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?	**$0** person / **$0** family In-network **$1,000** person / **$1,000** child(ren) / **$2,000** person + spouse 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?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	Yes. **$75** person / **$150** family benefit deductible per calendar 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?	**$2,500** person / **$5,000** family In-network **$4,000** person / **$4,000** child(ren) / **$8,000** person + spouse 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?	Copayments for certain services, 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	$25 Copay per visit	20% Coinsurance	None
	Specialist visit	$25 Copay per visit	20% Coinsurance	None
	Preventive care/screening/ immunization	No charge	20% Coinsurance to age 20; Not covered from age 20	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)	No charge Office setting; $25 Copay per visit Outpatient setting	20% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge Office setting; $25 Copay per visit Outpatient setting	20% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $200 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 need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.proactrx.com.	Generic drugs (Tier 1)	$15 Copay per prescription (retail); $30 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.	**$4,850** person / **$9,700** family annual Maximum out-of-pocket per calendar year Covers up to a 30-day supply (retail); 31-90 day supply (mail order); Covers up to a 30-day supply (specialty) Once the annual Out-of-pocket is met, you pay nothing for covered prescription medication
	Preferred brand drugs (Tier 2)	$25 Copay per prescription (retail); $50 Copay per prescription (mail order)		
	Non-preferred brand drugs (Tier 3)	$40 Copay per prescription (retail); $80 Copay per prescription (mail order)		
	Specialty brand drugs (Tier 4)	$15 Copay per prescription (generic); $25 Copay per prescription (preferred drugs); $40 Copay per prescription (non-preferred drugs)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$60 Copay per occurrence	20% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $200 of the total cost of the service.
	Physician/surgeon fees	No charge	20% Coinsurance	
If you need immediate medical attention	Emergency room care	$100 Copay per visit	$100 Copay per visit; Deductible Waived	Copay may be waived if admitted
	Emergency medical transportation	50% Coinsurance up to 50 miles; 25% Coinsurance over 50 miles Volunteer services; $35 Copay per trip all other services	50% Coinsurance up to 50 miles; 25% Coinsurance over 50 miles Volunteer services; $35 Copay per trip all other services; Deductible Waived	None
	Urgent care	$25 Copay per visit	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)	$250 Copay per admission	20% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $200 of the total cost of the service.
	Physician/surgeon fee	No charge	20% Coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$25 Copay per Office visit; No charge other outpatient services	20% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $200 of the total cost of the service.
	Inpatient services	$250 Copay per admission	20% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $200 of the total cost of the service.
If you are pregnant	Office visits	No charge	20% Coinsurance	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	20% Coinsurance	
	Childbirth/delivery facility services	$250 Copay per admission	20% 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	$25 Copay per visit	20% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $200 of the total cost of the service.
	Rehabilitation services	$25 Copay per visit	20% Coinsurance	90 Maximum visits per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $200 of the total cost of the service.
	Habilitation services	$250 Copay per admission Inpatient; $25 Copay per visit Outpatient	20% Coinsurance	60 Maximum days per condition per lifetime Inpatient; 90 Maximum visits per condition per lifetime Outpatient; Habilitation services for Learning Disabilities are not covered.
	Skilled nursing care	$250 Copay per visit	20% Coinsurance	30 Maximum days per calendar year; Copay may be waived if admitted from hospital; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $200 of the total cost of the service.
	Durable medical equipment	No charge	20% Coinsurance	Preauthorization is required for DME in excess of $500 for rentals or for purchases. If you don't get preauthorization, benefits could be reduced by $500 per occurrence.
	Hospice service	$250 Copay per confinement Inpatient; $25 Copay per home visit; No charge other services Outpatient	20% Coinsurance	210 Maximum days per lifetime
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	• Long-term care	• Routine eye care (Adult)
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• Routine foot care
• Dental care (Adult)	• Private-duty nursing	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Hearing aids	• Weight loss programs
• Chiropractic care	• Infertility treatment	

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 on how 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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-826-9781.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.