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.bmousbenefits.com or call 1-888-927-7700. 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 http://www.healthcare.gov/sbc-glossary/ or call 1-888-927-7700 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers $1,750/Individual or $3,500/family; for out-of-network providers $3,500 individual/ $7,000 family	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 policy, 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 is 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?	For in-network providers $3,425 individual / $6,850 family; for out-of-network providers $6,850 individual / $13,700 family	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, the overall family out-of-pocket limits must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, prescription drugs this plan doesn't cover, and precertification penalties.	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 http://bmo.welcometouhc.com/home or call 1-800-896-0067 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.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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
		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	Virtual visits may be available, please refer to your plan policy for more details.
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge, deductible does not apply	40% coinsurance, deductible does not apply	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% coinsurance	40% coinsurance	Preauthorization may be required; call the number on back of your ID card for details.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com/bmofinancialgroup or by calling member services at 1-877-795-2926.	Generic	$10 copay/prescription-retail $20 copay/prescription-mail (31-90)	Same as in-network, retail pricing applies. Mail order not covered.	Retail prescriptions limited to a 30-day supply or 90-day maintenance drug available at most retail pharmacies at 3 times the monthly retail copay/coinsurance amount. Mail order available for 31-90 day supply. Subject to deductible (some exclusions apply). Infertility medications lifetime limit of $40,000. The Dispense as Written (DAW1&2) program requires you to use a generic equivalent drug when available. If you choose to purchase a brand drug when a generic equivalent is available, you pay the generic copayment plus the difference in cost between the brand and the generic. Extra cost will not apply toward deductible or out-of-pocket maximum.
	Formulary	25% coinsurance/ prescription min $20, max $50-retail 25% coinsurance/ prescription min $40, max $100-mail (31-90 day)		
	Nonformulary	35% coinsurance/ prescription min $40, max $70-retail 35% coinsurance/ prescription min $80, max $140-mail (31-90 day)		
	Specialty drugs	Based on category (generic, Formulary, Nonformulary)	Not covered.	Required to be filled through Express Script's specialty mail order pharmacy, Accredo Health Group, Inc.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization may be required; call the number on back of your ID card for details.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at www.bmousbenefits.com.

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 need immediate medical attention	Emergency room care	20% coinsurance and $100 copay	40% coinsurance and $100 copay	Copay waived if admitted. In-network benefits apply if considered an emergency. Preauthorization required. Penalty of $400 for failure to precertify admission.
	Emergency medical transportation	20% coinsurance	40% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required. Penalty of $400 for failure to precertify.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Preauthorization may be required; call the number on back of your ID card for details. Penalty of $400 for failure to precertify inpatient services. Virtual visits may be available.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or deductible may apply. Preauthorization required. Penalty of $400 for failure to precertify extended lengths of stay for mother or newborn over 48 hours for vaginal delivery or 96 hours for cesarean section.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Up to 120 visits per calendar year. Preauthorization required. Penalty of $400 for failure to precertify.
	Rehabilitation services	20% coinsurance	40% coinsurance	Up to 60 combined visits for physical, occupational, and speech therapies. Preauthorization required. Penalty of $400 for failure to precertify.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Up to 60 days per confinement per calendar year. Preauthorization required. Penalty of $400 for failure to precertify.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization may be required. Penalty of $400 for failure to precertify.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization required. Penalty of $400 for failure to precertify.
If your child needs dental or eye care	Children's eye exam	20% coinsurance	40% coinsurance	Visual Acuity Screening only, no charge if preventive.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

* For more information about limitations and exceptions, see the plan or policy document at www.bmousbenefits.com.

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.)

- Cosmetic Surgery
- Dental Care (Adult) (certain exceptions apply)
- Long Term Care
- Routine foot care (certain exceptions apply)
- Weight loss programs

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

- Acupuncture (20 visits per calendar year)
- Bariatric Surgery
- Chiropractic Care (20 visits per calendar year)
- Hearing Aids
- Infertility treatment (fertility preservation when Medically Necessary)
- Most coverage provided outside the United States. See http://bmo.welcometouhc.com/home
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.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: UnitedHealthcare Customer Service at 1-800-896-0067 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Visit https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ for a list of state consumer assistance programs.

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 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 1-888-927-7700.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-927-7700.]

[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-888-927-7700.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-927-7700.]

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

* For more information about limitations and exceptions, see the plan or policy document at www.bmousbenefits.com.

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	$1750
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	$0
Coinsurance	$1,675
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,485**

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

The plan's overall deductible	$1750
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	$1,750
Copayments	$100
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,770**

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

The plan's overall deductible	$1750
Specialist copayment	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,960**

HEALTH PLAN NOTICE OF NONDISCRIMINATION

BMO Financial Corp. (BMO) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BMO does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

BMO:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Dennis Salentine at 1-262-827-2855.

If you believe that BMO has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Dennis Salentine, Director of U.S. Benefits, 395 N Executive Drive, Brookfield, WI 53005, 1-262-827-2855, fax 866-932-6312, dennis.salentine@bmo.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Dennis Salentine, Director of U.S. Benefits, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

You have the right to get help and information in your language at no cost. To request an interpreter, call 1-262-827-2855.

This letter is also available in other formats like large print. To request the document in another format, please call 1-262-827-2855.

Language	Translated Taglines
Español (Spanish)	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-26262-827-2855.
Polski (Polish)	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-262-827-2855.
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-262-827-2855.
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다1-262-827-2855.
Tagalog (Tagalog – Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-262-827-2855.
العربية (Arabic)	ملحوظة: إذا كنت تتحدث اذكر تتوافر لك المجان بالمساعدة خدمات فإن اللغة، اللغوية المساعدة خدمات فإن اللغة، تتوافر لك المجان بالرقم اتصل 1-262-827-2855.
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-262-827-2855.
ગુજરાતી (Gujarati)	સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-262-827-2855.
اردو (Urdu)	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-262-827-2855.
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-262-827-2855.
Italiano (Italian)	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-262-827-2855.
हिंदी (Hindi)	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-262-827-2855.
Français (French)	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-262-827-2855.
Ελληνικά (Greek)	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-262-827-2855.
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-262-827-2855.

Language	Translated Statements
Español (Spanish)	BMO cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo
Polski (Polish)	BMO postępuje zgodnie z obowiązującymi federalnymi prawami obywatelskimi i nie dopuszcza się dyskryminacji ze względu na rasę, kolor skóry, pochodzenie, wiek, niepełnosprawność bądź płeć.
繁體中文 (Chinese)	BMO 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障 或性別而歧視任何人。
한국어 (Korean)	BMO은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.
Tagalog (Tagalog – Filipino)	Sumusunod ang BMO sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.
العربية (Arabic)	يلتزم BMO بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.
Русский (Russian)	BMO соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.
ગુજરાતી (Gujarati)	BMO લાગુ પડતા સમવાયી નાગરિક અધિકાર કાયદા સાથે સુસંગત છે અને જાતિ, રંગ, રાષ્ટ્રીય મૂળ, ઉંમર, અશક્તતા અથવા લિંગના આધારે ભેદભાવ રાખવામાં આવતો નથી.
اُردُو (Urdu)	BMO قابلِ اطلاق وفاقی شہری حقوق کے قوانین کی تعمیل کرتا ہے اور یہ کہ نسل، رنگ ، قومیت، عمر، معذوری یا جنس کی بنیاد پر امتیاز نہیں کرتا۔
Tiếng Việt (Vietnamese)	BMO tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.
Italiano (Italian)	BMO è conforme a tutte le leggi federali vigenti in materia di diritti civili e non pone in essere discriminazioni sulla base di razza, colore, origine nazionale, età, disabilità o sesso.
हिंदी (Hindi)	BMO लागू होने योग्य संघीय नागरिक अधिकार क़ानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या लिंग के आधार पर भेदभाव नहीं करता है।
Français (French)	BMO respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.
Ελληνικά (Greek)	Η BMO συμμορφώνεται με τους ισχύοντες ομοσπονδιακούς νόμους για τα ατομικά δικαιώματα και δεν προβαίνει σε διακρίσεις με βάση τη φυλή, το χρώμα, την εθνική καταγωγή, την ηλικία, την αναπηρία ή το φύλο.
Deutsch (German)	BMO erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Posted October 2020