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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$ 500 / family for physician and other visits $ 1,000 / family for prescription drugs $ 750 / family PPL and Non-PPL* hospital $ 2,250 / family in combined Non-PPL* copayments	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. * PPL means Participating Provider List.
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 health care this plan doesn't cover. (This plan has no premiums.)	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	$30 copay / visit	$40 copay / visit	None
	Specialist visit	$30 copay / visit	$40 copay / visit	None
	Preventive care/screening/ immunization	$30 copay / visit	$40 copay / visit	Routine physical exams are covered 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. Copays apply.
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 or Preferred brand drugs	$25 copay per 30-day supply $10 copay per 90-day supply for mail order	$40 copay per 30-day supply	Maximum supply for non-mail order is 90 days.
	Brand drugs where generic is available	$25 copay per 30-day supply $10 copay per 90-day supply for mail order. Plus the difference in cost between the generic and brand product.	$40 copay per 30-day supply, plus the difference in cost between the brand and generic 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 brand drugs	$25 copay per 30-day supply $10 copay per 90-day supply for mail order. Plus the differential payment that is approximately equal to	$40 copay per 30-day supply, plus the differential payment that is approximately equal to the difference in cost between the Preferred and Non-preferred product.	If the prescribing physician obtains a medical necessity authorization there will be no additional payment for the use of the Non-preferred drug.

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)	
		the difference in cost between the Preferred and Non-Preferred product.		
	Preferred Specialty drugs Non-Preferred Specialty drugs Specialty drugs not on the Specialty Drug List	$10 per 30-day supply at CVS Specialty Pharmacy $10 per 30-day supply at CVS Specialty Pharmacy $10 per 30-day supply at CVS Specialty Pharmacy. $25 per 30-day supply at any other Specialty Pharmacy	If Specialty drugs are obtained at a non-network Specialty Pharmacy, a $40 per 30-day supply copay applies.	Pre-authorization is required for all Specialty drugs. All drugs on the Specialty Drug List must be obtained from a CVS 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	None
	Physician/surgeon fees	No charge	No charge	None
If you need immediate medical attention	Emergency room care	$30 copay per visit	$40 copay per visit	Copay only applies to physician's charge for the emergency room visit. There is an annual maximum of $1,250 per family for emergency room copayments.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$30 copay per visit	$40 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)	$750 copayment per hospitalization up to the annual out-of-pocket maximum	The Beneficiary is responsible for the $750 copay and then balance of charges (up to a maximum of $750) after the plan pays 90% of the Participating Provider rate.	Private rooms are not covered unless patient's condition requires isolation or no semi-private room is available. There is a $750 annual maximum per family for hospital copayments. Plan payment for non-PPL hospital and related

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)	
			Hold Harmless provisions may not apply.	benefits is limited to 90% of the amount that would have been paid to a PPL hospital.
	Physician/surgeon fees	$30 copay per visit	$40 copay per visit	Copay only applies to physician's charge for hospital visits.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay per visit	$40 copay per visit	Alcoholism and drug rehabilitation programs must be provided by an accredited facility.
	Inpatient services	$750 copayment per hospitalization up to the annual out-of-pocket maximum	The Beneficiary is responsible for the $750 copay and then balance of charges (up to a maximum of $750) after the plan pays 90% of the Participating Provider rate. 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	$30 copay per visit	$40 copay per visit	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	Copayment does not apply when childbirth/delivery is billed as a bundled service.
	Childbirth/delivery facility services	$750 copayment per hospitalization, up to the annual out-of-pocket maximum	The Beneficiary is responsible for the $750 copay and then balance of charges (up to a maximum of $750) after the plan pays 90% of the Participating Provider rate. 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.]

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	Home health care	No charge	No charge	Must be medically justified with skilled care.
	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.
	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 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.)

- 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

[* 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 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.

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, 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	$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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$860**

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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

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

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