**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.mymisterhealth.com or by calling 1-888-971-7277. 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.mymisterhealth.com or call 1-888-971-7277 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,400** person / **$2,800** family In-network<br>**$4,000** person / **$8,500** family Out-of-network | Generally, you must pay all 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 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. |
| **What is the out–of–pocket limit for this plan?** | **$6,000** person / **$12,000** family In-network<br>**$16,000** person / **$32,000** family Out-of-network | 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 have to 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 for certain services, penalties, premiums, balance billing 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. See www.mymisterhealth.com or call 1-888-971-7277 for a list of network providers. | 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 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 |
|---|---|---|---|---|
| | | In-network (You will pay the least) | Out-of-network (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 | $20 Copay per visit Premium Designation; $40 Copay per visit Non-premium Designation; Deductible Waived | 40% Coinsurance | None |
| | Specialist visit | $30 Copay per visit Premium Designation; $50 Copay per visit Non-premium Designation; Deductible Waived | 40% Coinsurance | None |
| | Preventive care/screening/ immunization | No charge; Deductible Waived | 40% Coinsurance | 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) | $20 Copay per visit Premium Designation; $40 Copay per visit Non-premium Designation PCP; $30 Copay per visit Premium Designation; $50 Copay per visit Non-premium Designation Specialist Office setting; No charge Outpatient setting; Deductible Waived | 40% Coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% Coinsurance | 40% Coinsurance | Preauthorization is required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network (You will pay the least) | Out-of-network (You will pay the most) | |
| **If you need drugs to treat your illness or condition.**<br><br>More information about prescription drug coverage is available at www.umr.com. | Tier 1 (generic and some brand-name) | $10 Copay per prescription (retail); $25 Copay per prescription (mail order) | If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount. | Out-of-pocket limit applies<br><br>Covers up to a 30-day supply (retail & specialty);<br>32-90 day supply (mail order)<br><br>You must pay the difference in cost between a Generic drug and Brand-name drug when a medical professional has not specified a Brand-name drug or has not indicated that the Brand-name drug is necessary, this difference is not applied to preferred brand-name products in the high priced generic strategy, until the out-of-pocket is met |
| | Tier 2 (preferred brand-name and some generic) | $35 Copay per prescription (retail); $87 Copay per prescription (mail order) | | |
| | Tier 3 (nonpreferred brand-name and nonpreferred generic) | $60 Copay per prescription (retail); $150 Copay per prescription (mail order) | | |
| | Tier 4 (specialty drugs) | $10 Copay per prescription (Tier 1); $35 Copay per prescription (Tier 2); $60 Copay per prescription (Tier 3) | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance | 40% Coinsurance | Preauthorization is required. |
| | Physician/surgeon fees | 20% Coinsurance | 40% Coinsurance | |
| **If you need immediate medical attention** | Emergency room care | $300 Copay per visit; Deductible Waived | $300 Copay per visit; Deductible Waived | Copay may be waived if admitted |
| | Emergency medical transportation | 20% Coinsurance | 20% Coinsurance | In-network deductible applies to Out-of-network benefits |
| | Urgent care | $50 Copay per visit; Deductible Waived | $50 Copay per visit; Deductible Waived | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network (You will pay the least) | Out-of-network (You will pay the most) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% Coinsurance | 40% Coinsurance | Preauthorization is required. |
| | Physician/surgeon fee | 20% Coinsurance | 40% Coinsurance | |
| **If you have mental health, behavioral health, or substance abuse services** | Outpatient services | $20 Copay per visit Premium Designation; $40 Copay per visit Non-premium Designation; Deductible Waived Office visits; 20% Coinsurance other outpatient services | 40% Coinsurance | Preauthorization is required for Intensive outpatient & Partial hospitalization. |
| | Inpatient services | 20% Coinsurance | 40% Coinsurance | Preauthorization is required. |
| **If you are pregnant** | Office visits | No charge; Deductible Waived | 40% Coinsurance | Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 20% Coinsurance | 40% Coinsurance | |
| | Childbirth/delivery facility services | 20% Coinsurance | 40% Coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network (You will pay the least) | Out-of-network (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | 20% Coinsurance | 40% Coinsurance | Preauthorization is required. |
| | Rehabilitation services | $50 Copay per visit; Deductible Waived | 40% Coinsurance | 60 Maximum visits per calendar year; If your plan excludes Learning Disabilities, habilitation services for learning disabilities are not covered, please refer to your plan document. |
| | Habilitation services | $50 Copay per visit; Deductible Waived | 40% Coinsurance | |
| | Skilled nursing care | 20% Coinsurance | 40% Coinsurance | 60 Maximum days per calendar year; Preauthorization is required. |
| | Durable medical equipment | 20% Coinsurance | 40% Coinsurance | Preauthorization is required for DME in excess of $1,500 for purchases and all rentals. |
| | Hospice service | 20% Coinsurance | 40% Coinsurance | None |
| **If your child needs dental or eye care** | Children's eye exam | No charge; Deductible Waived | No charge; Deductible Waived | 1 Maximum exam per calendar year |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | 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.) | | |
|---|---|---|
| • Acupuncture | • Infertility treatment | • Private-duty nursing |
| • Bariatric surgery | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Dental care (Adult) | | |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Chiropractic care | • Hearing aids | • Routine eye care (Adult) |

**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.HealthCare.gov. 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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

**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 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 1-888-971-7277.

*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** | **$1,400** |
| **Specialist copayment** | **$30** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **20%** |

**This EXAMPLE event includes services like:**
Specialist office visits *(pre-natal 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 | $1,400 |
| Copayments | $200 |
| Coinsurance | $1,700 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$3,300** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,400** |
| **Specialist copayment** | **$30** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **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)*

| **Total Example Cost** | **$5,600** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles* | $200 |
| Copayments | $1,300 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,520** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,400** |
| **Specialist copayment** | **$30** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **20%** |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles* | $1,200 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,700** |

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.mymisterhealth.com or call 1-888-971-7277.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"" row above.