




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? | Yes. \$300 deductible for any non-emergency hospital admission to a non-Preferred Provider List (PPL) hospital or other non-PPL service obtained without required precertification , and \$50 deductible / individual for dental services (does not apply to preventive services). There are no other specific deductibles . | 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. The \$300 deductible for services without required precertification is not applied to the out-of-pocket limit . |
| What is the out-of-pocket limit for this plan ? | \$240 / family for in-PPL physician visits and \$1,600 / family in combined non-PPL hospital and physician office visits per year. No out-of-pocket limit 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 ? | \$300 deductible for any non-emergency hospital admission to a non-PPL hospital or other | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |

| Important Questions | Answers | Why This Matters: |
|--|---|--|
| | specified service obtained from a non-PPL provider 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. | |
| 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 | \$12 copay / visit | \$20 copay / visit | None |
| | Specialist visit | \$12 copay / visit | \$20 copay / visit | None |
| | Preventive care/screening/immunization | No charge | \$20 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 |

| 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 | \$5 copay per 30-day supply \$0 copay per 90-day supply for mail order | \$10 copay per 30-day supply | Maintenance Choice Program – if a 90-day supply is obtained at a CVS Retail pharmacy \$0 copay per 90 day supply. |
| | 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. | \$10 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 | \$5 copay per 30-day supply.* \$0 copay per 90-day supply for mail order.* *Plus a surcharge for Non-Preferred drugs: Initial prescription – no surcharge First refill - \$7.50 surcharge Second and subsequent refills - \$15 surcharge | \$10 copay per 30-day supply.* *Plus a surcharge for Non-Preferred drugs: Initial prescription – no surcharge First refill - \$7.50 surcharge Second and subsequent refills - \$15 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 Non-Preferred Specialty drugs | \$0 copay per 30-day supply at a CVS Specialty Pharmacy \$0 per 30-day supply at a CVS Specialty Pharmacy | If Specialty drugs are obtained at a non-network Specialty pharmacy, a \$10 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. |

[* 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) | |
| | Specialty drugs not on the Specialty Drug List | \$0 per 30-day supply at a CVS Specialty Pharmacy \$10 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 | \$0 | \$0 | You may have to pay a copay for the physician's professional charge. |
| | Emergency medical transportation | No charge | No charge | None |
| | Urgent care | \$12 copay per visit | \$20 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) | No charge | The plan pays 90% of Participating Provider rate. The Beneficiary is responsible for the remaining balance of charges up to the \$1,600 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-emergency 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 | \$12 copay per visit | \$20 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 | \$12 copay per visit | \$20 copay per visit | Alcoholism and drug rehabilitation programs must be provided by an accredited facility. |
| | Inpatient services | No charge | The plan pays 90% of Participating Provider rate. The Beneficiary is responsible for the remaining balance of charges up to the \$1,600 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 | \$12 copay per visit | \$20 copay per visit | 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 | No charge | None |
| | Childbirth/delivery facility services | No charge | The plan pays 90% of Participating Provider rate. The Beneficiary is responsible for the remaining balance of charges up to the \$1,600 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 other special health needs | Home health care | No charge | No charge | Must be medically justified with skilled care. Limited to 60 days per year. |
| | 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. |

[* 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) | |
| | 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 age 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**

[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 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.* —————

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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 plan's overall deductible | \$0 |
| ■ Specialist copayment | \$12 |
| ■ Hospital (facility) copayment | \$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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|-------------|
| Deductibles | \$0 |
| Copayments | \$10 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$70 |

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 | \$12 |
| ■ Hospital (facility) copayment | \$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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$200 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$220 |

Mia's Simple Fracture

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

| | |
|---|------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$12 |
| ■ Hospital (facility) copayment | \$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 | \$2,800 |
|---------------------------|----------------|

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 |