**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?** | $150 deductible per family* for physician and non-hospital and related services | 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. *Family includes individuals without other family members on the plan. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care by a Participating Provider List (PPL) provider and routine vision care services are covered before you meet your deductible. | 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/. |
| **Are there other deductibles for specific services?** | Yes. $150 /family for hospital related services*<br>$300 /family for unauthorized non-PPL services**<br>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.<br>*Hospital related services are inpatient hospitalizations, Skilled Nursing Facility admissions, and outpatient emergency room services. **Unauthorized non-PPL services are services from a non-PPL provider obtained without required precertification |
| **What is the out-of-pocket limit for this plan?** | $1,000 /family for physician visits and hospital and related charges<br>$1,000 /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 uncovered health care. | Even though you pay these expenses, they don't count toward the out–of–pocket limit. The $300 deductible for unauthorized non-PPL services also does not count toward this limit. |
| **Will you pay less if you use a Preferred Provider?** | Yes. See www.umwafunds.org or call 1-800-291-1425 for the Participating Providers List (PPL). | This plan uses a PPL. You will pay less if you use a provider on the PPL. You will pay the most if you use a non-PPL 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 PPL provider might use a non-PPL 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 |
|---|---|---|---|---|
| | | PPL Provider (You will pay the least) | Non-PPL 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 |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.umwafunds.org. | Generic drugs and Preferred brand drugs | $20 copay for up to a 30-day supply* $30 reduced copay for up to a 90-day supply for mail order and where required by law* *Plus any difference in the cost if a brand name drug is prescribed when a generic is available. | $35 copay for up to a 30-day supply* Applicable law might provide PPL Provider treatment in certain locations. | Maintenance Choice Program – if a 90-day supply is obtained at a CVS Retail pharmacy $30 copay for up to a 90-day supply. 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 for up to a 30-day supply.* $30 reduced copay for up to a 90-day supply for mail order and where required by law.* *Plus surcharge | Unless applicable law provides otherwise, $35 copay for up to a 30-day supply.* *Plus surcharge | If the prescribing physician obtains a medical necessity authorization there will be no additional payment for the use of the Non-Preferred drug. If not, there is a Non-Preferred drug surcharge: Initial prescription – no surcharge First refill - $10 surcharge Second and subsequent refills - $20 surcharge |

[* 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 |
|---|---|---|---|---|
| | | PPL Provider (You will pay the least) | Non-PPL Provider (You will pay the most) | |
| | Preferred Specialty drugs<br><br>Specialty drugs not on the Specialty Drug List | $10 copay for up to a 30-day supply at a CVS Specialty Pharmacy and where required by law<br><br>$10 per 30-day supply at a CVS Specialty Pharmacy and where required by law<br>$20 per 30-day supply at any PPL Provider non-CVS Specialty Pharmacy | Unless applicable law provides otherwise, if Specialty drugs that are not on the Specialty Drug list are obtained at a non-PPL Provider Specialty pharmacy, a $35 for up to a 30-day supply copay applies. | Pre-authorization is required for Specialty drugs.<br><br>All drugs on the Specialty Drug List must be obtained from a CVS Specialty Pharmacy unless applicable law provides otherwise.<br><br>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-PPL outpatient hospital surgeries. Accredited facility requirements apply. |
| | 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. | None |
| | Emergency medical transportation | No charge | No charge | None |
| | Urgent care | $25 copay for per visit | $25 copay per visit | Copay only applies to physician's charge. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $25 copay per hospitalization | The plan pays 90% of PPL rate. The Beneficiary is responsible for the $35 copay and remaining balance of charges up to the $1,000 annual out-of-pocket maximum. There are no such charges for hospitalizations resulting from a medical emergency, but a $25 copayment will apply. | Accredited facility requirements apply.<br><br>Private rooms are not covered unless patient's condition requires isolation or no semi-private room is available.<br><br>Pre-authorization is required for all non-emergency non-PPL hospital stays. |

[* 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 |
|---|---|---|---|---|
| | | PPL Provider (You will pay the least) | Non-PPL Provider (You will pay the most) | |
| | Physician/surgeon fees | $25 copay per visit | $35 copay per visit<br>$25 copay per visit during emergency hospitalization | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services (office visits) | $25 copay per visit | $35 copay per visit | Accredited facility requirements apply. |
| | Inpatient services | $25 copay per hospitalization | The plan pays 90% of the PPL rate. The Beneficiary pays the $35 copay and remaining balance up to the out-of-pocket maximum. There are no such charges for hospitalizations resulting from a medical emergency, but a $25 copayment will apply. | Accredited facility requirements apply.<br><br>Private rooms are not covered unless patient's condition requires isolation or no semi-private room is available. |
| **If you are pregnant** | Office visits | $25 copay per visit | $35 copay per visit | Cost sharing does not apply for preventive services.<br>Depending on the type of services, a deductible or copayment may apply.<br>Copayment does not apply when childbirth/delivery is billed as a bundled service.<br>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 the PPL rate. The Beneficiary pays the $35 copay and remaining balance up to the out-of-pocket maximum. | 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 |
|---|---|---|---|---|
| | | PPL Provider (You will pay the least) | Non-PPL Provider (You will pay the most) | |
| **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. |
| | 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 program provider. Some equipment requires Pre-authorization. |
| | Hospice services | Not covered | Not covered | None |
| | Non-emergency transportation | No charge | No charge | Pre-authorization required. |
| **If you need dental or eye care** | Eye exam | $ 30.00 | Not Applicable | Covered once every 12 months. |
| | Glasses | $20.00 per lens single vision<br>$27.50 per lens bifocal<br>$32.50 per lens trifocal<br>$65.00 per lens lenticular<br>$115.00 per contact lens<br>$40.00 per set of frames | Not Applicable | Lenses are covered once every 12 months. Frames are 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 | 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.)**

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Dental care
- Infertility treatment except artificial insemination
- 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)
- Non-emergency care when traveling outside the U.S.
- Routine eye care

[* For more information about limitations and exceptions, see the plan or policy document at 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.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, kwiijigo 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.*



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

## 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 | $150 |
| 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** | **$12,300** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles * | $300 |
| Copayments | $40 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$400** |

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

| | |
|---|---|
| The plan's overall deductible | $150 |
| 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** | **$4,830** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $150 |
| Copayments | $600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$770** |

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

| | |
|---|---|
| The plan's overall deductible | $150 |
| 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** | **$2,410** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles * | $300 |
| Copayments | $90 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$390** |

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

The **plan** would be responsible for the other costs of these EXAMPLE covered services.