PPO MEDICAL PLAN HIGHLIGHTS

DEDUCTIBLE		
	IN-NETWORK	OUT OF NETWORK
INDIVIDUAL	$750	$1,500
FAMILY	$1,500	$3,000
OUT-OF-POCKET MAXIMUM (SYMBOL)		
	IN-NETWORK	OUT OF NETWORK
INDIVIDUAL	$3,000	$6,000
FAMILY	$6,000	$12,000
COPAYS		
	IN-NETWORK	OUT OF NETWORK
PREVENTIVE CARE	$0	30% After deductible
PRIMARY	$25	30% After deductible
SPECIALIST	$40	30% After deductible
TELADOC	$25	Not Covered
URGENT CARE	$25	30% After deductible
EMERGENCY ROOM	$300	$300
All other	20% after deductible	30% After deductible
PHARMACY		
	RETAIL	MAIL ORDER
GENERIC	$10/30 DAY SUPPLY	$20/90 DAY SUPPLY
PREFERRED	$30/30 DAY SUPPLY	$60/90 DAY SUPPLY
NON-PREFERRED	$60/30 DAY SUPPLY	$120/90 DAY SUPPLY
SPECIALTY	$100/30 DAY SUPPLY	$200/90 DAY SUPPLY

If you use a non-network pharmacy, you are responsible for payment up front. You may be reimbursed based on the lowest contracted amount

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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 1-800-826-9781. 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 1-800-826-9781 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$750 person / $1,500 family In-network $1,500 person / $3,000 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, 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?	$3,000 person / $6,000 family In-network $6,000 person / $12,000 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?	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 (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	$25 Copay per visit; Deductible Waived	30% Coinsurance	None
	Specialist visit	$40 Copay per visit; Deductible Waived	30% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	30% 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	30% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	30% Coinsurance	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 need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.caremark.com	Generic drugs (Tier 1)	$10 copay	100% up front. You may be reimbursed based on lowest contracted amount minus any applicable deductible or copay.	None
	Preferred brand drugs (Tier 2)	$30 copay		
	Non-preferred brand drugs (Tier 3)	$60 copay		
	Specialty drugs (Tier 4)	$100 copay		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	30% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	30% Coinsurance	None
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	$25 Copay per visit; Deductible Waived	30% Coinsurance	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	30% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
	Physician/surgeon fees	20% Coinsurance	30% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copay per visit; Deductible Waived office visits; 20% Coinsurance other outpatient services	30% Coinsurance	Preauthorization is required for Partial hospitalization. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
	Inpatient services	20% Coinsurance	30% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
If you are pregnant	Office visits	No charge; Deductible Waived	30% 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	30% Coinsurance	
	Childbirth/delivery facility services	20% Coinsurance	30% 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	30% Coinsurance	60 Maximum visits per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
	Rehabilitation services	20% Coinsurance	30% Coinsurance	30 Maximum visits per calendar year OT/PT; 20 Maximum visits per calendar year ST; Habilitation services for Learning Disabilities are not covered.
	Habilitation services	20% Coinsurance	30% Coinsurance	
	Skilled nursing care	20% Coinsurance	30% Coinsurance	60 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $250 of the total cost of the service.
	Durable medical equipment	20% Coinsurance	30% Coinsurance	1 Maximum purchase including repair & replacement every 3 calendar years; 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 $250 per occurrence.
	Hospice service	20% Coinsurance	30% 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 • Bariatric surgery • Cosmetic surgery • Dental care (Adult)	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine eye care (Adult) • 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.)		
• Chiropractic care – 24 visits per calendar year	• Hearing aids – 1 aid per ear every 3 years up to $2,500 including repair/replacement	• Infertility treatment - $10,000 per lifetime

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 1-800-826-9781.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-826-9781.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-826-9781

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf die do Nummer uff 1-800-826-9781.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-826-9781.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-826-9781.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-826-9781.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-826-9781.

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	**$750**
Specialist copayment	**$40**
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	$750
Copayments	$0
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$3,070**

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

The plan's overall deductible	**$750**
Specialist copayment	**$40**
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	$100
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,700**

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

The plan's overall deductible	**$750**
Specialist copayment	**$40**
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	$750
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,360**

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 1-800-826-9781.