




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:
<p>What is the overall deductible?</p>	<p>\$325 deductible / family for physician and non-hospital and related services</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Preventive care by a Participating Provider List (PPL) provider and routine vision care services are covered before you meet your deductible.</p>	<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>Yes. \$325 deductible / family for hospital and related services, \$300 deductible for any service obtained without required precertification, and \$50 deductible / individual for dental services (does not apply to preventive services). There are no other specific deductibles.</p>	<p>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.</p> <p>The \$300 deductible for services without required precertification is not applied to the out-of-pocket limit.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>\$1,000 / family for physician visits and hospital and related charges \$1,000 / family for prescription drugs</p>	<p>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.</p>

What is not included in the out-of-pocket limit ?	\$300 deductible for any service obtained without required precertification , the extra cost of using brand name or non-preferred drugs, balance-billing charges, premiums for dental benefits, 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 participating provider ?	Yes. See www.umwafunds.org or call 1-800-291-1425 for a list of participating providers .	This plan uses a Participating Provider List (PPL) 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
		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	\$25 copay / visit	\$35 copay / visit	None
	Specialist visit	\$25 copay / visit	\$35 copay / visit	None
	Preventive care/screening/immunization	No charge	\$35 copay / visit	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	No charge	None
	Imaging (CT/PET scans, MRIs)	No charge	No charge	None

[* 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)	
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.umwafunds.org.</p>	Generic drugs and Preferred brand drugs	\$20 copay per 30-day supply \$30 copay per 90-day supply for mail order	\$35 copay per 30-day supply	Maintenance Choice Program – if a 90-day supply is obtained at a CVS Retail pharmacy \$30 copay per 90 day supply.
	Brand drugs where generic is available	\$20 copay per 30-day supply \$30 copay per 90-day supply for mail order Plus the difference in cost between the generic and brand product	\$35 copay per 30-day supply, plus the difference in cost between the generic and brand product	If the prescribing physician obtains a medical necessity authorization there will be no additional payment for the use of the brand drug.
	Non-Preferred drugs	\$20 copay per 30-day supply \$30 copay per 90-day supply for mail order Plus a surcharge for Non-Preferred drugs: Initial prescription – no surcharge First refill - \$10 surcharge Second and subsequent refills - \$20 surcharge	\$35 copay per 30-day supply Plus a surcharge for Non-Preferred drugs: Initial prescription – no surcharge First refill - \$10 surcharge Second and subsequent refills - \$20 surcharge	If the prescribing physician obtains a medical necessity authorization, there will be no additional payment for the use of the Non-Preferred drug.
	Preferred Specialty drugs	\$10 copay per 30-day supply at a CVS Specialty Pharmacy	If Specialty drugs are obtained at a non-network Specialty Pharmacy, a \$35 per 30-day supply copay applies.	Pre-authorization is required for Specialty drugs . All drugs on the Specialty Drug List must be obtained from a CVS Specialty Pharmacy.

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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)	
	Non-Preferred Specialty drugs Specialty drugs not on the Specialty Drug List	\$10 per 30-day supply at a CVS Specialty Pharmacy \$10 per 30-day supply at a CVS Specialty Pharmacy \$20 per 30-day supply at any other Specialty Pharmacy		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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Precertification is required for all non-Preferred Provider List outpatient hospital surgeries.
	Physician/surgeon fees	No charge	No charge	None
If you need immediate medical attention	Emergency room care	\$35 copay for facility charge	\$35 copay for facility charge.	You may also have to pay a copay for the physician's professional charge.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	\$25 copay for per visit	\$35 copay per visit	Copay only applies to physician's charge for the visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$25 copay per hospitalization	The plan pays 90% of Participating Provider rate. The Beneficiary is responsible for the \$35 copay and remaining balance of charges up to the \$1,000 annual out-of-pocket maximum . Hold Harmless provisions may not apply.	Private rooms are not covered unless patient's condition requires isolation or no semi-private room is available. Precertification is required for all non-Preferred Provider List (PPL) hospital stays. Plan payment for non-PPL hospital and related benefits is limited to 90% of the amount that would have been paid to a PPL hospital.
	Physician/surgeon fees	\$25 copay per visit	\$35 copay per visit	None

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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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay per visit	\$35 copay per visit	Alcoholism and drug rehabilitation programs must be provided by an accredited facility.
	Inpatient services	\$25 copay per hospitalization	The plan pays 90% of Participating Provider rate. The Beneficiary is responsible for the \$35 copay and remaining balance of charges up to the \$1,000 annual out-of-pocket maximum . Hold Harmless provisions may not apply.	Inpatient services must be provided by an accredited facility. Plan payment for non-PPL hospital and related benefits is limited to 90% of the amount that would have been paid to a PPL hospital.
If you are pregnant	Office visits	\$25 copay per visit	\$35 copay per visit	Cost sharing does not apply for preventive services . Depending on the type of services, a deductible or 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	No charge	None
	Childbirth/delivery facility services	\$25 copay per hospitalization	The plan pays 90% of Participating Provider rate. The Beneficiary is responsible for the \$35 copay and remaining balance of charges up to the \$1,000 annual out-of-pocket maximum . Hold Harmless provisions may not apply.	Plan payment for non-PPL hospital and related benefits is limited to 90% of the amount that would have been paid to a PPL hospital.
If you need help recovering or have	Home health care	No charge	No charge	Must be medically justified with skilled care. Limited to 60 days per year.

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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)	
other special health needs	Rehabilitation services	No charge	No charge	Must be medically justified with skilled care.
	Habilitation services	No charge	No charge	Must be medically justified with skilled care.
	Skilled nursing care	No charge	No charge	Must be medically justified with skilled care. Limited to 100 days per benefit period.
	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	\$ 46.77	Not Applicable	Covered once every 24 months.
	Glasses	\$23.39 per lens single vision \$35.09 per lens bifocal \$46.77 per lens trifocal \$58.47 per lens lenticular \$35.09 per contact lens \$33.13 frames	Not Applicable	Covered once every 24 months. Lenses will not be covered unless the new prescription differs from the most recent one by an axis change of 20 degrees or .50 diopter sphere or cylinder change and the lens must improve visual acuity by at least one line on the standard chart.
	Dental care	\$50 deductible /individual \$0 deductible /individual for preventive services	Not Applicable	Covered benefits are limited to the Schedule of Benefits in the plan document. Patient is responsible for amounts in excess of amount paid by plan. There is a \$2 per family per month premium . Annual maximum dental benefit is \$1,754.50 / individual (not applicable to children 18 and under). Annual maximum orthodontic benefit is \$974.37 / individual. Lifetime maximum orthodontic benefit is \$2,923.09 / individual. Orthodontic benefits apply to dependents under age 26 only. The dental benefit year is October 1 through September 30. Preauthorization is required for orthodontia or if a course of treatment is expected to involve dentist's charges of \$150 or more.

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

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
- Chiropractic care
- Cosmetic surgery
- Long-term care
- Private-duty nursing unless necessary to preserve life and ICU is unavailable
- 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
- Dental care
- Hearing aids
- Infertility treatment (artificial insemination only)
- Non-emergency care when traveling outside the U.S.
- Routine eye care

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 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, kwijigo 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	\$325
■ Specialist copayment	\$25
■ Hospital (facility) copayment	\$25
■ Other copayment	\$20

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 *	\$325
Copayments	\$100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$485

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$325
■ Specialist copayment	\$25
■ Hospital (facility) copayment	\$25
■ Other copayment	\$20

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	\$325
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$925

Mia's Simple Fracture

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

■ The plan's overall deductible	\$325
■ Specialist copayment	\$25
■ Hospital (facility) copayment	\$25
■ Other copayment	\$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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles *	\$325
Copayments	\$80
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$405

*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.