UMR: LENNOX INTERNATIONAL INC.: Blue 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.LIIQuantum.com or by calling 1-877-220-2279. 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.LIIQuantum.com or call 1-877-220-2279 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$850 person / $2,550 family In-network $1,700 person / $5,100 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?	Yes. $250 Benefit deductible per calendar year for prescription drug expenses In-network	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out–of–pocket limit for this plan?	$7,825 person / $15,650 family In-network $15,650 person / $31,300 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?	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.LIIQuantum.com or call 1-877-220-2279 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% Coinsurance	40% Coinsurance	None
	Specialist visit	20% Coinsurance	40% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	Not covered	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)	No charge; 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. More information about prescription drug coverage is available at www.umr.com.	Tier 1 (generic and some brand-name)	10% Copay with a $10 Minimum up to a $20 Maximum per prescription (retail); 10% Copay with a $25 Minimum up to a $50 Maximum 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 Covers up to a 31-day supply (retail); 32-90 day supply (mail order); Covers up to a 31-day supply (specialty) You must pay the difference in cost between a Generic drug and a Brand-name drug, regardless of circumstances, 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)	30% Copay with a $50 Minimum up to a $100 Maximum per prescription (retail); 30% Copay with a $125 Minimum up to a $250 Maximum per prescription (mail order)		
	Tier 3 (nonpreferred brand-name and nonpreferred generic)	50% Copay with a $75 Minimum up to a $150 Maximum per prescription (retail); 50% Copay with a $187.50 Minimum up to a $375 Maximum per prescription (mail order)		
	Tier 4 (specialty drugs)	10% Copay with a $10 Minimum up to a $20 Maximum per prescription (Tier 1); 30% Copay with a $50 Minimum up to a $100 Maximum per prescription (Tier 2); 50% Copay with a $75 Minimum up to a $150 Maximum 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	

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 immediate medical attention	Emergency room care	$300 Copay per visit; 20% Coinsurance	$300 Copay per visit; 20% Coinsurance	In-network deductible applies to Out-of-network benefits; Copay may be waived if admitted
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	In-network deductible applies to Out-of-network benefits
	Urgent care	20% Coinsurance	40% Coinsurance	None
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 20% of the total cost of the service for Out-of-network only.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	40% Coinsurance	Preauthorization is required for Partial hospitalization.
	Inpatient services	20% Coinsurance	40% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service for Out-of-network only.
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 (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	60 Maximum visits per calendar year; Preauthorization is required.
	Rehabilitation services	20% Coinsurance	40% Coinsurance	None
	Habilitation services	20% Coinsurance	40% Coinsurance	Habilitation services for Learning Disabilities are not covered.
	Skilled nursing care	20% Coinsurance	40% Coinsurance	60 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service for Out-of-network only.
	Durable medical equipment	20% Coinsurance	40% Coinsurance	Preauthorization is required for DME in excess of $1,500 for purchases or all rentals.
	Hospice service	20% Coinsurance	40% Coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No charge; Deductible Waived	Not covered	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
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- 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 (In-network only)
- Chiropractic care – 40 visits per calendar year
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) - 1 exam per calendar year (In-network 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: 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 1-877-220-2279.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-877-220-2279.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-220-2279.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf die do Nummer uff 1-877-220-2279.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-220-2279.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-877-220-2279.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-877-220-2279.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-877-220-2279.

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	$850
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	$950
Copayments	$0
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,050**

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

The plan's overall deductible	$850
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*	$1,050
Copayments	$1,900
Coinsurance	$60
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,030**

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

The plan's overall deductible	$850
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*	$900
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

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.LIIQuantum.com or call 1-877-220-2279.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"" row above.

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