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 Contribution) 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, go to www.umr.com or call (866) 868-1395. 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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** person / **$1,000** family PPO **$1,000** person / **$2,000** family Non-PPO	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 plan, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	**Yes**. Preventive care and primary 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?	**No**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	**$4,000** PPO/ person **$12,000** PPO (Maximum per family) **Unlimited** Non-PPO.	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, they must meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments associated with specialty medications on the Select Drugs & Products list, Penalties, contributions, balance-billed charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. For a list of **PPO providers,** use the provider lookup function on www.umr.com.	This plan uses a provider 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 permission from this plan.

All **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
		Network Provider (You will pay the least)	Out-of-Network 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	No Charge	40% **Coinsurance**	PPO **Deductible** Waived
	Specialist visit	$35 Copay per visit	40% **Coinsurance**	PPO **Deductible** Waived Specialty medications listed on the Select Drugs and Products List administered by a provider require enrollment in the plan's Specialty Drug Program. See Specialty Drug section.
	Preventive care/screening/ immunization	No Charge	40% **Coinsurance**	PPO **Deductible** Waived. Frequency guidelines apply to preventive care. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	15% **Coinsurance**	40% **Coinsurance**	Routine blood work or x-rays, if done in your primary care or specialist's office, is included in your **copayment**.
	Imaging (CT/PET scans, MRIs)	15% **Coinsurance**	40% **Coinsurance**	Prior authorization required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	$5 – Retail $10 – Mail order	Not Covered	Covers up to a 30-day supply (retail); 31-90 day supply (mail order or at a CVS retail store). Maintenance medications must be filled at mail or a CVS retail store after the 2nd fill. Diabetic test strips, lancets & syringes copay: $10 retail, $20 Mail Order Specialty Medications – Failure to pre-certify a prescription drug or product listed on the Select Drugs and Products List will result in a cost containment penalty equal to 100% reduction in benefits payable. Specialty medications are subject to prior authorization/pre-certification, step-therapy, and administrative review that may require specific drug distribution channels be used.
	Preferred brand drugs	$25 – Retail $50 – Mail order	Not Covered	
	Non-preferred brand drugs	$50 – Retail $100 – Mail order	Not Covered	
	Specialty drugs	Must enroll in Plan's Specialty Drug Program or cost-containment penalty may apply.	Not Covered	

All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% **Coinsurance**	Not Covered	Prior authorization required.
	Physician/surgeon fees	15% **Coinsurance**	Not Covered	Prior authorization required.
If you need immediate medical attention	Emergency room care	$350 **Copayment** per visit for True emergency	$350 **Copayment** per visit for True emergency	PPO **Deductible** Waived. If you are admitted to the Hospital, refer to "If you have a Hospital Stay" for information
	Emergency medical transportation	15% **Coinsurance**	15% **Coinsurance**	PPO **Deductible** Applies
	Urgent care	$25 **Copayment** per visit	40% **Coinsurance**	PPO **Deductible** Waived
If you have a hospital stay	Facility fee (e.g., hospital room)	15% **Coinsurance**	$600 **Copayment** per admission: plus 40% **Coinsurance**	Prior authorization required. **Copayment** waived for Emergency admission. Prior authorization required.
	Physician/surgeon fees	15% **Coinsurance**	40% **Coinsurance**	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services Outpatient Counseling Psychiatry/Specialist	$ 0 **Copayment** per visit $35 **Copayment** per visit	40% **Coinsurance**	For assistance in finding a PPO Provider call (866) 868-1395 and say "BHO."
	Inpatient services	15% **Coinsurance**	$600 **Copayment** per admission: 40% **Coinsurance**	Prior authorization required. **Copayment** waived for Emergency admission.
If you are pregnant	Office visits (OB) Office visits (Specialist)	No Charge $35.00	40% **Coinsurance**	PPO **Deductible** Waived. Enroll in the Maternity Management Program during the 1st trimester and the Plan will pay 100% of the first $5,000 or 2nd Trimester 100% of the first $3, 000 of allowed charges as a benefit incentive after completion of the Maternity Management Program. Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC. Ultrasound and laboratory services payable as diagnostic tests (i.e. ultrasound). Prior authorization required for elective C-sections.
	Childbirth/delivery professional services	15% **Coinsurance**	40% **Coinsurance**	
	Childbirth/delivery facility services	15% **Coinsurance**	$600 **Copayment** per admission: plus 40% **Coinsurance**	

If you need help recovering or have other special health needs	Home health care	15% **Coinsurance**	40% **Coinsurance**	Prior authorization required.
	Rehabilitation services Inpatient Outpatient (speech, physical or occupational therapy)	15% **Coinsurance** $15 **Copayment** per visit	40% **Coinsurance**	Prior authorization required. Maximum 20 visits per calendar year for outpatient speech therapy; Maximum 40 visits per calendar year (combined) outpatient occupational/physical therapy per calendar year.
	Habilitation services	Not covered	Not Covered	
	Skilled nursing care	15% **Coinsurance**	40% **Coinsurance**	Prior authorization required.
	Durable medical equipment	$50 **Copayment** per item (per month for oxygen)	40% **Coinsurance**	Prior authorization required for items over $500.
	Hospice services	15% **Coinsurance**	40% **Coinsurance**	Prior authorization required.
If your child needs dental or eye care	Children's eye exam	Covered	Covered	See insured benefits offered through UHC Vision.
	Children's glasses	Covered	Covered	See insured benefits offered through UHC Vision.
	Children's dental check-up	100%	50%	Routine Diagnostic and Preventive

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.)

- Routine foot care
- Cosmetic surgery
- Long term care
- Habilitation services
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private/duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (Maximum of $1000 Per Calendar Year)
- Routine Eye Care (Adult)
- Dental Care (Adult)
- Chiropractic care (Maximum of $1000 Per Calendar Year)
- Real Appeal Virtual Weight Loss Program
- Wellness Benefit: Reimbursement of Weight Watchers and Trust Sponsored or Approved Events up to $250 per Calendar Year
- Weight Loss Surgery (Exclusive Provider Only)

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: Nevada, HHS, DOL, and/or other applicable agency contact information]. 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: UMR at (866) 868-1395. 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 and http://cciio.cms.gov/prgrams/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 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 (866) 868-1395.

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

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	$500
Specialist *[cost sharing]*	$35
Hospital (facility) *[cost sharing]*	15%
Other *[cost sharing]*	15%

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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$20
Coinsurance	$1,821
What isn't covered	
Limits or exclusions	N/A
The total Peg would pay is	**$2,341**

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$35
Hospital (facility) *[cost sharing]*	15%
Other *[cost sharing]*	15%

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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$134
Copayments	$865
Coinsurance	$0
What isn't covered	
Limits or exclusions	$33.93
The total Joe would pay is	**$1,033**

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$35
Hospital (facility) *[cost sharing]*	15%
Other *[cost sharing]*	15%

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$455
Coinsurance	$46
What isn't covered	
Limits or exclusions	N/A
The total Mia would pay is	**$1,001**

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