> ⚠️ 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 1-800-207-3172. 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 1-800-207-3172 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,500 person / $4,500 family In-network $3,000 person / $9,000 family 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 deductible?	Yes. Preventive care 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 deductibles for specific services?	Yes. $100 Benefit deductible per plan year for prescription drug expenses In-network	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?	$4,000 person / $8,000 family In-network $8,000 person / $16,000 family Out-of-network	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 1-800-207-3172 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	$25 Copay per visit; Deductible Waived	50% Coinsurance	None
	Specialist visit	$40 Copay per visit; Deductible Waived	50% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	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)	No charge; Deductible Waived	50% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	50% Coinsurance	None

[*For more information about limitations and exceptions, see the plan or policy document at www.umr.com.]

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.umr.com.	Tier 1 (generic and some brand-name)	$15 Copay per prescription	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.	Out-of-pocket limit applies Covers up to a 30-day supply (retail); 31-90 day supply (mail order); Covers up to a 30-day supply (specialty) You must pay the difference in cost between a Generic drug and Brand-name drug when a medical professional has not specified a Brand-name drug or has not indicated that the Brand-name drug is necessary, this difference is not applied to preferred brand-name products in the high priced generic strategy, until the Out-of-pocket is met
	Tier 2 (preferred brand-name and some generic)	$30 Copay per prescription (retail); $60 Copay per prescription (mail order)		
	Tier 3 (nonpreferred brand-name and nonpreferred generic)	$50 Copay per prescription (retail); $150 Copay per prescription (mail order)		
	Tier 4 (specialty drugs)	$100 Copay per prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$350 Copay per visit; 20% Coinsurance	$350 Copay per visit; 50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% not to exceed $500 of the total cost of the service.
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	
If you need immediate medical attention	Emergency room care	$250 Copay per visit	$250 Copay per visit	In-network deductible applies to Out-of-network benefits; Copay may be waived if admitted
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	In-network deductible applies to Out-of-network benefits
	Urgent care	$40 Copay per visit; Deductible Waived	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 you have a hospital stay	Facility fee (e.g., hospital room)	$350 Copay per admission; 20% Coinsurance	$350 Copay per admission; 50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% not to exceed $500 of the total cost of the service.
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copay per visit; Deductible Waived Office visits; 20% Coinsurance other outpatient services	50% Coinsurance	Preauthorization is required for Partial hospitalization. If you don't get preauthorization, benefits could be reduced by 50% not to exceed $500 of the total cost of the service.
	Inpatient services	$350 Copay per admission; 20% Coinsurance	$350 Copay per admission; 50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% not to exceed $500 of the total cost of the service.
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	20% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	$350 Copay per admission; 20% Coinsurance	$350 Copay per admission; 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)	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	50% Coinsurance	60 Maximum visits per plan year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% not to exceed $500 of the total cost of the service.
	Rehabilitation services	$40 Copay per visit	50% Coinsurance	None
	Habilitation services	$40 Copay per visit	50% Coinsurance	None
	Skilled nursing care	$350 Copay per admission; 20% Coinsurance	50% Coinsurance	60 Maximum days per plan year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% not to exceed $500 of the total cost of the service.
	Durable medical equipment	20% Coinsurance	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% not to exceed $500 per occurrence.
	Hospice service	$350 Copay per admission; 20% Coinsurance inpatient; 20% Coinsurance outpatient	50% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge; Deductible Waived	No charge; Deductible Waived	1 Maximum exam per plan 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 • Chiropractic care • Cosmetic surgery	• Dental care (Adult) • 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.)		
• Bariatric surgery (In-network only – 1 Surgery) • Hearing aids (In-network only – 1 per ear every 36 months)	• Non-emergency care when traveling outside the U.S. • Private-duty nursing (Outpatient care In-network only – 60 visits per Plan year)	• Routine eye care (Adult – 1 Exam per Plan year)

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.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. 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.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		**Managing Joe's Type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)		**Mia's Simple Fracture** (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	$1,500	■ The plan's overall deductible	$1,500	■ The plan's overall deductible	$1,500
■ Specialist copayment	$40	■ Specialist copayment	$40	■ Specialist copayment	$40
■ Hospital (facility) copayment	$350	■ Hospital (facility) copayment	$350	■ Hospital (facility) copayment	$350
■ Other coinsurance	20%	■ Other coinsurance	20%	■ Other coinsurance	20%

This EXAMPLE event includes services like:

Peg	Joe	Mia
Specialist office visits *(pre-natal care)* Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests *(ultrasounds and blood work)* Specialist visit *(anesthesia)*	Primary care physician office visits *(including disease education)* Diagnostic tests *(blood work)* Prescription drugs Durable medical equipment *(glucose meter)*	Emergency room care *(including medical supplies)* Diagnostic tests *(x-ray)* Durable medical equipment *(crutches)* Rehabilitation services *(physical therapy)*

Total Example Cost	**$12,700**	**Total Example Cost**	**$5,600**	**Total Example Cost**	**$2,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$400
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$300
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,620**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,500
Copayments	$400
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,970**

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