
 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:
What is the overall <a href="#">deductible</a> ?	\$ 0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Not Applicable	This <a href="#">Plan</a> does not have a <a href="#">deductible</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$ 500 / family for physician visits \$ 1,000 / family for <a href="#">prescription drugs</a> \$ 750 / family PPL and Non-PPL* hospital \$ 2,250 / family in combined Non-PPL* <a href="#">copayments</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.  Family includes individuals without other family members on the plan.
What is not included in the <a href="#">out-of-pocket limit</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 <a href="#">preferred provider</a> ?	Yes. See <a href="http://www.umwafunds.org">www.umwafunds.org</a> or call 1-800-291-1425 for the Participating <a href="#">Provider</a> List (PPL).	This <a href="#">plan</a> uses a PPL. You will pay less if you use a <a href="#">provider</a> on the PPL. You will pay the most if you use a non-PPL <a href="#">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="#">PPL provider</a> might use a <a href="#">non-PPL 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
		PPL Provider (You will pay the least)	Non-PPL Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	<a href="#">Primary care</a> visit to treat an injury or illness	\$30 <a href="#">copay</a> / visit	\$40 <a href="#">copay</a> / visit	None
	<a href="#">Specialist</a> visit	\$30 <a href="#">copay</a> / visit	\$40 <a href="#">copay</a> / visit	None
	<a href="#">Preventive care/screening/immunization</a>	\$30 <a href="#">copay</a> / visit	\$40 <a href="#">copay</a> / visit	Preventive care and preventive services specified in the Affordable Care Act are covered in addition to routine physical exams for ages under 6 and over 54; annually or semi-annually by a gynecologist; or by a specialist as part of the specialist's care of a medical condition. <a href="#">Copayments</a> apply.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	No charge	None
	Imaging (CT/PET scans, MRIs)	No charge	No charge	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.umwafunds.org">www.umwafunds.org</a> .	Generic drugs or Preferred brand drugs	\$25 <a href="#">copay</a> for up to a 30-day supply* \$10 reduced <a href="#">copay</a> for up to a 90-day supply for mail order* and where required by law. *Plus any difference in cost if a brand name drug or a preferred drug is prescribed when a generic or preferred drug is available	\$40 <a href="#">copay</a> for up to a 30-day supply*  Applicable law might provide PPL Provider treatment in certain locations.	Maximum non-mail order supply is 90 days. 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 will only be covered if the prescribing physician obtains a medical necessity authorization.
	Preferred <a href="#">Specialty drugs</a>	\$10 for up to a 30-day supply at CVS Specialty Pharmacy and where required by law	Unless applicable law provides otherwise, if <a href="#">Specialty drugs</a> that are not on the Specialty Drug List are obtained at a non-PPL Provider Specialty Pharmacy, a \$40 for up to a 30-day supply copay applies.	<a href="#">Pre-authorization</a> is required for all <a href="#">Specialty drugs</a> . All drugs on the <a href="#">Specialty Drug List</a> must be obtained from a CVS Specialty Pharmacy unless applicable law provides otherwise. 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.
	<a href="#">Specialty drugs</a> not on the <a href="#">Specialty Drug List</a>	\$10 for up to a 30-day supply at CVS Specialty Pharmacy and where required by law. \$25 per 30-day supply at any PPL Provider, non-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
		PPL Provider (You will pay the least)	Non-PPL Provider (You will pay the most)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Accredited facility requirements apply.
	Physician/surgeon fees	No charge	No charge	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$30 <a href="#">copay</a> per visit	\$30 <a href="#">copay</a> per visit	<a href="#">Copay</a> only applies to physician's charge for the emergency room visit.  There is an annual maximum of \$1,250 per family for emergency room <a href="#">copayments</a> .
	<a href="#">Emergency medical transportation</a>	No charge	No charge	None
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> per visit	\$30 <a href="#">copay</a> per visit	<a href="#">Copay</a> only applies to physician's charge for the visit.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$750 <a href="#">copayment</a> per <a href="#">hospitalization</a> up to the annual <a href="#">out-of-pocket maximum</a>	The Beneficiary is responsible for the \$750 <a href="#">copay</a> and then balance of charges (up to a maximum of \$750) after the plan pays 90% of the PPL rate.  There are no such charges for hospitalizations resulting from a medical emergency, but the \$750 copayment still applies.	Accredited facility requirements apply.  Private rooms are not covered unless patient's condition requires isolation or no semi-private room is available.
	Physician/surgeon fees	\$30 <a href="#">copay</a> per visit	\$40 <a href="#">copay</a> per visit \$30 <a href="#">copay</a> per visit during emergency hospitalizations	<a href="#">Copay</a> only applies to physician's charge for hospital visits.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPL Provider (You will pay the least)	Non-PPL Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services (office visits)	\$30 <a href="#">copay</a> per visit	\$40 <a href="#">copay</a> per visit	Accredited facility requirements apply.
	Inpatient services	\$750 <a href="#">copayment</a> per <a href="#">hospitalization</a> up to the annual <a href="#">out-of-pocket maximum</a>	The Beneficiary is responsible for the \$750 <a href="#">copay</a> and then balance of charges (up to a maximum of \$750) after the plan pays 90% of the PPL rate.  There are no such charges for hospitalizations resulting from a medical emergency, but the \$750 copayment still applies.	Accredited facility requirements apply.  Private rooms are not covered unless patient's condition requires isolation or no semi-private room is available.
<b>If you are pregnant</b>	Office visits	\$30 <a href="#">copay</a> per visit	\$40 <a href="#">copay</a> per visit	Depending on the type of services, a <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	<a href="#">Copayment</a> does not apply when childbirth/delivery is billed as a bundled service.
	Childbirth/delivery facility services	\$750 copayment per <a href="#">hospitalization</a> , up to the annual <a href="#">out-of-pocket maximum</a>	The Beneficiary is responsible for the \$750 <a href="#">copay</a> and then balance of charges (up to a maximum of \$750) after the plan pays 90% of the PPL rate.	None

[\* 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
		PPL Provider (You will pay the least)	Non-PPL Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	No charge	Must be medically justified with skilled care.
	<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.
	<a href="#">Durable medical equipment</a>	No charge	Not covered	Most equipment must be purchased through a DME program <a href="#">provider</a> . Some equipment must be prior approved.
	<a href="#">Hospice services</a>	Not covered	Not covered	None
	Non-emergency transportation	No charge	No charge	<a href="#">Prior approval</a> is required.
<b>If you need dental or eye care</b>	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 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](#).)**

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Birth control prescriptions</li> <li>• Chiropractic care</li> <li>• Cosmetic surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care</li> <li>• Long-term care</li> <li>• Infertility treatment other than artificial insemination</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing unless necessary to preserve life and ICU is unavailable</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|---|---|--|

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Hearing aids</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment (artificial insemination only)</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care</li> </ul> |
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[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.umwafunds.org](http://www.umwafunds.org).]

**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 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](http://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)

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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 [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$30
- Hospital (facility) [copayment](#) \$750
- Other [copayment](#) \$25

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$860</b>

**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](#) \$30
- Hospital (facility) [copayment](#) \$750
- Other [copayment](#) \$25

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$720</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$30
- Hospital (facility) [copayment](#) \$750
- Other [copayment](#) \$25

**This EXAMPLE event includes services like:**

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic](#) test (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$70
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$70</b>