



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, visit [www.umr.com](http://www.umr.com) or by calling 1-800-826-9781. 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.umr.com](http://www.umr.com) or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$500 person / \$1,000 family Platinum Tier \$1,000 person / \$2,000 family Tier 1 \$1,000 person / \$2,000 family Tier 2 \$2,500 person / \$5,000 family Out-of-network	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$3,000 person / \$6,000 family Platinum Tier \$4,000 person / \$8,000 family Tier 1 \$4,000 person / \$8,000 family Tier 2 \$7,500 person / \$15,000 family Out-of-network	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Penalties, <a href="#">premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.umr.com">www.umr.com</a> or call 1-800-826-9781 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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
		Platinum tier	Tier 1	Tier 2	Out of network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 Copay per visit; Deductible Waived	\$25 Copay per visit; Deductible Waived	20% Coinsurance	40% Coinsurance	None
	<u>Specialist</u> visit	\$55 Copay per visit; Deductible Waived	\$60 Copay per visit	20% Coinsurance	40% Coinsurance	None
	<u>Preventive care/ screening/ immunization</u>	No charge; Deductible Waived	No charge; Deductible Waived	No charge; Deductible Waived	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge; Deductible Waived	10% Coinsurance	20% Coinsurance	40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	\$100 Copay per test; Deductible Waived	\$200 Copay per test	20% Coinsurance	40% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Platinum tier	Tier 1	Tier 2	Out of network	
<b>If you need drugs to treat your illness or condition.</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com/">www.caremark.com/</a>	Generic drugs (Tier 1)	\$20 for one 30-day supply \$40 for one 90-day supply			Not covered	Certain drugs require prior authorization. Not all drugs are covered under the plan. If you receive a brand name drug when a generic equivalent is available, you will pay the applicable brand cost share plus the difference in cost between the brand and generic drug. CVS Caremark: 833-297-3187.
	Preferred brand drugs (Tier 2)	\$40 for one 30-day supply \$80 for one 90-day supply			Not covered	
	Non-preferred brand drugs (Tier 3)	\$60 for one 30-day supply \$120 for one 90-day supply			Not covered	
	<a href="#">Specialty drugs</a> (Tier 4)	20% after deductible Copay maximum \$250			Not covered	Certain drugs require prior authorization. Not all drugs are covered under the plan. CVS Caremark: 833-297-3187.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$120 Copay per visit; Deductible Waived	\$150 Copay per visit	30% Coinsurance	50% Coinsurance	None
	Physician/surgeon fees	No charge; Deductible Waived	No charge	30% Coinsurance	50% Coinsurance	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$500 Copay per visit	\$500 Copay per visit	\$500 Copay per visit	\$500 Copay per visit	Platinum Tier deductible applies to all tiers; Copay may be waived if admitted
	<a href="#">Emergency medical transportation</a>	\$100 Copay per visit	\$100 Copay per visit	\$100 Copay per visit	\$100 Copay per visit	Tier 1 deductible applies to Tier 2 & Out-of-network
	<a href="#">Urgent care</a>	Not applicable	\$75 Copay per visit; Deductible Waived	\$75 Copay per visit; Deductible Waived	\$75 Copay per visit	Platinum Tier deductible applies to Out-of-network benefits

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Platinum tier	Tier 1	Tier 2	Out of network	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 Copay per day up to \$600 per admission; Deductible Waived	\$250 Copay per day up to \$1,250 per admission	30% Coinsurance	50% Coinsurance	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$500 of the total cost of the service.
	Physician/surgeon fees	No charge; Deductible Waived	No charge	30% Coinsurance	50% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	\$15 Copay per visit; Deductible Waived Office visits; No charge other outpatient services	\$25 Copay per visit; Deductible Waived Office visits; 10% Coinsurance other outpatient services	20% Coinsurance	40% Coinsurance	<u>Preauthorization</u> is required for Partial <u>hospitalization</u> . If you don't get <u>preauthorization</u> , benefits could be reduced by \$500 of the total cost of the service.
	Inpatient services	\$150 Copay per day up to \$600 per admission facility; No charge physician; Deductible Waived	\$250 Copay per day up to \$1,250 per admission facility; No charge physician	30% Coinsurance	50% Coinsurance	
If you are pregnant	Office visits	No charge; Deductible Waived	No charge; Deductible Waived	No charge; Deductible Waived	40% Coinsurance	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>deductible</u> , <u>copayment</u> or <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge; Deductible Waived	No charge	30% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	\$150 Copay per day up to \$600 per admission; Deductible Waived	\$250 Copay per day up to \$1,250 per admission	30% Coinsurance	50% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Platinum tier	Tier 1	Tier 2	Out of network	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge; Deductible Waived	10% Coinsurance	20% Coinsurance	40% Coinsurance	60 Maximum visits per calendar year; <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 of the total cost of the service.
	<a href="#">Rehabilitation services</a>	\$20 Copay per visit; Deductible Waived	\$25 Copay per visit	20% Coinsurance	40% Coinsurance	None
	<a href="#">Habilitation services</a>	\$20 Copay per visit; Deductible Waived	\$25 Copay per visit	20% Coinsurance	40% Coinsurance	Habilitation services for Learning Disabilities are not covered.
	<a href="#">Skilled nursing care</a>	No charge; Deductible Waived	10% Coinsurance	20% Coinsurance	40% Coinsurance	100 Maximum days per lifetime; <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 of the total cost of the service.
	<a href="#">Durable medical equipment</a>	20% Coinsurance	20% Coinsurance	30% Coinsurance	50% Coinsurance	<a href="#">Preauthorization</a> is required for DME in excess of \$500 for rentals or \$1,500 for purchases. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$500 per occurrence.
	<a href="#">Hospice service</a>	No charge; Deductible Waived	10% Coinsurance	20% Coinsurance	40% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered	None

## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li><li>• Hearing aids</li></ul>	<ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul>
---	--	---

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

<ul style="list-style-type: none"><li>• Bariatric surgery</li></ul>	<ul style="list-style-type: none"><li>• Chiropractic care</li></ul>
---	---

**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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.HealthCare.gov](http://www.HealthCare.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://www.HealthInsuranceMarketplace.gov). For more information about the [Marketplace](http://www.HealthInsuranceMarketplace.gov), visit [www.HealthCare.gov](http://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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.HealthCare.gov](http://www.HealthCare.gov). Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at: [www.HealthCare.gov](http://www.HealthCare.gov) and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

### 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 Standard? 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 1-800-826-9781.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-826-9781.

Navajo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwijjigo holne' 1-800-826-9781.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf die do Nummer uff 1-800-826-9781.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-826-9781.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-826-9781.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-826-9781.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-826-9781.

*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 <a href="#">plan's overall deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$55
■ <a href="#">Hospital (facility) copayment</a>	\$150
■ <a href="#">Other coinsurance</a>	0%

This EXAMPLE event includes services like:  
[Specialist](#) office visits (*pre-natal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist visit](#) (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$770</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's overall deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$55
■ <a href="#">Hospital (facility) copayment</a>	\$150
■ <a href="#">Other coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$4,500</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's overall deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$55
■ <a href="#">Hospital (facility) copayment</a>	\$150
■ <a href="#">Other coinsurance</a>	0%

This EXAMPLE event includes services like:  
[Emergency room care](#) (*including medical supplies*)  
[Diagnostic tests](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$1,210</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [www.umr.com](http://www.umr.com) or call 1-800-826-9781.