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, see www.umr.com. 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 https://www.healthcare.gov/sbc-glossary or call 1-888-309-7348 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable	This plan does not have a deductible.
Are there other deductibles for specific services?	Yes. Network providers: **$100**/individual for certain outpatient services, **$100**/individual for most inpatient services. Out-of-network providers: **$100**/individual for certain outpatient services, **$100**/individual for most inpatient services. There are no other specific 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?	Network providers: **$5,000**/individual, **$10,000**/family; Out-of-network providers: No out-of-pocket limit; Prescription drugs: **$1,600**/individual, **$3,200**/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, penalties for failure to obtain preauthorization 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.umr.com or call 1-888-309-7348 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.

Important Questions	Answers	Why This Matters:
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	$10 copay per visit	50% coinsurance	None
	Specialist visit	$10 copay per visit	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% coinsurance	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)	20% coinsurance; inpatient deductible and/or outpatient deductible applies	50% coinsurance; inpatient deductible and/or outpatient deductible applies	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance; inpatient deductible and/or outpatient deductible applies	50% coinsurance; inpatient deductible and/or outpatient deductible applies	$250 penalty if preauthorization not obtained.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$10 copay per prescription at retail and mail order	$10 copay per prescription at retail and mail order	Limited to up to a 30-day supply at retail pharmacies. Limited to up to a 90-day supply at Caremark mail order pharmacy and at CVS. If a generic version of a non-preferred brand name drug is available, your cost will be the generic copay plus the price difference between the generic drug and the brand name drug. No charge for FDA-approved generic preventive medications (e.g., generic contraceptives) or brand name preventive medications if a generic is not medically appropriate.
	Preferred brand drugs	$20 copay per prescription at retail and mail order	$20 copay per prescription at retail and mail order	
	Non-preferred brand drugs	$30 copay per prescription at retail and mail order	$30 copay per prescription at retail and mail order	
	Specialty drugs	Covered as generic, preferred brand, or non-preferred brand drugs, above	Covered as generic, preferred brand, or non-preferred brand drugs, above	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance; outpatient deductible applies	50% coinsurance; outpatient deductible applies	$250 penalty if preauthorization not obtained. Coinsurance waived for non-surgical procedures.
	Physician/surgeon fees	20% coinsurance; outpatient deductible applies	50% coinsurance; outpatient deductible applies	$250 penalty if preauthorization not obtained.
If you need immediate medical attention	Emergency room care	$50 copay per visit	$50 copay per visit	Copay waived if admitted. Professional/physician charges may be billed separately.
	Emergency medical transportation	20% coinsurance	20% coinsurance for air ambulance services; 50% coinsurance for all other emergency medical transportation	None
	Urgent care	$50 copay per visit	$50 copay per visit	Copay waived if admitted.

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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance; inpatient deductible applies	50% coinsurance; inpatient deductible applies	$250 penalty if preauthorization not obtained.
	Physician/surgeon fees	20% coinsurance; inpatient deductible applies	50% coinsurance; inpatient deductible applies	$250 penalty if preauthorization not obtained.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay per office visit; 20% coinsurance for all other outpatient services, outpatient deductible applies	50% coinsurance; outpatient deductible applies	$250 penalty if preauthorization of partial hospitalization and intensive outpatient treatment not obtained.
	Inpatient services	20% coinsurance; inpatient deductible applies	50% coinsurance; inpatient deductible applies	$250 penalty if preauthorization not obtained.
If you are pregnant	Office visits	$10 copay per initial confirmation visit, then 20% coinsurance	50% coinsurance	Primary care physician or specialist benefit levels apply to initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copay or coinsurance may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance; inpatient deductible applies	50% coinsurance; inpatient deductible applies	
	Childbirth/delivery facility services	20% coinsurance; inpatient deductible applies	50% coinsurance; inpatient 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	20% coinsurance; outpatient deductible applies	50% coinsurance; outpatient deductible applies	$250 penalty if preauthorization not obtained. Limited to 60 days per calendar year and 16 hours per day. Limit does not apply to mental health and substance use disorder conditions.
	Rehabilitation services	$20 copay per visit	50% coinsurance for primary care physician or specialist visit	$250 penalty if preauthorization not obtained. Rehabilitation services, including cardiac rehabilitation and chiropractic services, are limited to 40 days per calendar year. Limit does not apply to physical, speech, and occupational therapy for mental health conditions.
	Habilitation services	$10 copay per visit	50% coinsurance for primary care physician or specialist visit	$250 penalty if preauthorization not obtained. Covered when medically necessary to treat a mental health condition (e.g., autism) or a congenital abnormality.
	Skilled nursing care	20% coinsurance; inpatient deductible applies	50% coinsurance; inpatient deductible applies	$250 penalty if preauthorization not obtained. Limited to 90 days per calendar year.
	Durable medical equipment	20% coinsurance; outpatient deductible applies	50% coinsurance; outpatient deductible applies	$250 penalty if preauthorization not obtained.
	Hospice services	20% coinsurance; inpatient deductible and/or outpatient deductible applies	50% coinsurance; inpatient deductible and/or outpatient deductible applies	$250 penalty if preauthorization not obtained.

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 your child needs dental or eye care	Children's eye exam	No charge	No charge up to $40 then 100%	Limited to one eye exam per calendar year. Vision benefits are separately administered by Cigna Vision.
	Children's glasses	Frames: No charge up to $90 then 100%; Lenses: No charge for single vision, bifocal or trifocal lenses	Frames: No charge up to $45 then 100%; Lenses: No charge up to $45 then 100% for single vision lenses	Frames limited to one set every two calendar years. Lenses limited to one set every calendar year. Vision benefits are separately administered by Cigna Vision.
	Children's dental check-up	No charge	20% coinsurance, plus balance billing	In-network dental services limited to $1,500 per person per calendar year. Out-of-network dental services limited to $1,000 per person per calendar year. Dental benefits are separately administered by Delta Dental.

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
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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

- Bariatric surgery (covered in-network only; surgery limited to $10,000 per lifetime)
- Chiropractic care
- Dental care (Adult)(limited to $1,500 per person per year in-network and $1,000 per person per year out-of-network)
- Routine eye care (Adult)
- Routine foot care (limited to $1,000 per calendar year)
- Weight loss programs

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 Department of Labor's Employee Benefits Security Administration at 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: UMR Customer service at 1-888-309-7348. You may also contact the Department of Labor's 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 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

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	**$0**
Specialist *copay*	**$10**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$400
Copayments	$10
Coinsurance	$2,360
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,830**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist *copay*	**$10**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$110
Copayments	$690
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$800**

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

The plan's overall deductible	**$0**
Specialist *copay*	**$10**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$100
Copayments	$180
Coinsurance	$190
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$470**

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