
 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, call 1-800-291-1425 or go to www.umwafunds.org. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-800-291-1425 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$ 0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes	This Plan does not have a deductible . But a copayment may apply.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$ 100 / family copay maximum \$ 50 / family for prescription drugs	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 , the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit ?	The extra cost of using brand name or non-preferred drugs, balance-billing charges, and health care this plan doesn't cover. (This plan has no premiums .)	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.umwafunds.org or call 1-800-291-1425 for a list of participating Durable Medical Equipment providers .	This plan uses a network for Durable Medical Equipment. Most equipment must be purchased through a DME network provider .
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
		Participating Provider (You will pay the least)	Non-Participating 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	\$5 copay / visit	Not applicable	Copayment applies to visits, allergy shots, physical therapy, dialysis, chemotherapy.
	Specialist visit	\$5 copay / visit	Not applicable	Copayment applies to visits, allergy shots, physical therapy, dialysis, chemotherapy.
	Preventive care/screening/immunization	No charge	Not applicable	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)	\$5 copay / visit	Not applicable	None
	Imaging (CT/PET scans, MRIs)	\$5 copay / visit	Not applicable	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.umwafunds.org .	Generic drugs or Preferred brand drugs	\$5 copay per 30-day supply \$0 copay for mail order	Not applicable	None
	Brand drugs where generic is available	\$5 copay per 30-day supply \$0 copay per 90-day supply for mail order. Plus the difference in cost between the generic and brand product.	Not applicable	If the prescribing physician obtains a medical necessity authorization there will be no additional payment for the use of the brand drug.
	Non-preferred brand drugs	\$5 copay per 30-day supply \$0 copay per 90-day supply for mail order. Plus a surcharge for non-preferred drugs:	Not applicable	If the prescribing physician obtains a medical necessity authorization there will be no additional payment for the use of the Non-Preferred drug.

[* For more information about limitations and exceptions, see the [plan](#) or policy document at www.umwafunds.org.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
		Initial prescription – no surcharge First refill - \$10 surcharge Second and subsequent refills - \$20 surcharge		
	Preferred Specialty drugs	\$0 per 30-day supply at CVS-caremark Specialty Pharmacy	Not applicable	<p>Pre-authorization is required for all specialty drugs.</p> <p>All drugs on the specialty drug list must be obtained from a CVS-caremark Specialty Pharmacy.</p> <p>If a Non-Preferred Specialty drug within the classes on the Specialty Drug List is selected, the prescriber will be asked to consider a Preferred drug to be used before the Non-Preferred drug will be covered.</p>
	Non-Preferred Specialty drugs	\$0 per 30-day supply at CVS-caremark Specialty Pharmacy		
	Specialty drugs not on the Specialty Drug list	<p>\$0 per 30-day supply at CVS-caremark Specialty Pharmacy</p> <p>\$5 per 30-day supply at any other Specialty pharmacy</p>		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$5 copay / visit	Not applicable	None
	Physician/surgeon fees	No charge	Not applicable	None
If you need immediate medical attention	Emergency room care	\$5 copay per visit	Not applicable	None
	Emergency medical transportation	No charge	Not applicable	None
	Urgent care	\$5 copay per visit	Not applicable	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not applicable	Private rooms are not covered unless patient's condition requires isolation or no semi-private room is available.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Physician/surgeon fees	\$5 copay per visit	Not applicable	Copay only applies to physician's charge for hospital visits.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$5 copay per visit	Not applicable	Alcoholism and drug rehabilitation programs must be provided by an accredited facility.
	Inpatient services	No charge	Not applicable	Inpatient services must be provided by an accredited facility.
If you are pregnant	Office visits	\$5 copay per visit	Not applicable	Cost sharing does not apply for preventive services . Depending on the type of services, a copayment may apply. Copayment does not apply when childbirth/delivery is billed as a bundled service. Maternity care may include tests and services described elsewhere in the SBC (i.e. Ultrasound.)
	Childbirth/delivery professional services	No charge	Not applicable	Copayment does not apply when childbirth/delivery is billed as a bundled service.
	Childbirth/delivery facility services	No charge	Not applicable	None
If you need help recovering or have other special health needs	Home health care	No charge	Not applicable	Must be medically justified with skilled care.
	Rehabilitation services	No charge	Not applicable	Must be medically justified with skilled care.
	Habilitation services	No charge	Not applicable	Must be medically justified with skilled care.
	Skilled nursing care	No charge	Not applicable	Must be medically justified with skilled care.
	Durable medical equipment	No charge	Not covered	Most equipment must be purchased through a DME network provider. Some equipment must be prior approved.
	Hospice services	Not covered	Not covered	None
If you need dental or eye care	Eye exam	\$20	Not Applicable	Covered once every 24 months.

[* For more information about limitations and exceptions, see the [plan](#) or policy document at www.umwafunds.org.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Glasses	\$10 per lens single vision \$15 per lens bifocal \$20 per lens trifocal \$25 per lens lenticular \$15 per contact lens \$14 frames	Not Applicable	Maximum of 2 lenses and 1 frame covered once every 24 months. New lenses will be covered if the new prescription differs from the most recent one by an axis change of 20 degrees or .50 diopter sphere or cylinder change and visual acuity is improved by at least one line on the standard chart.
	Dental check-up	Not covered	Not covered	None

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](#).)

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|--|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Chiropractic care • Cosmetic surgery | <ul style="list-style-type: none"> • Dental care • Long-term care • Private-duty nursing unless necessary to preserve life and ICU is unavailable | <ul style="list-style-type: none"> • Routine foot care • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|---|--|--|
| <ul style="list-style-type: none"> • Bariatric surgery • Hearing aids | <ul style="list-style-type: none"> • Infertility treatment (artificial insemination only) • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Routine eye care |
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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: the 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: The UMWA Funds at 1-800-291-1425 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 1-800-291-1425 (TTY: 711)

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-291-1425 (TTY: 711)

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-291-1425 (TTY: 711)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-291-1425 (TTY: 711)

_____ *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](#) \$0
- [Specialist copayment](#) \$5
- Hospital (facility) [cost sharing](#) 0%
- Other [copayment](#) \$5

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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$60
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$120

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$5
- Hospital (facility) [cost sharing](#) 0%
- Other [copayment](#) \$5

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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$100

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$5
- Hospital (facility) [cost sharing](#) 0%
- Other [copayment](#) \$5

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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$30
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$30