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?	**$250** person / **$500** family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay.
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?	**$1,000** person	The out-of-pocket limit is the most you could pay in a year for covered services.
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 (a 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	20% Coinsurance	20% Coinsurance	None
	Specialist visit	20% Coinsurance	20% Coinsurance	None
	Preventive care/ screening/immunization	No charge; Deductible Waived Preventive care employees & spouses over age 19; 20% Coinsurance Preventive care dependents up to age 26 & immunizations; No charge; Deductible Waived first $300 per calendar year, then 20% Coinsurance after deductible Preventive screening	No charge; Deductible Waived Preventive care employees & spouses over age 19; 20% Coinsurance Preventive care dependents up to age 26 & immunizations; No charge; Deductible Waived first $300 per calendar year, then 20% Coinsurance after deductible Preventive screening	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)	20% Coinsurance office setting; No charge; Deductible Waived first $300 per calendar year, then 20% Coinsurance after deductible outpatient setting	20% Coinsurance office setting; No charge; Deductible Waived first $300 per calendar year, then 20% Coinsurance after deductible outpatient setting	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance office setting; No charge; Deductible Waived first $300 per calendar year, then 20% Coinsurance after deductible outpatient setting	20% Coinsurance office setting; No charge; Deductible Waived first $300 per calendar year, then 20% Coinsurance after deductible outpatient setting	Preauthorization is required for services over $500 for MRIs and multiple scans.

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 www.express-scripts.com.	Generic drugs (Tier 1)	$15 Copay per prescription (retail); $30 Copay per prescription (mail order)	Not covered	Covers up to a 30-day supply (retail & specialty); 31-90 day supply (mail order)
	Preferred brand drugs (Tier 2)	$30 Copay per prescription (retail); $60 Copay per prescription (mail order)		
	Non-preferred brand drugs (Tier 3)	$30 Copay per prescription (retail); $60 Copay per prescription (mail order)		
	Specialty drugs (Tier 4)	$15 Copay per prescription (Generic); $30 Copay per prescription (Preferred & Non-preferred drugs)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	20% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance physician; No charge; Deductible Waived first $1,000, then 20% Coinsurance after deductible surgeon	20% Coinsurance	None
If you need immediate medical attention	Emergency room care	20% Coinsurance True ER; Not covered Non-true ER	20% Coinsurance True ER; Not covered Non-true ER	None
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	$100 Maximum benefit per occurrence Mileage charges
	Urgent care	20% Coinsurance	20% 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 you have a hospital stay	Facility fee (e.g., hospital room)	No charge; Deductible Waived	No charge; Deductible Waived	70 Maximum days per calendar year
	Physician/surgeon fee	No charge; Deductible Waived first $15 of visit, then 20% Coinsurance after deductible physician; No charge; Deductible Waived first $1,000 of visit, then 20% Coinsurance after deductible surgeon	No charge; Deductible Waived first $15 of visit, then 20% Coinsurance after deductible physician; No charge; Deductible Waived first $1,000 of visit, then 20% Coinsurance after deductible surgeon	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	20% Coinsurance	20% Coinsurance	None
	Inpatient services	No charge; Deductible Waived facility; No charge; Deductible Waived first $15 of visit, then 20% Coinsurance after deductible physician; No charge; Deductible Waived first $1,000 of visit, then 20% Coinsurance after deductible surgeon	No charge; Deductible Waived	70 Maximum days per calendar year
If you are pregnant	Office visits	No charge; Deductible Waived	No charge; Deductible Waived	4 Maximum days per hospitalization Childbirth/delivery facility services; 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; Deductible Waived	No charge; Deductible Waived	
	Childbirth/delivery facility services	No charge; Deductible Waived	No charge; Deductible Waived	

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 help recovering or have other special health needs	Home health care	20% Coinsurance	20% Coinsurance	Preauthorization is required for services over $500.
	Rehabilitation services	20% Coinsurance	20% Coinsurance	None
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% Coinsurance	20% Coinsurance	70 Maximum days per calendar year
	Durable medical equipment	20% Coinsurance	20% Coinsurance	Preauthorization is required for services over $500.
	Hospice service	No charge; Deductible Waived	No charge; Deductible Waived	16 Maximum days per lifetime
If your child needs dental or eye care	Children's eye exam	No charge; Deductible Waived	No charge; Deductible Waived	$150 Maximum benefit per calendar year combined with glasses
	Children's glasses	No charge; Deductible Waived	No charge; Deductible Waived	$150 Maximum benefit per calendar year combined with eye exams
	Children's dental check-up	20% Coinsurance	20% Coinsurance	$1,000 Maximum benefit per calendar year

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.)		
• Cosmetic surgery • Infertility treatment	• Long-term care • Private-duty nursing	• 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.)		
• Acupuncture • Bariatric surgery (if medically necessary) • Chiropractic care	• Dental care (Adult) • Hearing aids	• Non-emergency care when traveling outside the U.S. • Routine eye care (Adult)

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 page.

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** **$250**
- **Specialist coinsurance** **20%**
- **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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$100
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$850**

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

- **The plan's overall deductible** **$250**
- **Specialist coinsurance** **20%**
- **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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$250
Copayments	$1,300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,770**

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

- **The plan's overall deductible** **$250**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$250
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

*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.