



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](http://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:
<b>What is the overall deductible?</b>	\$325 <a href="#">deductible</a> / family for physician and non-hospital and related services	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> by a Participating <a href="#">Provider</a> List (PPL) provider and routine vision care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$325 <a href="#">deductible</a> / family for hospital and related services. \$300 <a href="#">deductible</a> for any service obtained without required <a href="#">precertification</a> . There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.  The \$300 <a href="#">deductible</a> for services without required <a href="#">precertification</a> is not applied to the <a href="#">out-of-pocket limit</a> .
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$1,000 / family for physician visits and hospital and related charges \$1,000 / family for <a href="#">prescription drugs</a>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	\$300 <a href="#">deductible</a> for any service obtained without required <a href="#">precertification</a> , the extra cost of using brand name or non-preferred drugs, <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover. (This <a href="#">plan</a> has no <a href="#">premiums</a> .)	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Will you pay less if you use a participating provider?	Yes. See <a href="http://www.umwafunds.org">www.umwafunds.org</a> or call 1-800-291-1425 for a list of participating providers.	This <a href="#">plan</a> uses a Participating Provider List (PPL) <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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 <a href="#">provider's</a> office or clinic	<a href="#">Primary care</a> visit to treat an injury or illness	\$25 <a href="#">copay</a> / visit	\$35 <a href="#">copay</a> / visit	None
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a> / visit	\$35 <a href="#">copay</a> / visit	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	\$35 <a href="#">copay</a> / visit	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	No charge	None
	Imaging (CT/PET scans, MRIs)	No charge	No charge	None

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</p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.umwafunds.org">www.umwafunds.org</a>.</p>	Generic drugs and Preferred brand drugs	\$20 <a href="#">copay</a> per 30-day supply \$30 <a href="#">copay</a> per 90-day supply for mail order	\$35 <a href="#">copay</a> per 30-day supply	Maintenance Choice Program – if a 90-day supply is obtained at a CVS Retail pharmacy \$30 <a href="#">copay</a> per 90 day supply.
	Brand drugs where generic is available	\$20 <a href="#">copay</a> per 30-day supply \$30 <a href="#">copay</a> per 90-day supply for mail order  Plus the difference in cost between the generic and brand product.	\$35 <a href="#">copay</a> per 30-day supply  Plus the difference in cost between the generic and brand product.	If the prescribing physician obtains a <a href="#">medical necessity</a> authorization there will be no additional payment for the use of the brand drug.
	Non-Preferred drugs	\$20 <a href="#">copay</a> per 30-day supply \$30 <a href="#">copay</a> 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 <a href="#">copay</a> 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 <a href="#">medical necessity</a> authorization there will be no additional payment for the use of the Non-Preferred drug.
	Preferred <a href="#">Specialty drugs</a>	\$10 <a href="#">copay</a> per 30-day supply at a CVS Specialty Pharmacy	If <a href="#">Specialty drugs</a> are obtained at a non-network Specialty Pharmacy, a \$35 per 30-day supply copay applies.	<a href="#">Pre-authorization</a> is required for <a href="#">Specialty drugs</a> . All drugs on the <a href="#">Specialty Drug</a> List must be obtained from a CVS Specialty Pharmacy.

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.umwafunds.org](http://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)	
	Non-Preferred <a href="#">Specialty drugs</a>  <a href="#">Specialty drugs</a> not on the <a href="#">Specialty Drug List</a>	\$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 <a href="#">Specialty drug</a> within the classes on the <a href="#">Specialty Drug List</a> 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)  Physician/surgeon fees	No charge  No charge	No charge  No charge	<a href="#">Precertification</a> is required for all non-PPL outpatient hospital surgeries.  None
If you need immediate medical attention	<a href="#">Emergency room care</a>  <a href="#">Emergency medical transportation</a>  <a href="#">Urgent care</a>	\$35 <a href="#">copay</a> for facility charge  No charge  \$25 <a href="#">copay</a> for per visit	\$35 <a href="#">copay</a> for facility charge.  No charge  \$35 <a href="#">copay</a> per visit	You may also have to pay a <a href="#">copay</a> for the physician's professional charge.  None  <a href="#">Copay</a> only applies to physician's charge for the visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$25 <a href="#">copay</a> per hospitalization	The <a href="#">plan</a> pays 90% of Participating <a href="#">Provider</a> rate. The Beneficiary is responsible for the \$35 <a href="#">copay</a> and remaining balance of charges up to the \$1,000 annual <a href="#">out-of-pocket maximum</a> . Hold Harmless provisions may not apply.	Private rooms are not covered, unless patient's condition requires isolation or no semi-private room is available  <a href="#">Precertification</a> is required for all non-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.

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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	\$25 <a href="#">copay</a> per visit	\$35 <a href="#">copay</a> per visit	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 <a href="#">copay</a> per visit	\$35 <a href="#">copay</a> per visit	Alcoholism and drug rehabilitation programs must be provided by an accredited facility.
	Inpatient services	\$25 <a href="#">copay</a> per hospitalization	The <a href="#">plan</a> pays 90% of Participating <a href="#">Provider</a> rate. The Beneficiary is responsible for the \$35 <a href="#">copay</a> and remaining balance of charges up to the \$1,000 annual <a href="#">out-of-pocket maximum</a> . 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.
<b>If you are pregnant</b>	Office visits	\$25 <a href="#">copay</a> per visit	\$35 <a href="#">copay</a> per visit	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .  Depending on the type of services, a <a href="#">deductible</a> or <a href="#">copayment</a> may apply. <a href="#">Copayment</a> 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 <a href="#">copay</a> per hospitalization	The <a href="#">plan</a> pays 90% of Participating <a href="#">Provider</a> rate. The Beneficiary is responsible for \$35 <a href="#">copay</a> and remaining balance of charges up to the \$1,000 annual <a href="#">out-of-pocket maximum</a> . 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.

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.umwafunds.org](http://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)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	No charge	Must be medically justified with skilled care. Limited to 60 days per year.
	<a href="#">Rehabilitation services</a>	No charge	No charge	Must be medically justified with skilled care.
	<a href="#">Habilitation services</a>	No charge	No charge	Must be medically justified with skilled care.
	<a href="#">Skilled nursing care</a>	No charge	No charge	Must be medically justified with skilled care. Limited to 100 days per benefit period.
	<a href="#">Durable medical equipment</a>	No charge	Not covered	Most equipment must be purchased through a DME network provider. Some equipment must be prior approved.
	<a href="#">Hospice services</a>	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 check-up	Not covered	Not Applicable	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](#).)

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Dental care
- 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
- 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](http://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](http://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](http://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)

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*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$325
<a href="#">Specialist copayment</a>	\$25
Hospital (facility) <a href="#">copayment</a>	\$25
Other <a href="#">copayment</a>	\$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:

Cost Sharing	
Deductibles *	\$325
Copayments	\$100
Coinsurance	\$0
What isn't covered	
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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$325
<a href="#">Specialist copayment</a>	\$25
Hospital (facility) <a href="#">copayment</a>	\$25
Other <a href="#">copayment</a>	\$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:

Cost Sharing	
Deductibles	\$325
Copayments	\$600
Coinsurance	\$0
What isn't covered	
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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$325
<a href="#">Specialist copayment</a>	\$25
Hospital (facility) <a href="#">copayment</a>	\$25
Other <a href="#">copayment</a>	\$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:

Cost Sharing	
Deductibles *	\$325
Copayments	\$80
Coinsurance	\$0
What isn't covered	
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.