



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 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 or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	\$9,100 individual / \$18,200 family In-network \$18,200 individual / \$36,400 family Out-of-network Maximum amount that any one person will satisfy towards the annual family deductible: \$9,100 In-network / \$18,200 Out-of-network	Generally, you must pay all 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 <u>deductible</u>?	Yes. Preventive care and Teladoc services 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 <u>deductibles</u> for specific services?	Yes. <i>Journal</i> - and non- <i>Journal</i> -Listed Christian Science Care \$300 individual / \$900 family	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket limit</u> for this plan?	\$9,100 individual / \$18,200 family In-network \$20,000 individual / \$40,000 family Out-of-network <i>Journal</i> -Listed Christian Science Care \$5,000 individual / \$10,000 family Non- <i>Journal</i> -Listed Christian Science Care \$7,500 individual / \$22,500 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 <u>out-of-pocket limit</u>?	Penalties, premiums , balance billing charges, 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 <u>network provider</u> ?	Yes. See www.umr.com or call 1-800-826-9781 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
 All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> 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	No charge	50% Coinsurance	None
	<u>Specialist</u> visit	No charge	50% Coinsurance	None
	<u>Preventive care/screening/immunization</u>	No charge; Deductible Waived	50% Coinsurance	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.

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 a test	Diagnostic test (x-ray, blood work)	No charge	50% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	50% Coinsurance	None
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.umr.com .	Tier 1 (generic and some brand-name)	\$10 Copay per prescription (retail); \$20 Copay per prescription (mail order)	If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.	Deductible and Out-of-pocket limit applies Covers up to a 31-day supply (retail); 32-90 day supply (mail order); Covers up to a 30-day supply (specialty)
	Tier 2 (preferred brand-name and some generic)	\$35 Copay per prescription (retail); \$70 Copay per prescription (mail order)		Once the annual out-of-pocket limit is met, you pay nothing for covered prescription medication
	Tier 3 (nonpreferred brand-name and nonpreferred generic)	\$60 Copay per prescription (retail); \$120 Copay per prescription (mail order)		
	Tier 4 (specialty drugs)	\$75 Copay per prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	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)	
	Physician/surgeon fees	No charge	50% Coinsurance	None
If you need immediate medical attention	Emergency room care	No charge	No charge	In-network deductible applies to Out-of-network benefits
	Emergency medical transportation	No charge	No charge	In-network deductible applies to Out-of-network benefits
	Urgent care	No charge	50% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% Coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service for Out-of-network.
	Physician/surgeon fees	No charge	50% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	No charge	50% Coinsurance	Preauthorization is required for Partial hospitalization . If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service for Out-of-network.
	Inpatient services	No charge	50% Coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service for Out-of-network.

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 are pregnant	Office visits	No charge; Deductible Waived	50% Coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, deductible , copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	50% Coinsurance	
	Childbirth/delivery facility services	No charge	50% Coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	50% Coinsurance	60 Maximum visits per calendar year; Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service for Out-of-network.
	Rehabilitation services	No charge	50% Coinsurance	None
	Habilitation services	No charge	50% Coinsurance	Habilitation services for Learning Disabilities are not covered.
	Skilled nursing care	No charge	50% Coinsurance	60 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service for Out-of-network.

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)	
	Durable medical equipment	No charge	50% Coinsurance	Preauthorization is required for DME in excess of \$500 for rentals or \$1,500 for purchases. If you don't get preauthorization , benefits could be reduced by 50% per occurrence for Out-of-network.
	Hospice service	No charge	50% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	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	• Dental care (Adult)	• Routine eye care (Adult)	• Routine foot care
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
• Chiropractic care	• Infertility treatment	• Non-emergency care when traveling outside the U.S.	• Hearing aids

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](#). 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 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](#). 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](#) and <http://cciio.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 1-800-826-9781.

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 at'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 plan's overall deductible	\$9,100
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	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*)

Total Example Cost **\$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$9,100
Copayments	\$20
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
The total Peg would pay is	\$9,120

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$9,100
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	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*	\$5,400
Copayments	\$0
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$5,420

Mia's Simple Fracture

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

■ The plan's overall deductible	\$9,100
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	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*)

Total Example Cost **\$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$2,800
Copayments	\$0
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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 or call 1-800-826-9781.

*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.