UMR: WINDSTREAM SERVICES, LLC.: $6,550 Plan

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 1-844-368-6189. 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 1-844-368-6189 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$6,550 Single Only/ $13,100 family In-network $13,100 Single Only/ $26,200 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?	$6,550 per person / $13,100 family In-network $13,100 per person / $26,200 family Out-of-network Annual Coinsurance out-of-pocket maximum	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 1-800-826-9781 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 (a 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	0% Coinsurance After Deductible	0% Coinsurance After Deductible	None
	Specialist visit	0% Coinsurance After Deductible	0% Coinsurance After Deductible	None
	Preventive care/screening/ immunization	No Charge Deductible Waived	0% Coinsurance After Deductible	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. Current listing of required preventive care can be accessed at: www.HealthCare.gov/center/regulations/prevention.htm l and www.cdc.gov/vaccines/recs/acip
If you have a test	Diagnostic test (x-ray, blood work)	0% Coinsurance After Deductible	0% Coinsurance After Deductible	None
	Imaging (CT/PET scans, MRIs)	0% Coinsurance After Deductible	0% Coinsurance After Deductible	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 More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs (Tier 1)	0% Coinsurance After Deductible	0% Coinsurance After Deductible	Express Scripts' Preventive Medication program supports consumer directed healthcare (CDH) plans. The program allows certain drugs to bypass the deductible in accordance with the U.S. Internal Revenue Service's "safe harbor" provision for preventive medications. Your plan offers a number of preventive medications for just a coinsurance payment. 30-day supply (retail); 90-day supply (mail order and at Walgreens locations). Mail order mandatory for maintenance drugs after 2 retail fills. No coverage for out-of-network mail order. Using the Express Advantage preferred network will help you get your Rx at the lowest cost. Specialty 30-day supply. Requires Accredo delivery after 1 retail fill. Some drugs require prior authorization or step therapy. If necessary authorization is not obtained, the drug may not be covered.
	Preferred drugs (Tier 2)	0% Coinsurance After Deductible	0% Coinsurance After Deductible	
	Non-preferred drugs (Tier 3)	0% Coinsurance After Deductible	0% Coinsurance After Deductible	
	Specialty drugs (Tier 4)	0% Coinsurance After Deductible	0% Coinsurance After Deductible	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% Coinsurance After Deductible	0% Coinsurance After Deductible	Preauthorization is required.
	Physician/surgeon fees	0% Coinsurance After Deductible	0% Coinsurance After Deductible	None
If you need immediate medical attention	Emergency room care	0% Coinsurance After Deductible	0% Coinsurance After Deductible	None
	Emergency medical transportation	0% Coinsurance After Deductible	0% Coinsurance After Deductible	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)	
	Urgent care	0% Coinsurance After Deductible	0% Coinsurance After Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% Coinsurance After Deductible	0% Coinsurance After Deductible	Preauthorization is required.
	Physician/surgeon fee	0% Coinsurance After Deductible	0% Coinsurance After Deductible	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	0% Coinsurance After Deductible	0% Coinsurance After Deductible	None
	Inpatient services	0% Coinsurance After Deductible	0% Coinsurance After Deductible	Preauthorization is required.
If you are pregnant	Office visits	0% Coinsurance After Deductible	0% Coinsurance After Deductible	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	0% Coinsurance After Deductible	0% Coinsurance After Deductible	
	Childbirth/delivery facility services	0% Coinsurance After Deductible	0% Coinsurance After Deductible	

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	0% Coinsurance After Deductible	0% Coinsurance After Deductible	120 Maximum visits per calendar year; Preauthorization is required.
	Rehabilitation services	0% Coinsurance After Deductible	0% Coinsurance After Deductible	None
	Habilitation services	0% Coinsurance After Deductible	0% Coinsurance After Deductible	None
	Skilled nursing care	0% Coinsurance After Deductible	0% Coinsurance After Deductible	120 Maximum days per calendar year; Preauthorization is required.
	Durable medical equipment	0% Coinsurance After Deductible	0% Coinsurance After Deductible	Preauthorization is required for DME in excess of $500 for rentals or purchases.
	Hospice service	0% Coinsurance After Deductible	0% Coinsurance After Deductible	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No Charge	50% Coinsurance	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 (This isn't a complete list. Check your policy for other excluded services.)		
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• Routine foot care
• Dental care (adult)	• Routine eye care (adult)	• Weight loss programs
• Long-term care		

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)		
• Acupuncture	• Chiropractic care	• Infertility treatment
• Bariatric surgery	• Hearing aids	• Private-duty nursing (Outpatient 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: 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
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, kwiijigo 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	$6,550
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$12,840

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,550
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$6,610

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

The plan's overall deductible	$6,550
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$7,460

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$6,650
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$6,610

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

The plan's overall deductible	$6,550
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$2,010

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$2,010
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,010

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