

St. Luke's Hospital

Premium Plan 2019 SCHEDULE OF BENEFITS

(This Summary of Benefits provides a simplified overview of the medical plan. The plan is governed by the terms of legal documents. We have taken care to ensure that the following are accurate. However, if there is a conflict between this Summary of Benefits chart and the legal documents, the legal documents will be followed.)

DESCRIPTION OF MEDICAL BENEFITS – Premium Plan	ST. LUKE'S NETWORK Tier 1	UNITED HEALTHCARE NETWORK Tier 2	OUT OF NETWORK Tier 3
Calendar Year Deductible			
• Individual	\$150	\$375	\$750
• Family	\$450	\$1000	\$2000
Calendar Year Out-of-Pocket Maximum (Includes deductible amount listed above)			
• Individual	\$700	\$2,830	\$5,325
• Family	\$1050	\$5,690	\$10,360
Pharmacy Calendar Year Out-of-Pocket Maximum			
• Individual	\$750	\$1,000	\$2,500
• Family	\$1,050	\$1,500	\$5,000
Pre-Certification Requirements*			
<ul style="list-style-type: none"> • Inpatient <ul style="list-style-type: none"> ○ Elective admissions must be pre-certified prior to any elective admission to a Hospital, Hospice Facility, Residential Treatment Facility or Skilled Nursing Facility, or within 2 working days for emergency admissions. ○ A \$500 deductible for each period of confinement may be imposed for failure to pre-certify inpatient confinements. This deductible does not apply to the Out-of-Pocket Maximum. • Treatment Plan Certification <ul style="list-style-type: none"> ○ Treatment plans may be required for some services (i.e., Chemotherapy) in order to determine length and type of service for payment purposes. • Additional Care Requiring Precertification <ul style="list-style-type: none"> ○ Clinical Trials ○ Spinal/Back Surgery for Tier 2 and Tier 3 ○ Pain Management including injectables for Tier 2 and Tier 3 			
<p>*All plan options may require pre-certification, pre-determination, preauthorization, treatment plan information, or a letter of medical necessity depending upon the specific medical treatment or procedure. You may contact UMR at 1-800-826-9781 for specific information.</p>			
Hospital / Facility Services	95%	75%	60%
• Inpatient	After deductible	After deductible	After deductible
• Outpatient – including, but not limited to X-Ray, Lab and other Diagnostic Services	95%	75%	60%
	After deductible	After deductible	After deductible
• Outpatient – CT Scan, MRI and PET Scan	95%	75%	60%
	After deductible	After deductible	After deductible
Emergency Room Services			
Only Medical Emergencies as defined by the Plan are covered. Copay waived if patient is admitted as an Inpatient, then Inpatient benefits apply	\$150 copay then 100% No deductible	\$150 copay then 100% No deductible	\$150 copay then 100% No deductible
		UNITED	

DESCRIPTION OF MEDICAL BENEFITS – Premium Plan	ST. LUKE'S NETWORK Tier 1	HEALTHCARE NETWORK Tier 2	OUT OF NETWORK Tier 3
Urgent Care Facility	\$20 copay then 100% No deductible	\$35 copay then 100% No deductible	60% After deductible
Pre-Admission Testing	95% After deductible	75% After deductible	60% After deductible
Outpatient Surgery At Hospital or Ambulatory Surgical Center	95% After deductible	75% After deductible	60% After deductible
<ul style="list-style-type: none"> Facility Surgeon and Anesthesiologist Pathologist and Radiologist 	95% After Tier 1 deductible		60% After deductible
Voluntary Second Surgical Opinion			
<ul style="list-style-type: none"> Primary Care Physician 	\$20 copay then 100% No deductible		60% After deductible
<ul style="list-style-type: none"> Specialist 	\$30 copay then 100% No deductible		60% After deductible
Physician Office Services – All services performed in the Physician's office including:			
<ul style="list-style-type: none"> Office visits Surgical procedures Laboratory and x-ray (test obtained and processed in office only) Eye Exam, limited to 1 per calendar year Allergy injections Allergy testing Chemotherapy administration, injectables, medications, casts, and other treatment materials (see Pre-cert requirements). 			
- Primary Care Physician	\$20 copay then 100% No deductible		60% After deductible
- Specialist	\$30 copay then 100% No deductible		60% After deductible
Physician Services Other – Inpatient or Outpatient			
<ul style="list-style-type: none"> Surgeon and Assistant Surgeon Anesthesiologist, Radiologist and Pathologist – services rendered by a Tier 3 Anesthesiologist, Radiologist or Pathologist at a Tier 1 or Tier 2 facility will be paid at the higher coinsurance level of the facility. 	95% After Tier 1 deductible		60% After deductible
Labs Performed Outside Physician Office – Diagnostic	95% After deductible	75% After deductible	60% After deductible
Wellness Care			
<ul style="list-style-type: none"> Preventative/Routine adult office visit (18yrs+), including diabetes screening, routine lab and x-ray, counseling and screening for HIV, as necessary to obtain covered preventative services, 1 per calendar year (all appropriate immunizations per UMR guidelines) 			
- Facility	100% No deductible		60% After deductible
- Physician	100% No deductible		100% After deductible
	ST. LUKE'S	UNITED HEALTHCARE	OUT OF

DESCRIPTION OF MEDICAL BENEFITS – Premium Plan	NETWORK Tier 1	NETWORK Tier 2	NETWORK Tier 3
<ul style="list-style-type: none"> Well woman gynecological exams and pap smear, including routine lab processing, as necessary to obtain covered preventative services Obstetrical Care, as necessary to obtain specified preventative services including routine prenatal visits, tobacco cessation counseling and immunizations (note: this does not include delivery or high risk maternity services) Screening and counseling for STD's and domestic violence HPV testing and counseling (30yrs+ 1 every 3 years) 2 ultrasounds covered at 100% of allowable, gestational diabetes screening (2 per pregnancy) Approved contraceptive methods, including sterilization Breastfeeding supplies, counseling and support, including rental of breast pump. Covers purchase of non-hospital grade breast pump or new supplies for existing pump (1 per pregnancy) <ul style="list-style-type: none"> - Facility 	100% No deductible	100% No deductible	60% After deductible
<ul style="list-style-type: none"> - Physician 	100% No deductible	100% No deductible	100% No deductible
<ul style="list-style-type: none"> Mammograms <ul style="list-style-type: none"> - Facility 	100% No deductible	100% No deductible	60% After deductible
<ul style="list-style-type: none"> - Physician 	100% No deductible	100% No deductible	100% No deductible
<ul style="list-style-type: none"> Colonoscopy, limited to 1 routine test every 10 years starting at age 50. Includes anesthesia <ul style="list-style-type: none"> - Facility 	100% No deductible	100% No deductible	60% After deductible
<ul style="list-style-type: none"> - Physician 	100% No deductible	100% No deductible	100% No deductible
<ul style="list-style-type: none"> Well man PSA, including routine lab, limited to 1 per calendar year. <ul style="list-style-type: none"> - Facility 	100% No deductible	100% No deductible	60% After deductible
<ul style="list-style-type: none"> - Physician 	100% No deductible	100% No deductible	100% No deductible
<ul style="list-style-type: none"> Well baby care/pediatric exams (up to age 18), including all appropriate immunizations per UMR guidelines, lab and x-ray. (Note: annual school physicals are not covered.) <ul style="list-style-type: none"> - Facility 	100% No deductible	100% No deductible	50% No deductible
<ul style="list-style-type: none"> - Primary Care Physician 	100% No deductible	100% No deductible	100% No deductible
<ul style="list-style-type: none"> Other preventative/routine care as required under the Women's Preventative Services 	100% No deductible	100% No deductible	60% No deductible
DESCRIPTION OF MEDICAL BENEFITS – Premium Plan	ST. LUKE'S NETWORK Tier 1	UNITED HEALTHCARE NETWORK Tier 2	OUT OF NETWORK Tier 3

Mental/Nervous Disorders			
<ul style="list-style-type: none"> • Inpatient Treatment <ul style="list-style-type: none"> - Partial/Day program - Residential Treatment Facility 	95% After Tier 1 deductible		60% After deductible
<ul style="list-style-type: none"> • Outpatient Treatment <ul style="list-style-type: none"> - Primary Care Physician 	\$20 copay 100% No deductible		60% After deductible
<ul style="list-style-type: none"> - Specialist 	\$30 copay 100% No deductible		60% After deductible
Alcoholism and Drug Abuse			
<ul style="list-style-type: none"> • Inpatient Treatment <ul style="list-style-type: none"> - Partial/Day program - Residential Treatment Facility 	95% After Tier 1 deductible		60% After deductible
<ul style="list-style-type: none"> • Outpatient Treatment <ul style="list-style-type: none"> - Primary Care Physician 	\$20 copay 100% No deductible		60% After deductible
<ul style="list-style-type: none"> - Specialist 	\$30 copay 100% No deductible		60% After deductible
Skilled Nursing Facility	95% After deductible	75% After deductible	60% After deductible
All stays are pre-certified for medical necessity.			
Clinical Trials			
<ul style="list-style-type: none"> • Includes services typically provided for other conditions • *Excludes investigational items or devices, data collection costs or services outside established standards of care. 	85% After deductible*	75% After deductible*	60% After deductible*
Home Health Care			
Must be within 14 days of a Hospital or Skilled Nursing Facility confinement, with a maximum of 90 visits (in combination with Outpatient Hospice Care) in a 12-month period. (Excludes custodial care).			
	95% After deductible	75% After deductible	60% After deductible
Hospice Care Services			
<ul style="list-style-type: none"> • Inpatient (See pre-certification requirements) 	95% After deductible	75% After deductible	60% After deductible
<ul style="list-style-type: none"> • Outpatient 	95% After deductible	75% After deductible	60% After deductible
Private Duty Nursing			
\$5,000 maximum per Calendar Year for all Inpatient and Outpatient private duty nursing combined (excludes custodial care).			
<ul style="list-style-type: none"> • Inpatient 	95% After Tier 2 deductible		50% After deductible
<ul style="list-style-type: none"> • Outpatient 	95% After Tier 2 deductible		50% After deductible
Maternity	Same as any other Illness		
Female Employees and Dependents			
Newborn	Same as any other Illness		
Well newborn covered first 5 days only by mother's coverage for nursery. Physician and circumcision (excludes grandchildren).			
Ambulance Services	95% After Tier 1 deductible		
DESCRIPTION OF MEDICAL BENEFITS – Premium Plan	ST. LUKE'S NETWORK Tier 1	UNITED HEALTHCARE NETWORK Tier 2	OUT OF NETWORK Tier 3
Physical Therapy			

Maximum of 60 visits in combination with occupational therapy and speech therapy.			
<ul style="list-style-type: none"> Facility 	95% After deductible	75% After deductible	60% After deductible
<ul style="list-style-type: none"> Physician 			60% After deductible
<ul style="list-style-type: none"> - Primary Care Physician 	\$20 copay then 100% No deductible		60% After deductible
<ul style="list-style-type: none"> - Specialist 	\$30 copay then 100% No deductible		60% After deductible
Occupational Therapy			
Maximum of 60 visits in combination with physical therapy and speech therapy.			
<ul style="list-style-type: none"> Facility 	95% After deductible	75% After deductible	60% After deductible
<ul style="list-style-type: none"> Physician 			60% After deductible
<ul style="list-style-type: none"> - Primary care Physician 	\$20 copay then 100% No deductible		60% After deductible
<ul style="list-style-type: none"> - Specialist 	\$30 copay then 100% No deductible		60% After deductible
Speech Therapy			
Maximum of 60 visits in combination with physical therapy and occupational therapy.			
<ul style="list-style-type: none"> Facility 	95% After deductible	75% After deductible	60% After deductible
<ul style="list-style-type: none"> Physician 			60% After deductible
<ul style="list-style-type: none"> - Primary Care Physician 	\$20 copay then 100% No deductible		60% After deductible
<ul style="list-style-type: none"> - Specialist 	\$30 copay then 100% No deductible		60% After deductible
Habilitation Services			
	95% After deductible	75% After deductible	60% After deductible
Inhalation Therapy and Radiation Therapy			
<ul style="list-style-type: none"> Facility 	95% After deductible	75% After deductible	60% After deductible
<ul style="list-style-type: none"> Physician 			60% After deductible
<ul style="list-style-type: none"> - Primary Care Physician 	\$20 copay then 100% No deductible		60% After deductible
<ul style="list-style-type: none"> - Specialist 	\$30 copay then 100% No deductible		60% After deductible
Transplant Services:			
<ul style="list-style-type: none"> - Physician - Facility – Designated Transplant Centers of Excellence 	90% After Tier 1 deductible		Not Covered
Transplant Services:			
<ul style="list-style-type: none"> - Travel and housing Maximum Benefit per transplant 	\$10,000		Not Covered
DESCRIPTION OF MEDICAL BENEFITS – Premium	ST. LUKE’S NETWORK	UNITED HEALTHCARE NETWORK	OUT OF NETWORK
	Tier 1	Tier 2	Tier 3
Durable Medical Equipment – Charges over \$500 must be pre-certified.	85% After Tier 2 deductible		60% After deductible
	90%		60%

Artificial Limbs/Prosthesis	After Tier 2 deductible		After deductible
Chiropractic Care	Not Covered		
All Other Covered Facility Charges	95% After deductible	85% After deductible	60% After deductible
All Other Covered Physician Charges	95% After Tier 1 deductible		60% After deductible
Services for Inpatient Neonatal Intensive Care Unit, Inpatient Pediatric Intensive Care Unit, Inpatient Burns and Inpatient Eating Disorders	95% After Tier 1 deductible		60% After deductible
<p>Prescription Drugs The amounts you pay for the plan's copays, coinsurance, and deductible for any preferred prescription drug for which there is a medically appropriate generic prescription drug available and for non-preferred prescription drugs, as well as all related penalties and additional charges for such drugs, are excluded from the Out-of-Pocket Maximum amounts. For more information about which generic and preferred prescription drugs constitute Essential Health Benefits and under what circumstances, please contact St. Luke's Benefit Office.</p> <ul style="list-style-type: none"> Retail – (Prescriptions refilled at Tier 1 network will be discounted). 	<p><u>Tier 1 & Tier 2-3 First Fills (Copay)</u> Generic - \$9.00 Preferred - \$25.00 Non-Preferred - \$50.00</p>		<p><u>Tier 2 & 3 Refills (Copay)</u> Generic - \$15.00 Preferred - \$30.00 Non-Preferred - \$55.00</p>
<ul style="list-style-type: none"> Specialty Rx/30 day All specialty prescriptions must be filled through Accredo/Express Scripts or at St. Luke's Hospital pharmacy 	<p><u>Minimum Copay \$75.00</u> <u>Maximum Copay \$150.00</u></p>		
<ul style="list-style-type: none"> Mail Order / 90-day Generic Preferred Brand Non-Preferred Brand 	<p>\$18.00 copay \$50.00 copay \$100.00 copay</p>	<p>\$30.00 copay \$67.50 copay \$130.00 copay</p>	
<p>Note:</p> <ol style="list-style-type: none"> Covered Expenses rendered by a non Tier 1 or Tier 2 provider will be paid at the Tier 1 level (not subject to usual and customary limits) if the Covered Person is a student attending school outside the service area, except in the case of elective surgery, or routine visits or checkups. Covered Person traveling outside the service area with a Medical Emergency will have hospital charge paid at the Tier 1 level. For questions about services not provided at St. Luke's Hospital please contact the Benefits Office. 			

Revised 10/18



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.umar.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.umar.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 \$375 person / \$1,000 family Tier 2 \$750 person / \$2,000 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.umar.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 <u>prescription drug coverage</u> is available at; www.express.scripts.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](#).)

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (adult) | <ul style="list-style-type: none"> • Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$30
Coinsurance	\$640
<i>What isn't covered</i>	
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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$150
Copayments	\$120
Coinsurance	\$370
<i>What isn't covered</i>	
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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$150
Copayments	\$30
Coinsurance	\$95
<i>What isn't covered</i>	
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.umar.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.