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 deductible?	None.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	**$7,000** person / **$14,000** 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?	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 network provider?	Yes. See www.umr.com or call 1-800-826-9781 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
		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	$35 Copay per visit	Not covered	None
	Specialist visit	$70 Copay per visit	Not covered	None
	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 you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$35 Copay per visit PCP; $70 Copay per visit Specialist office setting; No charge outpatient setting	Not covered	None
	Imaging (CT/PET scans, MRIs)	$35 Copay per visit PCP; $70 Copay per visit Specialist office setting; $300 Copay per visit outpatient setting	Not covered	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 you need drugs to treat your illness or condition. More information about prescription drug coverage is available at express-scripts.com.	Generic drugs (Tier 1)	$20 copay retail 1–30-day supply $0 copay retail 1-90-day supply	Not covered	**Manufacturer Copay Assistance Program (MCAP)** 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. If you choose not to enroll, your responsibility will be a 30% coinsurance. Please contact SaveOnSP at 800.683.1074, a patient advocate will assist you with completing your enrollment. **Generic Policy - Dispense As Written (DAW)** If your doctor writes a prescription stating that a Generic may be dispensed, we will only pay for the Generic drug. If you choose to buy the Brand name drug in this situation, you will be required to pay the Brand copay/coinsurance plus the difference in cost between the Generic and Brand name drug. The Generic Policy does not apply if your doctor requires a brand name medication. **Specialty Medications** Specialty medications are high-cost drugs that are often injected or infused and require special storage and monitoring. These medications must be obtained through Accredo specialty pharmacy by calling Accredo at 1.800.803.2523. Some exceptions apply. These medications are limited to a 1-30 day supply.
	Preferred brand drugs (Tier 2)	$60 copay retail 1–30-day supply $60 copay retail 1-90-day supply	Not covered	
	Non-preferred brand drugs (Tier 3)	$60 copay retail 1–30-day supply $90 copay retail 1-90-day supply	Not covered	
	Specialty drugs (Tier 4)	25% coinsurance ($500 Maximum) 1–30-day supply Mail Only All Tiers	Not covered	
	Facility fee (e.g., ambulatory surgery center)	$700 Copay per visit	Not covered	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 you have outpatient surgery	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$600 Copay per visit	$600 Copay per visit	Copay may be waived if admitted
	Emergency medical transportation	$250 Copay per trip ground; $500 Copay per trip air	$250 Copay per trip ground; $500 Copay per trip air	None
	Urgent care	$75 Copay per visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$600 Copay per day for 1st 3 days then No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fee	No charge	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$35 Copay per office visit; $700 Copay per visit other outpatient services	Not covered	None
	Inpatient services	$600 Copay per day for 1st 3 days then No charge facility; No charge physician	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.

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	Not covered	Cost sharing does not apply to certain 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	Not covered	
	Childbirth/delivery facility services	$600 Copay per day for 1st 3 days then No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	$25 Copay per visit	Not covered	90 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.
	Rehabilitation services	$35 Copay per visit	Not covered	30 Maximum visits per calendar year OT/PT; 20 Maximum visits per calendar year ST; Habilitation services for Learning Disabilities are not covered.
	Habilitation services	$35 Copay per visit	Not covered	
	Skilled nursing care	$100 Copay per day	Not covered	90 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.
	Durable medical equipment	No charge	Not covered	Preauthorization is required for DME in excess of $500 for rentals or $1,500 for purchases.

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)	
	Hospice service	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	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
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

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

- Chiropractic care (In-network only)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Outpatient care) (In-network only)
- Routine eye care (Adult) (In-network only)

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 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: 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.

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 copayment	$70
Hospital (facility) copayment	$600
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	$0
Copayments	$3,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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 copayment	$70
Hospital (facility) copayment	$600
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*	$0
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

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

The plan's overall deductible	$0
Specialist copayment	$70
Hospital (facility) copayment	$600
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*	$0
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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.

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