




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>	\$150 <a href="#">deductible</a> / family* for physician and non-hospital and related services. *Family includes individuals without other family members on the plan.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Routine vision care <a href="#">and</a> <a href="#">preventive</a> dental and PPL care	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$50 / individual for dental services \$150 / family for hospital related services* \$300 for unauthorized non-PPL service** 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. *Hospital related services are inpatient <a href="#">hospitalizations</a> , Skilled Nursing Facility admissions, and outpatient <a href="#">emergency room services</a> . **Unauthorized non-PPL services are services from a non-PPL provider obtained without required <a href="#">precertification</a>
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$1,000 / family for physician visits and hospital and related services \$1,000 / family 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>	The extra cost of non-preferred or brand name drugs, <a href="#">balance-billing</a> charges, dental <a href="#">premiums</a> , uncovered health care	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> . The \$300 <a href="#">deductible</a> for unauthorized non-PPL services also does not count toward this limit.
<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 the Participating <a href="#">Providers List (PPL)</a> .	This <a href="#">plan</a> uses a PPL. You will pay less if you use a <a href="#">provider</a> on the <a href="#">plan's</a> 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 non-PPL <a href="#">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
		PPL Provider (You will pay the least)	Non-PPL Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	<a href="#">Primary care</a> visit to treat an injury or illness	\$25 <a href="#">copay</a> / visit	\$35 <a href="#">copay</a> / visit	None
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a> / visit	\$35 <a href="#">copay</a> / visit	None
	<a href="#">Preventive care/screening</a> /immunization	No charge	\$35 <a href="#">copay</a> / 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.
If you have a test	<a href="#">Diagnostic test</a> (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 <a href="#">prescription drug coverage</a> is available at <a href="http://www.umwafunds.org">www.umwafunds.org</a> .	Generic drugs and Preferred brand drugs	\$20 <a href="#">copay</a> for up to a 30-day supply* \$30 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 is prescribed when a generic is available.	\$35 <a href="#">copay</a> 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 <a href="#">copay</a> per 90 day supply.  If the prescribing physician obtains a <a href="#">medical necessity</a> authorization there will be no additional payment for the use of the brand name drug.
	Non-Preferred drugs	\$20 <a href="#">copay</a> for up to a 30-day supply.* \$30 reduced <a href="#">copay</a> for up to a 90-day supply for mail order and where required by law.*  *Plus surcharge	Unless applicable law provides otherwise, \$35 <a href="#">copay</a> for up to a 30-day supply  Plus 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. If not, there is a surcharge for Non-Preferred drugs: 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](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)	
	<p>Preferred <a href="#">Specialty drugs</a></p> <p><a href="#">Specialty drugs</a> not on the <a href="#">Specialty Drug</a> List</p>	<p>\$10 reduced <a href="#">copay</a> for up to a 30-day supply at a CVS Specialty Pharmacy and where required by law.</p> <p>\$10 reduced copay for up to a 30-day supply at a CVS Specialty Pharmacy and where required by law</p> <p>\$20 for up to a 30-day supply at Provider, non-CVS Specialty Pharmacy</p>	<p>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 \$35 for up to a 30-day supply <a href="#">copay</a> applies.</p>	<p><a href="#">Pre-authorization</a> is required for <a href="#">Specialty drugs</a>.</p> <p>All drugs on the <a href="#">Specialty Drug</a> List must be obtained from a CVS Specialty Pharmacy unless applicable law provides otherwise.</p> <p>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 Preferred drug to be used before the Non-Preferred drug will be covered.</p>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	<a href="#">Precertification</a> is required for all non-Preferred <a href="#">Provider</a> List outpatient hospital surgeries. Accredited facility requirements apply.
	Physician/surgeon fees	No charge	No charge	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$35 <a href="#">copay</a> for facility charge	\$35 <a href="#">copay</a> for facility charge.	You may also 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>	\$25 <a href="#">copay</a> for per visit	\$25 <a href="#">copay</a> per visit	<a href="#">Copay</a> only applies to physician's charge for the visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$25 <a href="#">copay</a> per hospitalization	The <a href="#">plan</a> pays 90% of the PPL rate. The Beneficiary is responsible for the \$35 <a href="#">copay</a> and remaining balance of charges up to the \$1,000 annual <a href="#">out-of-pocket maximum</a> . There are no such charges for hospitalizations resulting from a medical emergency, but a \$25 <a href="#">copay</a> will apply.	<p>Accredited facility requirements apply.</p> <p>Private rooms are not covered unless patient's condition requires isolation or no semi-private room is available.</p> <p><a href="#">Precertification</a> is required for all non-PPL hospital stays unless the stay results from a medical emergency.</p>
	Physician/surgeon fees	\$25 <a href="#">copay</a> per visit	<p>\$35 <a href="#">copay</a> per visit</p> <p>\$25 <a href="#">copay</a> per visit during emergency hospitalizations</p>	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 mental health, behavioral health, or substance abuse services</b>	Outpatient services (office visits)	\$25 <a href="#">copay</a> per visit	\$35 <a href="#">copay</a> per visit	Accredited facility requirements apply.
	Inpatient services	\$25 <a href="#">copay</a> per hospitalization	<p>The <a href="#">plan</a> pays 90% of Participating <a href="#">Provider</a> rate. The Beneficiary pays the \$35 <a href="#">copay</a> and remaining balance up to the <a href="#">out-of-pocket maximum</a>.</p> <p>There are no such charges for hospitalizations resulting from a medical emergency, but a \$25 <a href="#">copay</a> will apply</p>	<p>Accredited facility requirements apply.</p> <p>Private rooms are not covered unless patient's condition requires isolation or no semi-private room is available.</p> <p><a href="#">Precertification</a> is required for all non-PPL hospital stays unless the stay results from a medical emergency.</p>
<b>If you are pregnant</b>	Office visits	\$25 <a href="#">copay</a> per visit	\$35 <a href="#">copay</a> per visit	<p><a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a>.</p> <p>Depending on the type of services, a <a href="#">deductible</a> or <a href="#">copayment</a> may apply. <a href="#">Copayment</a> does not apply when childbirth/delivery is billed as a bundled service.</p> <p>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</p>
	Childbirth/delivery professional services	No charge	No charge	None
	Childbirth/delivery facility services	\$25 <a href="#">copay</a> per hospitalization	The <a href="#">plan</a> pays 90% of the PPL rate. The Beneficiary pays the \$35 <a href="#">copay</a> and remaining balance up to the <a href="#">out-of-pocket maximum</a> .	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)	
If you need help recovering or have other special health needs	<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.
	<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 program <a href="#">provider</a> . Some equipment requires <a href="#">Pre-authorization</a> .
	<a href="#">Hospice services</a>	Not covered	Not covered	None
	Non-emergency transportation	No charge	No charge	<a href="#">Pre-authorization</a> is required.
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 <a href="#">deductible</a> /individual  \$0 <a href="#">deductible</a> /individual for <a href="#">preventive services</a>	Not Applicable	The dental benefit year is October 1 through September 30. 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 <a href="#">premium</a> . Annual maximum dental benefit is \$1,754.50 / individual (except for children 18 and under). Maximum orthodontic benefit is \$974.37 / individual annually and \$2,923.09 lifetime. Orthodontic benefits apply to dependents under age 26 only. <a href="#">Pre-authorization</a> 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](http://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
- 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
- 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$150
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">copayment</a>	\$25
■ Other <a href="#">copayment</a>	\$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*)

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

Cost Sharing	
Deductibles *	\$300
Copayments	\$40
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$400</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$150
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">copayment</a>	\$25
■ Other <a href="#">copayment</a>	\$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*)

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

Cost Sharing	
Deductibles	\$150
Copayments	\$600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$770</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$150
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">copayment</a>	\$25
■ Other <a href="#">copayment</a>	\$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*)

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

Cost Sharing	
Deductibles *	\$300
Copayments	\$90
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$390</b>

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