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, for medical contact UMR at 1-866-268-3489 or www.umr.com or for prescription drugs contact CVS Caremark at 1-800-925-5795 or www.caremark.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,500**/individual/**$3,000**/family in-network **$3,000**/individual/**$6,000**/family out-of-network	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes, preventive care	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?	No	
What is the out-of-pocket limit for this plan?	**$4,000**/individual/**$8,000**/family in-network **$8,000**/individual/**$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?	Premiums, balance-billed 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.anthem.com or call 1-866-452-1275 for a list of network providers and see www.caremark.com or call 1-800-925-5795 for pharmacy 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 bill). 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 (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	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No cost	40% coinsurance	Not subject to deductible. 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)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or call 1-800-925-5795	Generic drugs	$15/retail script/$30/ mail script	50%/retail script/mail not covered	Deductible not applied if preventive care drug. Retail up to 30-day supply, mail up to 90-day supply.
	Formulary brand drugs	$40/retail script/$80/mail script	50%/retail script/mail not covered	Deductible not applied if preventive care drug. Retail up to 30-day supply, mail up to 90-day supply.
	Non-Formulary brand drugs	$60/retail script/$120/mail script	50%/retail script/mail not covered	Deductible not applied if preventive care drug. Retail up to 30-day supply, mail up to 90-day supply.
	Specialty drugs	$200/mail script	Not covered	Deductible not applied if preventive care drug. Mail only, 30-90 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Non-emergency use of emergency room is not covered.
	Emergency medical transportation	20% coinsurance	40% coinsurance	None
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Failure to obtain pre-certification may result in non-coverage or reduced benefits.

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Failure to obtain pre-certification may result in non-coverage or reduced benefits.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Pre-certification required if stay exceeds 48 hours for normal delivery or 96 hours for cesarean delivery.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	120 visit maximum. Pre-certification required.
	Rehabilitation services	20% coinsurance	40% coinsurance	60 visit maximum for physical and occupation therapy. 20 visit maximum for speech therapy.
	Habilitation services	20% coinsurance	40% coinsurance	Habilitation visits count towards rehabilitation limit.
	Skilled nursing care	20% coinsurance	40% coinsurance	120 day maximum. Pre-certification required.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	None. Pre-certification required.
If your child needs dental or eye care	Children's eye exam	20% coinsurance	40% coinsurance	Medical eye care exam. 100% if preventive.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Covered under dental plan.

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 – separate dental plan
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care – separate vision plan 1/1/2020
- 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
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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

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 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: UMR for medical at 1-866-268-3489 or CVS Caremark for prescription drugs at 1-800-925-5795 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
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 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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-877-339-5751.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-339-5751.
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-339-5751.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-339-5751.

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**	**$3,000**
■ **Specialist *[coinsurance]***	**20%**
■ **Hospital (facility) *[coinsurance]***	**20%**
■ **Other *[copayment]***	**$15**

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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$15
Coinsurance	$985
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

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 *[coinsurance]***	**20%**
■ **Hospital (facility) *[coinsurance]***	**20%**
■ **Other *[copayment]***	**$15/$40**

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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$220
Coinsurance	$296
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,016**

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

■ **The plan's overall deductible**	**$1,500**
■ **Specialist *[coinsurance]***	**20%**
■ **Hospital (facility) *[coinsurance]***	**20%**
■ **Other *[coinsurance]***	**20%**

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$85
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,585**

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