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 view the Glossary at www.dol.gov/ebsa/healthreform.com or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 / individual or $500 / family	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, some preventive care and primary care services are covered before you meet your deductible. This plan is grandfathered and doesn't cover all preventive services.	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 the SPD for a listing). 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 deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these 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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, any pharmacy penalty 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 1-877-790-2583 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	20% coinsurance after deductible.	Out-of-network providers may balance bill.
	Specialist visit	$20 copay/visit	20% coinsurance after deductible.	Out-of-network providers 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)	10% coinsurance after deductible.	20% coinsurance after deductible.	Out-of-network providers may balance bill.
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible.	20% coinsurance after deductible.	May require preauthorization. Out-of-network 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/pharmacy	Generic drugs	$10 copay 1-30 days; $20 copay 84-90 days (retail & mail order)	In-network copay **plus** 25% coinsurance based on BCBSM approved amount.	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.
	Preferred brand drugs	$40 copay 1-30 days; $80 copay 84-90 days (retail & mail order)	In-network copay **plus** 25% coinsurance based on BCBSM approved amount.	
	Non-preferred brand drugs	$40 copay 1-30 days; $80 copay 84-90 days (retail & mail order)	In-network copay **plus** 25% coinsurance based on BCBSM approved amount.	
	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.	Out-of-network providers 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)	
If you need immediate medical attention	Emergency room care	$50 copay/visit; deductible does not apply	$50 copay/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. Out-of-network providers (other than air ambulances) may balance bill.
	Urgent care	$20 copay/visit	20% coinsurance after deductible.	Covered: Deductible, Copayment and Coinsurance does not apply to accidental or medical emergencies. Out-of-network 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.	Out-of-network 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. Out-of-network providers 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	0% coinsurance	20% coinsurance after deductible.	Out-of-network providers may balance bill.
	Childbirth/delivery professional services	10% coinsurance after deductible.	20% coinsurance after deductible.	
	Childbirth/delivery facility services	10% coinsurance after deductible.	20% coinsurance after deductible.	Non-participating facilities are not covered.
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-

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)	
	Habilitation services	10% coinsurance after deductible.	20% coinsurance after deductible.	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.	Out-of-network providers may balance bill.
	Hospice services	0% coinsurance	0% coinsurance	Must be provided through a participating hospice provider.
If your child needs dental or eye care	Children's eye exam	$20 copay for exam; $20 copay 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.
	Children's glasses	20% coinsurance	Not covered	Coverage limited to one pair of glasses/year.
	Children's dental check-up	0% coinsurance for preventive services only		Out-of-network 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.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Cosmetic surgery (not medically necessary)
- Hearing aids
- Infertility treatment
- Long-term care
- 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)
- Chiropractic care
- Dental care (Adult) with Delta Dental
- Private-duty nursing
- Routine eye care (Adult)
- Prescription contraceptive devices , injections and mediations

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 Benefits 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: www.uwuabenefits.org or call 1-800-920-8116. You may also contact the Department of Laborer Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.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 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 copayment** **$20**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$250
Copayments	$20
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,330**

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** **10%**
- **Other coinsurance** **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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$250
Copayments	$1,000
Coinsurance	$10
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,280**

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** **10%**
- **Other coinsurance** **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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$250
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

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