Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit <a href="https://www.umr.com">www.umr.com</a> or by calling 1-800-826-9781. For general definitions of common terms, such as <a href="https://www.umr.com">allowed amount</a>, <a href="https://www.umr.com">balance billing</a>, <a href="https://coinsurance">coinsurance</a>, <a href="https://coinsurance">copayment</a>, <a href="https://deductible">deductible</a>, <a href="https://provider">provider</a>, or other <a href="https://www.umr.com">underlined</a> terms, see the Glossary. You can view the Glossary at <a href="https://www.umr.com">www.umr.com</a> or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$500 person / \$1,000 family In-network \$1,000 person / \$2,000 family Out-of-network	Generally, you must pay all the costs from providers

Common Medical Event	Services You May Need	What Yo	Limitations Evacations 9 Other		
		In-network (You will pay the least)	Out-of-network (You will pay the most)	Limitations, Exceptions, & Other Important Information	
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)	Benefits are applied by outside vendor	Benefits are applied by outside vendor		
	Preferred brand drugs (Tier 2)	Benefits are applied by outside vendor	Benefits are applied by outside vendor	Nama	
	Non-preferred brand drugs (Tier 3)	Benefits are applied by outside vendor	Benefits are applied by outside vendor	None	
	Specialty drugs (Tier 4)	Benefits are applied by outside vendor	Benefits are applied by outside vendor		
If you have outpatient surgery	Facility fee (e.g., ambulatory				

Common Medical Event		What Yo	Limitations Everytions 0 Other		
	Services You May Need	In-network (You will pay the least)	Out-of-network (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Preauthorization is required.	
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance		
If you have mental health, behavioral health, or	Outpatient services	\$20 Copay per visit; Deductible Waived Office visits; 20% Coinsurance other outpatient services	40% Coinsurance	Preauthorization is required for Partial hospitalization.	
substance abuse services	Inpatient services	20% Coinsurance	40% Coinsurance	Preauthorization is required.	

Common	Services You May Need	What You Will Pay		Limitations Eventions 9 Other	
Medical Event		In-network (You will pay the least)	Out-of-network (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	Preauthorization is required.	
	Rehabilitation services	\$20 Copay per visit; Deductible Waived office therapy; 20% Coinsurance hospital therapy	40% Coinsurance	90 Maximum visits per calendar year OT; 90 Maximum visits per calendar year PT; 40 Maximum visits per calendar year ST; Habilitation services for Learning Disabilities are not covered.	
	Habilitation services	\$20 Copay per visit; Deductible Waived office therapy; 20% Coinsurance hospital therapy	40% Coinsurance		
	Skilled nursing care	20% Coinsurance			
	Durable medical equipment	20% Coinsurance	40% Coinsurance	None	
	Hospice service				

## **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

- Routine foot care
- Weight loss programs

**About these Coverage Examples:** 

## Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>

■ <u>Specialist copayment</u> \$20

■ Hospital (facility) <u>coinsurance</u> 20%

Other coinsurance 20%

## This EXAMPLE event includes services like:

Specialist office visits (pre-natal care)

Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

<u>Diagnostic tests</u> (ultrasounds and blood work)

Specialist visit (anesthesia)

## Total Example Cost

\$12,700

\$500

In this example, Peg would pay: Ct8 (9TJ ET Q q 220.8 234.88 49.2 15 re W n BT /CS0 cs 0 scn /TT1 1 Tf 12 -0 0 12 234.08 180.Tm (\$)Tj ET Q q 220.8 162.88 49.2 15 re

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$

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

Mia's Simple Fracture

(in-network emergency room visit and follow up care)