



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, visit [www.ump.com](http://www.ump.com) or by calling 1-800-826-9781 or visit [www.caremark.com](http://www.caremark.com) or call 866-477-1626. 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 [www.ump.com](http://www.ump.com) or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	<b>\$200</b> person / <b>\$400</b> family Tier 1 <b>\$1,500</b> person / <b>\$3,000</b> family Tier 2 <b>\$3,000</b> person / <b>\$6,000</b> family Tier 3	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . Tier 1 and Tier 2 <u>deductibles</u> cross-feed.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<b>\$1,000</b> person / <b>\$2,000</b> family Tier 1 <b>\$4,000</b> person / <b>\$8,000</b> family Tier 2 <b>Unlimited</b> person / <b>Unlimited</b> family Tier 3	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. Tier 1 and Tier 2 <u>out-of-pocket maximums</u> cross-feed.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Penalties, <u>premiums</u> , <u>balance billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.ump.com">www.ump.com</a> or call 1-800-826-9781 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (a <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
--	-----	--



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
		Tier 1 (You will pay the least)	Tier 2	Tier 3 (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$10 Copay per visit; <u>Deductible</u> Waived	\$20 Copay per visit; <u>Deductible</u> Waived	50% <u>Coinsurance</u>	None
	<u>Specialist</u> visit	\$20 Copay per visit; <u>Deductible</u> Waived	\$40 Copay per visit; <u>Deductible</u> Waived	50% <u>Coinsurance</u>	None
	<u>Preventive care/ screening/ immunization</u>	No charge; <u>Deductible</u> Waived	No charge; <u>Deductible</u> Waived	50% <u>Coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Office setting: No charge Copay per visit outpatient setting: \$125 Copay; <u>Deductible</u> Waived	Office setting: No charge Copay per visit outpatient setting: \$250 Copay; <u>Deductible</u> Waived	50% <u>Coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (You will pay the least)	Tier 2	Tier 3 (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	Office visit setting and outpatient setting: \$125 Copay per visit; <u>Deductible Waived</u>	Office visit setting and outpatient setting: \$250 Copay per visit; <u>Deductible Waived</u>	50% <u>Coinsurance</u>	None
<b>If you need drugs to treat your illness or condition.</b>  More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com">www.caremark.com</a> .	Generic drugs (Tier 1)	\$10 copay	N/A	N/A	If a generic drug is available and you or your doctor chooses a brand-name drug, you will be responsible for the generic <u>coinsurance</u> or copay amount, plus the difference in cost between the brand dispensed and the generic.  Tier 2 out of pocket maximum applies.
	Preferred brand drugs (Tier 2)	20% <u>coinsurance</u> - max cost of \$50	N/A	N/A	
	Non-preferred brand drugs (Tier 3)	30% <u>coinsurance</u> - max cost of \$150	N/A	N/A	
	<u>Specialty drugs</u> (Tier 4)	30% <u>coinsurance</u> - max cost of \$200	N/A	N/A	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$125 Copay per visit; <u>Deductible Waived</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	None
	Physician/surgeon fees	0% <u>Coinsurance</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	None
<b>If you need immediate medical</b>	<u>Emergency room care</u>	\$150 Copay per visit; <u>Deductible Waived</u>	\$250 Copay per visit; <u>Deductible Waived</u>	\$250 Copay per visit; <u>Deductible Waived</u>	Copay may be waived if admitted. Tier 2 <u>deductible</u> applies to Tier 3 benefits

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (You will pay the least)	Tier 2	Tier 3 (You will pay the most)	
<b>attention</b>	<u>Emergency medical transportation</u>	10% <u>Coinsurance</u>	10% <u>Coinsurance</u>	10% <u>Coinsurance</u>	Tier 2 <u>deductible</u> applies to Tier 3 benefits
	<u>Urgent care</u>	\$15 Copay per visit; <u>Deductible</u> Waived	\$40 Copay per visit; <u>Deductible</u> Waived	50% <u>Coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250 Copay per admission; <u>Deductible</u> Waived	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$500 of the total cost of the service.
	Physician/surgeon fee	0% <u>Coinsurance</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	None
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Outpatient services	\$10 Copay per visit; <u>Deductible</u> Waived Office visits; 10% <u>Coinsurance</u> other outpatient services	\$20 Copay per visit; <u>Deductible</u> Waived Office visits; 20% <u>Coinsurance</u> other outpatient services	50% <u>Coinsurance</u>	Preauthorization is required for Partial hospitalization. If you don't get preauthorization, benefits could be reduced by \$500 of the total cost of the service for Partial hospitalization.
	Inpatient services	\$250 Copay per admission; <u>Deductible</u> Waived	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$500 of the total cost of the service.
<b>If you are pregnant</b>	Office visits	No charge; <u>Deductible</u> Waived	No charge; <u>Deductible</u> Waived	50% <u>Coinsurance</u>	Cost sharing does not apply to certain preventive services. Depending on the type of services, <u>deductible</u> ,

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (You will pay the least)	Tier 2	Tier 3 (You will pay the most)	
	Childbirth/delivery professional services	10% <u>Coinsurance</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	<u>copayment</u> or <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	\$250 Copay per admission; <u>Deductible</u> Waived	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>Coinsurance</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	100 Maximum visits per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$500 of the total cost of the service.
	<u>Rehabilitation services</u>	\$20 Copay per visit; <u>Deductible</u> Waived	\$40 Copay per visit; <u>Deductible</u> Waived	50% <u>Coinsurance</u>	30 Maximum visits per calendar year OT/PT; 20 Maximum visits per calendar year ST
	<u>Habilitation services</u>	10% <u>Coinsurance</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	None
	<u>Skilled nursing care</u>	10% <u>Coinsurance</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	60 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$500 of the total cost of the service.
	<u>Durable medical equipment</u>	10% <u>Coinsurance</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by \$500 of the total cost of the service.
	<u>Hospice service</u>	10% <u>Coinsurance</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (You will pay the least)	Tier 2	Tier 3 (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (adult)
- 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.)**

- Acupuncture
- Bariatric surgery (Tier 1 only)
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.

**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: U.S. 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: U.S. 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). Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

**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 Standard? 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 1-800-826-9781.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-826-9781.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-826-9781.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-826-9781.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

**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** \$200
- **Specialist copayment** \$20
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

**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>\$12,800</b>
---------------------------	-----------------

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

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$20
<u>Coinsurance</u>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$620</b>

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

- **The plan's overall deductible** \$200
- **Specialist copayment** \$20
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

**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>\$7,400</b>
---------------------------	----------------

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

<i>Cost Sharing</i>	
<u>Deductibles*</u>	\$200
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,000</b>

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

- **The plan's overall deductible** \$200
- **Specialist copayment** \$20
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$1,900</b>
---------------------------	----------------

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

<i>Cost Sharing</i>	
<u>Deductibles*</u>	\$200
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$380</b>

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [www.bravowell.com/ardent](http://www.bravowell.com/ardent) or call 1-844-529-5547.

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