
 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 <a href="#">deductible</a>?</b>	\$ 0	See the Common Medical Events chart below for your costs for services this plan covers.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes.	This <a href="#">Plan</a> does not have a <a href="#">deductible</a> . But a <a href="#">copayment</a> may apply.
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$300 <a href="#">deductible</a> for any non-emergency hospital admission to a non-Participating <a href="#">Provider</a> List (PPL) hospital or other non-PPL service obtained without required <a href="#">precertification</a> , and \$50 <a href="#">deductible</a> / individual for dental services (does not apply to <a href="#">preventive</a> services). 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>	\$240 / family for in-PPL physician visits and \$1,600 / family in combined non-PPL hospital and physician office visits per year. No <a href="#">out-of-pocket limit</a> 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 non-emergency hospital admission to a non-PPL hospital or other	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Important Questions	Answers	Why This Matters:
	specified service obtained from a non-PPL <a href="#">provider</a> without required <a href="#">precertification</a> , the extra cost of using brand name or non-preferred drugs, <a href="#">balance-billing</a> charges, <a href="#">premiums</a> for dental benefits, and health care this <a href="#">plan</a> doesn't cover.	
<b>Will you pay less if you use a participating <a href="#">provider</a>?</b>	Yes. See <a href="http://www.umwafunds.org">www.umwafunds.org</a> or call 1-800-291-1425 for a list of participating <a href="#">providers</a> .	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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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)	
<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	\$12 <a href="#">copay</a> / visit	\$20 <a href="#">copay</a> / visit	None
	<a href="#">Specialist</a> visit	\$12 <a href="#">copay</a> / visit	\$20 <a href="#">copay</a> / visit	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	\$20 copay / 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.
<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

[\* 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)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.umwafunds.org">prescription drug coverage</a> is available at <a href="http://www.umwafunds.org">www.umwafunds.org</a>.</p>	Generic drugs and Preferred brand drugs	\$5 <a href="#">copay</a> per 30-day supply \$0 <a href="#">copay</a> per 90-day supply for mail order	\$10 <a href="#">copay</a> per 30-day supply	Maintenance Choice Program – if a 90-day supply is obtained at a CVS Retail pharmacy \$0 <a href="#">copay</a> per 90 day supply.
	Brand drugs where generic is available	\$5 <a href="#">copay</a> per 30-day supply.* \$0 <a href="#">copay</a> per 90-day supply for mail order.*  *Plus the difference in cost between the generic and brand product.	\$10 <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	\$5 <a href="#">copay</a> per 30-day supply.* \$0 <a href="#">copay</a> 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 <a href="#">copay</a> 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 <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>  Non-Preferred <a href="#">Specialty drugs</a>	\$0 <a href="#">copay</a> per 30-day supply at a CVS Specialty Pharmacy  \$0 per 30-day supply at a CVS Specialty Pharmacy	If <a href="#">Specialty drugs</a> are obtained at a non-network Specialty pharmacy, a \$10 per 30-day supply <a href="#">copay</a> 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.  If a Non-Preferred <a href="#">Specialty drug</a> within the classes on the <a href="#">Specialty Drug</a> List is selected, the prescriber will be asked to consider a

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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)	
	<a href="#">Specialty drugs</a> not on the <a href="#">Specialty Drug List</a>	\$0 per 30-day supply at a CVS Specialty Pharmacy  \$10 per 30-day supply at any in- <a href="#">network</a> , non-CVS Specialty pharmacy		Preferred drug to be used before the Non-Preferred drug will be covered.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	<a href="#">Precertification</a> is required for all non-Participating Provider List outpatient hospital surgeries.
	Physician/surgeon fees	No charge	No charge	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$0	\$0	You may have to pay a <a href="#">copay</a> for the physician's professional charge.
	<a href="#">Emergency medical transportation</a>	No charge	No charge	None
	<a href="#">Urgent care</a>	\$12 <a href="#">copay</a> per visit	\$20 <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)	No charge	The <a href="#">plan</a> pays 90% of Participating <a href="#">Provider</a> rate. The Beneficiary is responsible for the remaining balance of charges up to the \$1,600 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-emergency non-Participating <a href="#">Provider</a> 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 <a href="#">copay</a> per visit	\$20 <a href="#">copay</a> 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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$12 <a href="#">copay</a> per visit	\$20 <a href="#">copay</a> per visit	Alcoholism and drug rehabilitation programs must be provided by an accredited facility.
	Inpatient services	No charge	The <a href="#">plan</a> pays 90% of Participating <a href="#">Provider</a> rate. The Beneficiary is responsible for the remaining balance of charges up to the \$1,600 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	\$12 <a href="#">copay</a> per visit	\$20 <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="#">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	No charge	The <a href="#">plan</a> pays 90% of Participating <a href="#">Provider</a> rate. The Beneficiary is responsible for the remaining balance of charges up to the \$1,600 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.
<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. 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.

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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)	
	<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
	Non-emergency transportation	No charge	No charge	<a href="#">Prior approval</a> 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 care	\$50 <a href="#">deductible</a> /individual  \$0 <a href="#">deductible</a> /individual for <a href="#">preventive services</a>	Not Applicable	Covered benefits are limited to the Schedule of Benefits in the <a href="#">plan</a> document. Patient is responsible for amounts in excess of amount paid by <a href="#">plan</a> .  There is a \$2 per family per month <a href="#">premium</a> . 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. <a href="#">Preauthorization</a> is required for orthodontia or if a course of treatment is expected to involve dentist's charges of \$150 or more.

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## 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](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

[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:

Cost Sharing	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$70</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](#) \$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:

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

**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:

Cost Sharing	
Deductibles	\$0
Copayments	\$30
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$30</b>