




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.umn.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.umn.com or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$3,300 person / \$6,600 family In-network \$5,000 person / \$10,000 family Out-of-network \$3,300 In-network / \$5,000 Out-of-network Maximum amount that any one person will satisfy toward the annual family deductible	Generally, you must pay all the costs from providers up to the deductible amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible. Medical and pharmacy expenses apply to deductible until the deductible is met.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This plan covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive</u> services without <u>cost-sharing</u> and before you meet your deductible. See a list of covered <u>preventive</u> services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the medical out-of-pocket for this plan?	\$3,300 person / \$6,600 family In-network \$7,500 person / \$15,000 family Out-of-network	Medical deductibles apply to the medical out-of-pocket for this plan. This includes the medical deductible amount.
What is the pharmacy out-of-pocket for this plan?	\$3,150 person / \$6,300 family In-network \$7,500 person / \$15,000 family Out-of-network	Pharmacy co-pays apply to the pharmacy out-of-pocket for this plan after the medical deductible has been met.
What is the Maximum out-of-pocket limit for this <u>plan</u> ?	\$6,450 person / \$12,900 family In-network \$12,500 person / \$25,000 family Out-of-network	The maximum out-of-pocket limit is the most you could pay in a year in deductibles, coinsurance and co-pays for covered services.
What is not included in the out-of-pocket limit?	Penalties, <u>premiums</u> , <u>balance billing</u> charges, and health care this plan doesn't cover.	If you have other family members in this <u>plan</u> , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.

<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.umr.com or call 1-800-826-9781 for a list of <u>network providers</u>.</p>	<p>This plan uses a provider network. You will pay less if you use a provider in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, 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.</p>	
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a referral.</p>	
<p> All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.</p>			

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)	
	Primary care visit to treat an injury or illness	No charge	30% Coinsurance	None
If you visit a health care provider's office or clinic	Specialist visit	No charge	30% Coinsurance	None
	Preventive care/screening/immunization	No charge; Deductible Waived	30% Coinsurance	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.

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 test	Diagnostic test (X-ray, blood work)	No charge	30% Coinsurance	None
		Imaging (CT/PET scans, MRIs)	No charge	30% Coinsurance
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.umn.com .	Tier 1 (generic and some brand-name)	\$10 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.	Deductible and 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) Once the annual out-of-pocket limit is met, you pay nothing for covered prescription medication
		\$30 Copay per prescription		
		\$50 Copay per prescription		
		Tier 3 (nonpreferred brand-name and nonpreferred generic)		
Tier 2 (preferred brand-name and some generic)	\$10 Copay per prescription (Tier 1);	30% Coinsurance	None	
	\$30 Copay per prescription (Tier 2);			
	\$50 Copay per prescription (Tier 3)			
Tier 4 (specialty drugs)				
Facility fee (e.g., ambulatory surgery center)	No charge	30% 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 outpatient surgery	Physician/surgeon fees	No charge	30% Coinsurance	None
	<u>Emergency room care</u>	No charge	No charge	In-network deductible applies to Out-of-network benefits
	<u>Emergency medical transportation</u>	No charge	No charge	In-network deductible applies to Out-of-network benefits
If you need immediate medical attention	<u>Urgent care</u>	No charge	No charge	In-network deductible applies to Out-of-network benefits
	Facility fee (e.g., hospital room)	No charge	30% Coinsurance	Preauthorization is required.
	Physician/surgeon fees	No charge	30% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	No charge	30% Coinsurance	None
	Inpatient services	No charge	30% Coinsurance	<u>Preauthorization is required.</u>

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; Deductible Waived	30% Coinsurance	Cost sharing does not apply for <u>preventive services</u> . 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	30% Coinsurance	
	Childbirth/delivery facility services	No charge	30% Coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	30% Coinsurance	30 Maximum visits per calendar year Out-of-network; Preauthorization is required.
	Rehabilitation services	No charge	30% Coinsurance	60 Maximum visits per calendar year OT; 60 Maximum visits per calendar year PT; 20 Maximum visits per calendar year ST; Habilitation services for Learning Disabilities are not covered.
	Habilitation services	No charge	30% Coinsurance	
	Skilled nursing care	No charge	30% Coinsurance	Preauthorization is required.

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)	
	Durable medical equipment	No charge	30% Coinsurance	Preauthorization is required for DME in excess of \$500 for rentals or \$1,500 for purchases.
	Hospice service	No charge	30% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge; Deductible Waived	30% Coinsurance	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
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Chiropractic care
- Private-duty nursing (Outpatient care)
- 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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or

www.ccilio.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://ccilio.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.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-826-9781.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijijgo holne' 1-800-826-9781.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf die do Nummer uff 1-800-826-9781.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-826-9781.

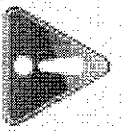
Samoa (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-826-9781.

Carolinian (Kapasal Falawasch): ngere aukke ghut allilis reel kapasal Falawasch au fataingi tilifon ye 1-800-826-9781.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, á'gang 1-800-826-9781.

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 \$3,300
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- 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	\$3,300
Copayments	\$40
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$3,340

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$3,300
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- 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*	\$3,300
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,820

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$3,300
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- 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*	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$2,810

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.umt.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.