UMR: NEW HOLSTEIN SCHOOL DISTRICT: 76-440288 001

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?	$1,000 person / $2,000 family In-network $2,000 person / $4,000 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?	$4,000 person / $8,000 family In-network $8,000 person / $16,000 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 1-800-207-3172 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 costs shown in this chart are applied before the deductible; coinsurance costs are applied after your deductible has been met, as applicable.

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	$25 Copay per visit; Deductible Waived	30% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	30% Coinsurance for Preventive care & screening; No charge; Deductible Waived for Immunizations	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.
If you have a test	Diagnostic test (x-ray, blood work)	$25 Copay per visit; Deductible Waived office setting; No charge outpatient setting	30% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	30% Coinsurance	None

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 for a 30-day supply, retail; $30 for a 31–90-day supply, retail; $20 for up to a 90-day supply, mail order.	$10 for a 30-day supply, retail; $30 for a 31–90-day supply, retail; $20 for up to a 90-day supply, mail order.	Deductible waived. Covered prescriptions on the Value Priced Generic Drug List have no copay. If you enroll in PrudentRx for any specialty medications you require, those medications will be covered at 100%. If you do not enroll in PrudentRx, specialty medications are subject to coinsurance shown under *What you will pay*. *Specialty prescriptions can only be obtained through a CVS Pharmacy or by CVS Caremark mail order to a maximum 30-day supply.
	Preferred brand drugs (Tier 2)	$30 for a 30-day supply, retail; $90 for a 31–90-day supply, retail; $60 for up to a 90-day supply, mail order.	$30 for a 30-day supply, retail; $90 for a 31–90-day supply, retail; $60 for up to a 90-day supply, mail order.	
	Non-preferred brand drugs (Tier 3)	$60 for a 30-day supply, retail; $180 for a 31–90-day supply, retail; $120 for up to a 90-day supply, mail order.	$60 for a 30-day supply, retail; $180 for a 31–90-day supply, retail; $120 for up to a 90-day supply, mail order.	
	Specialty drugs (Tier 4)	30% Coinsurance for up to a 30-day supply, retail, or mail order*.	30% Coinsurance for up to a 30-day supply, retail, or mail order*.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% Coinsurance	None
	Physician/surgeon fees	No charge	30% Coinsurance	None
If you need immediate medical attention	Emergency room care	$250 Copay per visit; Deductible Waived	$250 Copay per visit; Deductible Waived	Copay may be waived if admitted
	Emergency medical transportation	No charge	No charge	In-network deductible applies to Out-of-network benefits
	Urgent care	$100 Copay per visit; Deductible Waived	30% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% up to $250 of the total cost of the service for Out-of-network.
	Physician/surgeon fees	No charge	30% Coinsurance	

If you have mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copay per visit; Deductible Waived office visits; No charge other outpatient services	30% Coinsurance	None
	Inpatient services	No charge	30% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 25% up to $250 of the total cost of the service for Out-of-network.
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	No charge	30% Coinsurance	
	Childbirth/delivery facility services	No charge	30% Coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	30% Coinsurance	100 Maximum visits per calendar year
	Rehabilitation services	$25 Copay per visit; Deductible Waived	30% Coinsurance	60 Maximum combined visits per calendar year; Preauthorization is required. Habilitation services for Learning Disabilities are not covered.
	Habilitation services	$25 Copay per visit; Deductible Waived	30% Coinsurance	
	Skilled nursing care	No charge	30% Coinsurance	30 Maximum days per confinement; Preauthorization is required. If you don't get preauthorization, benefits

				could be reduced by 25% up to $250 of the total cost of the service for Out-of-network.
	Durable medical equipment	No charge	30% Coinsurance	Preauthorization is required for DME in excess of $1,000 for rentals or for purchases. If you don't get preauthorization, benefits could be reduced by 25% up to $250 per occurrence for Out-of-network.
	Hospice service	No charge	30% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge; Deductible Waived	No charge; Deductible Waived	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)
- 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.)

- Chiropractic care
- Hearing aids (to age 18)
- Non-emergency care when traveling outside the U.S.
- 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 U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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 18003182596.

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. 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
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.

This is only a summary. It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for the complete terms of this plan.

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	$1,000
Specialist copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$1,000
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$1,270**

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

The plan's overall deductible	$1,000
Specialist copayment	$25
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$420**

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

The plan's overall deductible	$1,000
Specialist copayment	$25
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,410**

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