total charges after approved amount	None
	Childbirth/delivery professional services	No charge	Remainder of total charges after approved amount	None
	Childbirth/delivery facility services	No charge	Remainder of total charges after approved amount	None
If you need help recovering or have other special health needs	**Home health care**	No charge	N/A	Must be medically necessary. Participating providers only.
	Rehabilitation services	No charge	Remainder of total charges after approved amount	Services provided in a freestanding outpatient physical therapy facility are covered only when the facility is a participating facility.
	Habilitation services	No charge	Remainder of total charges after approved amount	Services provided in a freestanding outpatient physical therapy facility are covered only when the facility is a participating facility.
	Skilled nursing care	20% coinsurance after deductible	N/A	Participating **providers** only. 100 days maximum.
	Durable medical equipment	10% coinsurance after deductible	10% of approved amount plus remainder of total charges	None
	Hospice services	No charge	N/A	Participating **providers** only.
If your child needs dental or eye care	Children's eye exam	No charge	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 every 12 months. For out-of-network services, Davis Vision reimburses up to $40 for an eye exam. Non-covered vision expenses may be reimbursed via Individual HRA Account with manual submission including an "Explanation of Benefits" from Davis Vision and completed Individual HRA application. May not be reimbursed through Miscellaneous Account

	Children's glasses	No charge for Davis Vision collection frames. $250 allowance for other provider frames, 80% of cost over $250. No charge for plastic or lenticular lenses.	Total cost charged by **provider** over $30 for single vision lenses, $50 for bifocal, $70 for trifocal or lenticular, $140 for frames, $300 for contacts	Coverage for in-network glasses or contacts provided every 12 months. No charge for fashion, designer or premier level frames from Davis Vision collection. $250 allowance for other frames, must pay 80% of balance over allowance. No charge for single vision, bifocal, or trifocal standard plastic lenses, or lenticular lenses. Co-payments applicable to premium lenses.
	Children's dental check-up	No charge	Total cost charged by **provider** over the Nonparticipating Dentist Fee	Dental benefits are provided through Delta Dental. Delta pays 100% of the Approved Amount for in-network preventive benefits. For out-of-network preventive services, Delta Dental will pay 100% of the Dental Nonparticipating Dentist Fee. If less than the amount charged, you are responsible for the difference.

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
- Cosmetic surgery
- Infertility Treatment
- Long-term care
- Private-duty nursing
- Non-emergency care outside the U.S., absent prior approval from the Plan's Board of Trustees
- Weight Loss Programs
- Services to treat an injury or condition that is a direct or indirect result of a motor vehicle accident
- Skilled nursing over 100 days

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 BCBSM)
- Chiropractic care (38 visits per year)
- Routine eye care - Adult (Vision benefits provided through Davis Vision)
- Hearing aids ($5,000 every 36 months)
- Weight Loss Drugs (Prescribed)
- Routine foot care
- Private-duty nursing (10% coinsurance)
- Adult dental care (Dental benefits provided through Delta Dental)

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 Centers for Medicare & Medicaid Services – Office of COBRA Continuation Coverage at 1-866-444-3272. 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, call 1-888-390-7473 or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or on the web at www.dol.gov/agencies/ebsa.

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.

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]*	20%
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$400**

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]*	20%
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	$100
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
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

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	**$1,350**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$150**

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