## UMR: SCHREIBER FOODS, INC.: 7670-00-415092 003 004



**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.umr.com or by calling 1-800-207-3172. 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.umr.com or call 1-800-207-3172 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $3,000 person / $6,000 family In-network<br>$6,000 person / $12,000 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, the overall family deductible must be met before the plan begins to pay. |
| **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>$12,000 person / $24,000 family Out-of-network<br>$8,700 In-network / $12,000 Out-of-network<br>Maximum amount that any one person will satisfy toward the annual family out-of-pocket | 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?** | 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.umr.com or call 1-800-207-3172 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 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 | 20% coinsurance | 40% coinsurance | None |
| | Specialist visit | 20% coinsurance | 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 needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network Provider (You will pay the least) | Out-of-network Provider (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.mysmithrx.com. | Generic drugs (Tier 1) | 20% coinsurance | 20% coinsurance | Coinsurance subject to meeting the overall deductible first. Preventative medications are not subject to the deductible.<br><br>Retail: up to a 90-day supply<br>Mail order: up to a 90 day supply<br>Specialty medications: up to a 30-day supply<br><br>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by SmithRx. |
| | Preferred brand drugs (Tier 2) | 20% coinsurance | 20% coinsurance | |
| | Non-preferred brand drugs (Tier 3) | 20% coinsurance | 20% coinsurance | |
| | Specialty drugs (Tier 4) | 20% coinsurance | 20% coinsurance | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | 20% coinsurance | In-network deductible applies to Out-of-network benefits |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | In-network deductible applies to Out-of-network benefits |
| | Urgent care | 20% coinsurance | 20% coinsurance | In-network deductible applies to Out-of-network benefits |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge Mental health; 20% coinsurance Substance use disorder | 40% coinsurance | 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. |
| | Inpatient services | No charge Mental health; 20% coinsurance Substance use disorder | 40% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service. |
| **If you are pregnant** | Office visits | No charge; deductible waived | 40% coinsurance | Cost sharing does not apply for 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 Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | 40 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. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | Speech therapy is covered only when required for treatment of a speech impediment or speech dysfunction that results from Accidental Injury, stroke, cancer, Congenital Anomaly or autism spectrum disorder. Habilitation services for Learning Disabilities are not covered. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | 60 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. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Preauthorization is required for DME in excess of $500 for rentals or $1,500 for purchases. If you don't get preauthorization, benefits could be reduced by $500 per occurrence. |
| | Hospice service | 20% coinsurance | 40% coinsurance | None |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | None |
| | 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 – unless through Carrot Fertility | • Routine eye care (Adult) |
| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care (Adult) | • Private-duty nursing | • 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 | • Hearing aids - $3,000 for both ears every 36 months | • Non-emergency care when traveling outside the U.S. |
| • Chiropractic care – 25 visits per calendar year | | |

**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://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

**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 1-800-207-3172.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-207-3172.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-207-3172.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf die do Nummer uff 1-800-207-3172.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-207-3172.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-207-3172.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-207-3172.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-207-3172.

***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 | $3,000 |
| Specialist coinsurance | 20% |
| 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 | $3,000 |
| Copayments | $0 |
| Coinsurance | $1,900 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$4,900** |

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

| | |
|---|---|
| The plan's overall deductible | $3,000 |
| Specialist coinsurance | 20% |
| 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 | $3,000 |
| Copayments | $0 |
| Coinsurance | $520 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$3,520** |

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

| | |
|---|---|
| The plan's overall deductible | $3,000 |
| Specialist coinsurance | 20% |
| 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 | $2,800 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,800** |

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.umr.com or call 1-800-207-3172.

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