UMR: ST. LUKE'S HOSPITAL: 7670-00-410532 002 Premium 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.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?	$150 person / $450 family Tier 1 $330 person / $990 family Tier 2 $625 person / $1,500 family Tier 3	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the 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, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out–of–pocket limit for this plan?	$700 person / $1,050 family Tier 1 $2,830 person / $5,690 family Tier 2 $5,325 person / $10,360 family Tier 3	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
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 (a 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
		Tier 1 (You will pay the least)	Tier 2	Tier 3 (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 Copay per visit	$20 Copay per visit	40% Coinsurance	Deductible Waived Tiers 1 & 2
	Specialist visit	$30 Copay per visit	$30 Copay per visit	40% Coinsurance	Deductible Waived Tiers 1 & 2
	Preventive care/screening/ immunization	Physician – No charge Facility – No charge	Physician – No charge Facility – No charge	Physician – 100% after deductible Facility – 40% coinsurance	Deductible Waived Preventive Care & screening to age 18;Deductible Waived Immunizations Tiers 1 & 2 to age 18; Deductible applies Immunizations Tier 3 to age 18 Deductible Waived Tiers 1 & 2 from age 18; Deductible Applies Tier 3 from age 18
If you have a test	Diagnostic test (x-ray, blood work)	Office Setting – $20 Copay for PCP $30 Copay for Specialist Outpatient Setting - 5% Coinsurance	Office Setting – $20 Copay for PCP – $30 Copay for Specialist Outpatient Setting – 25% Coinsurance	40% Coinsurance	Deductible Waived Tiers 1 & 2 office setting; Deductible Applies Tier 1 & 2 outpatient setting

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (You will pay the least)	Tier 2	Tier 3 (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	Office Setting – $20 Copay for PCP $30 Copay for Specialist Outpatient Setting - 5% Coinsurance	Office Setting – $20 Copay for PCP – $30 Copay for Specialist Outpatient Setting – 25% Coinsurance	40% Coinsurance	Deductible Waived Tiers 1 & 2 office setting; Deductible Applies Tier 1 outpatient setting
If you need drugs to treat your illness or condition.	Generic drugs	$9 Copay (retail); $18 Copay (mail order)	Retail Copays – First Fills $9 Refills $15 Mail Order Copays – First Fills $18 Refills $30	Retail Copays – First Fills $9 Refills $15 Mail order Copays – First Fills $18 Refills $30	Covers up to a 30 day supply (retail); 31-90 day supply (mail order More information about prescription drug coverage is available at; www.express.spripts.com or 844-583-7036
	Preferred brand drugs	$25 Copay (retail); $50 Copay (mail order)	Retail Copays – First Fills $25 Refills $30 Mail Order Copays – First Fills $50 Refills $67.50	Retail Copays – First Fills $25 Refills $30 Mail Order Copays – First Fills $50 Refills $67.50	
	Non-preferred brand drugs	$50 Copay (retail); $100 Copay (mail order)	Retail Copays- First Fills $50 Refills $55 Mail Order Copays – First Fills $100 Refills $130.	Retail Copays – First Fills $50 Refills $55 Mail Order Copays – First Fills $100 Refills $130.	
	Specialty drugs	Min $75 Copay Max $150 Copay	Min $75 Copay Max $150 Copay	Min $75 Copay Max $150 Copay	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (You will pay the least)	Tier 2	Tier 3 (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% Coinsurance	25% Coinsurance	40% Coinsurance	None
	Physician/surgeon fees	5% Coinsurance	5% Coinsurance	40% Coinsurance	Tier 1 deductible applies to Tier 2 benefits.
If you need immediate medical attention	Emergency room care	$150 Copay per visit	$150 Copay per visit	$150 Copay per visit	Deductible waived Copay may be waived if admitted
	Emergency medical transportation	5% Coinsurance	5% Coinsurance	5% Coinsurance	Tier 1 deductible applies to Tier 2 & 3 benefits.
	Urgent care	$20 Copay per visit	$35 Copay per visit	40% Coinsurance	Deductible waived Tier 1 & 2
If you have a hospital stay	Facility fee (e.g., hospital room)	5% Coinsurance	25% Coinsurance	40% Coinsurance	Prior authorization is required or benefit is reduced by $500 per admission
	Physician/surgeon fee	5% Coinsurance	5% Coinsurance	40% Coinsurance	Tier 1 deductible applies to Tier 2

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (You will pay the least)	Tier 2	Tier 3 (You will pay the most)	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$20 Copay per visit PCP $30 Copay per visit Specialist	$20 Copay per visit PCP $30 Copay per visit Specialist	40% Coinsurance	Deductible Waived Tiers 1 & 2
	Inpatient services	5% Coinsurance	5% Coinsurance	40% Coinsurance	Tier 1 deductible applies to Tier 2 benefits. Prior authorization is required or benefit reduced by $500 per admission
If you are pregnant	Office visits	$20 Copay per visit PCP $30 Copay per visit Specialist	$20 Copay per visit PCP $30 Copay per visit Specialist	40% Coinsurance	Tier 1 deductible applies to Tier 1 & 2 benefits for physician
	Childbirth/delivery professional services	5% Coinsurance	5% Coinsurance	40% Coinsurance	
	Childbirth/delivery facility services	5% Coinsurance	25% Coinsurance	40% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (You will pay the least)	Tier 2	Tier 3 (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	5% Coinsurance	25% Coinsurance	40% Coinsurance	90 Maximum visits per calendar year combined with Hospice Outpatient; Prior authorization is required
	Rehabilitation services	$20 Copay per visit PCP; $30 Copay per visit Specialist office therapy; 5% Coinsurance hospital therapy	$20 Copay per visit PCP; $30 Copay per visit Specialist office therapy; 25% Coinsurance hospital therapy	40% Coinsurance	60 Maximum visits per calendar year
	Habilitation services	5% Coinsurance	25% Coinsurance	40% Coinsurance	None
	Skilled nursing care	5% Coinsurance	25% Coinsurance	40% Coinsurance	Prior authorization required.
	Durable medical equipment	15% Coinsurance	15% Coinsurance	40% Coinsurance	Tier 1 deductible applies to Tier 2 Prior authorization is required for DME in excess of $500 for rentals or $1,500 for purchases
	Hospice service	5% Coinsurance	25% Coinsurance	40% Coinsurance	90 Maximum visits per calendar year combined with Home Healthcare; Prior authorization is required
If your child needs dental or eye care	Children's eye exam	$20 Copay per visit PCP $30 Copay per visit Specialist	$20 Copay per visit PCP $30 Copay per visit Specialist	40% Coinsurance	Deductible Waived Tiers 1 & 2 1 Maximum exam per calendar year
	Children's glasses	Not covered	Not covered	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (You will pay the least)	Tier 2	Tier 3 (You will pay the most)	
	Children's dental check-up	Not covered	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)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- 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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this plan Provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

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

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	$150
Specialist copayment	$30
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$150
Copayments	$30
Coinsurance	$640
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$820

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

The plan's overall deductible	$150
Specialist copayment	$30
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$150
Copayments	$120
Coinsurance	$370
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$640

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

The plan's overall deductible	$150
Specialist copayment	$30
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$150
Copayments	$30
Coinsurance	$95
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$275

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.
*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.