**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?** | For network providers $1,500 person / $3,000 family; no coverage available for out- of-network providers unless specifically stated herein. | Generally, you must pay all of 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. Prescription drugs, in-network preventive care, in-network physician/specialist exam charges, second surgical opinions, urgent care services, in-network Physical/Occupational/Speech therapy, in-network chiropractic care, in-network outpatient/office/independent laboratory diagnostic tests, radiology and pathology administration and interpretation services, renal dialysis, and emergency room 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?** | There are no other specific deductibles. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | For network providers $5,000 individual / $10,000 family; no coverage available for out- of-network providers unless specifically stated herein. | 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 for failure to obtain precertification/preauthorization, services in excess of Plan maximums or limits, 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. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **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 |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $25 copay/office visit, deductible does not apply | Not covered | Copay applies to exam charge only. Does not include office surgery, labs or x-rays. Limited to general practice, family practice, OB/GYN, internal medicine, osteopaths, pediatricians, nurse practitioners, physician assistants and mental health providers. Chiropractic coverage is limited to 24 visits. See Plan Document for other services and services related to maternity. |
| | Specialist visit | $40 copay/visit, deductible does not apply | Not covered | Copay applies to exam charge only. Does not include office surgery. See Plan Document for other services and services related to maternity. |
| | Preventive care/screening/ immunization | No charge, deductible does not apply | Not covered | 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 does not apply | Not covered | Does not include emergency room diagnostic services. See Plan Document for services related to maternity. |

| 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 | |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | Not covered | See Plan Document for services related to maternity. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.caremark.com | Generic drugs (Tier 1) | $20 copay/prescription (retail) $60 copay/prescription (extended retail) $40 copay/prescription (mail-order) | Not covered | Covers up to a 30-day supply (retail prescription); 90-day supply (extended retail and mail order prescription). Deductible does not apply. Once the out-of-pocket maximum has been met, prescription drugs shall be covered at 100% for the remainder of the calendar year. *See Plan Document for non-use of generic drug penalty. |
| | Preferred brand drugs (Tier 2) | $35 copay/prescription (retail) $105 copay/prescription (extended retail) $70 copay/prescription (mail-order) | Not covered | |
| | Non-preferred brand drugs (Tier 3) | $50 copay/prescription (retail) $150 copay/prescription (extended retail) $100 copay/prescription (mail-order) | Not covered | |
| | Specialty drugs (Tier 4) | $20 copay/generic prescription $35 copay/brand prescription $50 copay/non-preferred brand prescription | Not covered | |

| 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 | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | Not covered | Preauthorization is required. Certain services must be pre-certified in order to avoid $750 penalty per occurrence. |
| | Physician/surgeon fees | No charge, deductible does not apply | Not covered | See Plan Document for services related to maternity. |
| **If you need immediate medical attention** | Emergency room care | $150 copay/visit, deductible does not apply | $150 copay/visit, deductible does not apply | The copay is waived if admitted to Hospital directly from Emergency Room. |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | Transportation from the city or town in which the Covered Person becomes disabled, to and from the nearest Hospital qualified to provide treatment for the accidental bodily Injury or disease. |
| | Urgent care | $25 copay/office visit, deductible does not apply | $25 copay/office visit, deductible does not apply | None. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance | Not covered | Preauthorization is required. Services must be pre-certified in order to avoid $750 penalty per occurrence. |
| | Physician/surgeon fees | 30% coinsurance | Not covered | See Plan Document for services related to maternity. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay/office visit, deductible does not apply, and 30% coinsurance for other outpatient services | Not covered | None |
| | Inpatient services | 30% coinsurance | Not covered | Preauthorization is required. Services must be pre-certified in order to avoid $750 penalty per occurrence. |

| 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 | |
| **If you are pregnant** | Office visits | No charge, deductible does not apply | Not covered | Primary or Specialist benefit levels apply for the initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Services must be pre-certified for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid $750 penalty. |
| | Childbirth/delivery professional services | No charge, deductible does not apply | Not covered | |
| | Childbirth/delivery facility services | No charge, deductible does not apply | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance | Not covered | 100 visits per calendar year. Preauthorization is required. Services must be pre-certified in order to avoid $750 penalty per occurrence. |
| | Rehabilitation services | $25 copay/office visit, deductible does not apply | Not covered | Physical and Occupational therapy: limited to a combined maximum of 40 visits of office and outpatient facility services per calendar year. Speech therapy: limited to a combined maximum of 20 visits of office and outpatient facility services per calendar year. |
| | Habilitation services | $25 copay/office visit, deductible does not apply | Not covered | |
| | Skilled nursing care | 30% coinsurance | Not covered | 100 days per calendar year. Preauthorization is required. Services must be pre-certified in order to avoid $750 penalty per occurrence. |
| | Durable medical equipment | 30% coinsurance | Not covered | Must be prescribed by a doctor. Preauthorization is required. Select services must be pre-certified in order to avoid $750 penalty per occurrence. |
| | Hospice services | 30% coinsurance | Not covered | Preauthorization is required. Services must be pre-certified in order to avoid $750 penalty per occurrence. |

| 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 | |
| **If your child needs dental or eye care** | Children's eye exam | No charge, deductible does not apply | Not covered | Applies from birth through age 5. |
| | Children's glasses | Not covered | Not covered | Not covered |
| | Children's dental check-up | Not covered | Not covered | Not covered |

**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
- ☐ Dental Care (Adult)
- ☐ Dental check-ups (Child)
- ☐ Glasses (Child)
- ☐ Long Term Care
- ☐ Non-emergency care when traveling outside the U.S.
- ☐ Private-duty nursing
- ☐ 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.)**

- ☐ Bariatric Surgery (limited to one surgical procedure per Lifetime)
- ☐ Chiropractic Care (limited to 24 visits per calendar year)
- ☐ Hearing Aids (Limited to 2 devices per 36 months, up to a maximum total allowance of $5,000)
- ☐ Infertility treatment (except promotion of conception)
- ☐ Weight Loss Programs (non-surgical obesity treatment is limited to $5,000 per person per Lifetime)

**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: 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: the Plan Administrator at 858-810-3000 or 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.

***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** | **No charge** |
| **Specialist copayment** | **$0** |
| **Hospital (facility) coinsurance** | **No charge** |
| **Other coinsurance** | **No charge** |

**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 | $0 |
| Copayments | $10 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$70** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,500** |
| **Specialist copayment** | **$25** |
| **Hospital (facility) coinsurance** | **30%** |
| **Other coinsurance** | **30%** |

**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 | $800 |
| Copayments | $900 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,720** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,500** |
| **Specialist copayment** | **$25** |
| **Hospital (facility) coinsurance** | **30%** |
| **Other coinsurance** | **30%** |

**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 | $1,200 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,600** |

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