



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 1-877-370-5217. 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 1-877-370-5217 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$5,000 person / \$10,000 family In-network \$10,000 person / \$20,000 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>	\$7,000 person / \$14,000 family In-network Unlimited 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>	<a href="#">Copayments</a> for certain services, penalties, deductible for out-of-network charges, <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 1-877-370-5217 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
		In-network (You will pay the least)	Out-of-network (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	\$40 Copay per visit; Deductible Waived	50% Coinsurance	None
	<a href="#">Specialist</a> visit	\$80 Copay per visit; Deductible Waived	50% Coinsurance	None
	<a href="#">Preventive care/screening/immunization</a>	No charge; Deductible Waived	50% Coinsurance	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge; Deductible Waived	50% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	50% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
<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="#">express-scripts.com</a> or call 1.800.334.8134.	Generic drugs (Tier 1)	\$20 Copay Retail 1-30DS \$60 Copay Retail 1-90DS \$50 Copay Mail Order 1-90DS	Not Covered.	<b>Generic Policy - Dispense As Written (DAW)</b> If a Brand name drug is filled when a Generic equivalent is available, you will be required to pay the Brand cost share plus the difference in cost between the Generic and Brand name drug. The Generic Policy does not apply if the prescription indicates the Brand must be dispensed.
	Preferred brand drugs (Tier 2)	\$50 Copay Retail 1-30DS \$150 Copay Retail 1-90DS \$125 Copay Mail Order 1-90DS	Not Covered.	
	Non-preferred brand drugs (Tier 3)	\$80 Copay Retail 1-30DS \$240 Copay Retail 1-90DS \$200 Copay Mail Order 1-90DS	Not Covered.	<b>Manufacturer Copay Assistance Program (MCAP)</b> Specialty medications are used to treat complex chronic conditions and have a high cost. In order to help manage the cost to you, your employer is offering a copay assistance program coordinated by SaveOnSP. Enrolling in the program provides members the opportunity for \$0 cost on select medications.
	Specialty drugs (Tier 4)	30% Coinsurance (\$100 min, \$300 max) Retail 1-30DS	Not Covered.	<b>Maintenance Drug</b> A medication that is used for chronic health conditions on an ongoing or long-term basis (e.g., antihypertensive medication taken daily to control high blood pressure). Your plan allows maintenance medications to be filled in 90-day supplies by mail order pharmacy or at a retail pharmacy location.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	Not covered Outpatient surgery centers; 50% Coinsurance all other facilities	None
	Physician/surgeon fees	30% Coinsurance	Not covered Outpatient surgery centers; 50% Coinsurance all other physician/surgeon	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$200 Copay per visit; 30% Coinsurance; Deductible Waived	\$200 Copay per visit; 30% Coinsurance; Deductible Waived	Copay may be waived if admitted
	<a href="#">Emergency medical transportation</a>	30% Coinsurance	30% Coinsurance	In-network deductible applies to Out-of-network benefits; <a href="#">Preauthorization</a> is required for air ambulance transfers between facilities.
	<a href="#">Urgent care</a>	\$75 Copay per visit; Deductible Waived	50% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance	50% Coinsurance	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$250 of the total cost of the service.
	Physician/surgeon fees	30% Coinsurance	50% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
<b>If you have mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$40 Copay per visit; Deductible Waived Office visits; 30% Coinsurance other outpatient services	50% Coinsurance	<a href="#">Preauthorization</a> is required for Partial <a href="#">hospitalization</a> .
	Inpatient services	30% Coinsurance	50% Coinsurance	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$250 of the total cost of the service.
<b>If you are pregnant</b>	Office visits	No charge; Deductible Waived	50% Coinsurance	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">deductible</a> , <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	30% Coinsurance	50% Coinsurance	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	30% Coinsurance	50% Coinsurance	60 Maximum visits per calendar year; <a href="#">Preauthorization</a> is required.
	<a href="#">Rehabilitation services</a>	30% Coinsurance	50% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If your child needs dental or eye care	<a href="#">Habilitation services</a>	30% Coinsurance	50% Coinsurance	Habilitation services for Learning Disabilities are not covered.
	<a href="#">Skilled nursing care</a>	30% Coinsurance	50% Coinsurance	60 Maximum days per calendar year; <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by \$250 of the total cost of the service.
	<a href="#">Durable medical equipment</a>	30% Coinsurance	50% Coinsurance	<a href="#">Preauthorization</a> is required for DME in excess of \$500 for rentals or \$1,500 for purchases.
	<a href="#">Hospice service</a>	No charge; Deductible Waived	50% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	\$25 Copay per visit; Deductible Waived	\$25 Copay per visit; Deductible Waived	1 Maximum exam per calendar year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	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](#).)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

- Dental care (Adult)

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

• Chiropractic care – 25 visits per calendar year	• Hearing aids - \$1,000 per calendar year	• Routine eye care (Adult) – 1 exam per calendar year
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**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](#). For more information about the [Marketplace](#), 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://ccilio.cms.gov/programs/consumer/capgrants/index.html>.

**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 1-877-370-5217.

Traditional Chinese (中文): 如果需要中文的帮助, 請撥打這個號碼 1-877-370-5217.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-877-370-5217.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf die do Nummer uff 1-877-370-5217.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-370-5217.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-877-370-5217.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-877-370-5217.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-877-370-5217.

*[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</a> overall <a href="#">deductible</a>	\$5,000
■ <a href="#">Specialist copayment</a>	\$80
■ <a href="#">Hospital (facility) coinsurance</a>	30%
■ <a href="#">Other coinsurance</a>	30%

**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>
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**In this example, Peg would pay:**

Cost Sharing	
<a href="#">Deductibles</a>	\$5,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,800

*What isn't covered*

Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$6,870</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,000
■ <a href="#">Specialist copayment</a>	\$80
■ <a href="#">Hospital (facility) coinsurance</a>	30%
■ <a href="#">Other coinsurance</a>	30%

**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>
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**In this example, Joe would pay:**

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

*What isn't covered*

Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$4,800</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,000
■ <a href="#">Specialist copayment</a>	\$80
■ <a href="#">Hospital (facility) coinsurance</a>	30%
■ <a href="#">Other coinsurance</a>	30%

**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>
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**In this example, Mia would pay:**

Cost Sharing	
<a href="#">Deductibles</a>	\$1,400
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$300

*What isn't covered*

Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$2,110</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 1-877-370-5217.