UMR: ST LUKE'S HOSPITAL: 7670-02-410532 002

Coverage for: Individual + Family | **Plan Type:** PPO

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?	**$200** person / **$450** family Tier 1 **$600** person / **$1,500** family Tier 2 **$1,500** person / **$2,200** family Tier 3	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?	**$1,250** person / **$2,000** family Tier 1 Pharmacy Specific - **$750** person / **$1,050** Family Tier 1 **$3,700** person / **$7,000** family Tier 2 Pharmacy Specific - **$1,000** person / **$1,500** Family Tier 2 **$6,325** person / **$11,360** family Tier 3 Pharmacy Specific - **$2,500** person / **$5,000** Family Tier 3	The out-of-pocket limit is the most you could pay in a year for covered services. If you take medications, you must also meet the pharmacy specific out-of-pocket. 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
		Tier 1	Tier 2	Tier 3	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 Copay per visit; Deductible Waived	$10 Copay per visit; Deductible Waived	40% Coinsurance	None
	Specialist visit	$15 Copay per visit; Deductible Waived	$15 Copay per visit; Deductible Waived	40% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	No charge; Deductible Waived	No charge; Deductible Waived physician all ages; 40% Coinsurance; Deductible Waived facility to age 18; 40% Coinsurance facility from age 18	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1	**Tier 2**	**Tier 3**	
If you have a test	Diagnostic test (x-ray, blood work)	No charge; Deductible Waived office setting; 10% Coinsurance outpatient setting	No charge; Deductible Waived office setting; 25% Coinsurance outpatient setting	40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge; Deductible Waived office setting; 10% Coinsurance outpatient setting	No charge; Deductible Waived office setting; 25% Coinsurance outpatient setting	40% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 and Tier 2-3 First Fill	**Tier 2 Refills**	**Tier 3 Refills**	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at https://app.cap-rx.com/login.	Generic drugs (Tier 1)	**30-day supply -** $10.00 **> 30-day supply -** $20.00	**30-day supply -** $15.00 **> 30-day supply -** $30.00	**30-day supply -** $15.00 **> 30-day supply -** $30.00	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 (Tier 3), as well as all related penalties and additional charges for such drugs, are excluded from the Out-of-Pocket Maximum amounts. Prescription drugs considered non-formulary are not covered. 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 or call Capital Rx Customer Care at 1-888-302-2779.
	Preferred brand drugs (Tier 2)	**30-day supply -** $25.00 **> 30-day supply -** $50.00	**30-day supply -** $30.00 **> 30-day supply -** $67.50	**30-day supply -** $30.00 **> 30-day supply -** $67.50	
	Non-preferred brand drugs (Tier 3)	**30-day supply -** $50.00 **> 30-day supply -** $100.00	**30-day supply -** $75.00 **> 30-day supply -** $187.00	**30-day supply -** $75.00 **> 30-day supply -** $187.00	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	
	Specialty drugs (Tier 4)	**All fills** - $150	**All fills** - $150	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	25% Coinsurance	40% Coinsurance	None
	Physician/surgeon fees	10% Coinsurance	10% Coinsurance	40% Coinsurance	Tier 1 deductible applies to Tier 2 benefits physician/surgeon
If you need immediate medical attention	Emergency room care	$200 Copay per visit; Deductible Waived	$200 Copay per visit; Deductible Waived	$200 Copay per visit; Deductible Waived	Copay may be waived if admitted
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	10% Coinsurance	Tier 1 deductible applies to Tier 2 & 3 benefits
	Urgent care	$20 Copay per visit; Deductible Waived	$35 Copay per visit; Deductible Waived	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	25% Coinsurance	40% Coinsurance	Tier 1 deductible applies to Tier 2 benefits physician/surgeon; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Physician/surgeon fee	10% Coinsurance	10% Coinsurance	40% Coinsurance	
If you have mental health, behavioral health, or substance	Outpatient services	$10 Copay per visit; Deductible Waived office visits;	$10 Copay per visit; Deductible Waived office visits; 25% Coinsurance facility; 10% Coinsurance	40% Coinsurance	Tier 1 deductible applies to Tier 2 benefits physician other outpatient services

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	
abuse services		10% Coinsurance other outpatient services	physician other outpatient services		
	Inpatient services	10% Coinsurance	25% Coinsurance facility; 10% Coinsurance physician	40% Coinsurance	Tier 1 deductible applies to Tier 2 benefits physician; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
If you are pregnant	Office visits	No charge; Deductible Waived	No charge; Deductible Waived	40% Coinsurance	Tier 1 deductible applies to Tier 2 benefits physician; Cost sharing does not apply to certain 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	10% Coinsurance	10% Coinsurance	40% Coinsurance	
	Childbirth/delivery facility services	10% Coinsurance	25% Coinsurance	40% Coinsurance	
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	25% Coinsurance	40% Coinsurance	90 Maximum visits in a 12 month period; Preauthorization is required.
	Rehabilitation services	$10 Copay per visit PCP; $15 Copay per visit Specialist; Deductible Waived office therapy; 10% Coinsurance hospital therapy	$10 Copay per visit PCP; $15 Copay per visit Specialist; Deductible Waived office therapy; 25% Coinsurance hospital therapy	40% Coinsurance	60 Maximum visits per calendar year
	Habilitation services				

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	
	Skilled nursing care	10% Coinsurance	25% Coinsurance	40% Coinsurance	Preauthorization is required.
	Durable medical equipment	15% Coinsurance	15% Coinsurance	40% Coinsurance	Tier 2 deductible applies to Tier 1 benefits; Preauthorization is required for DME in excess of $500 for rentals or purchases.
	Hospice service	10% Coinsurance	25% Coinsurance	40% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	$10 Copay per visit PCP; $15 Copay per visit Specialist; Deductible Waived	$10 Copay per visit PCP; $15 Copay per visit Specialist; Deductible Waived	40% Coinsurance	1 Maximum exam per calendar year
	Children's glasses	Not covered	Not covered	Not covered	None
	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
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Bariatric surgery
- Private-duty nursing (Outpatient care)
- 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 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. 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-826-9781.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-826-9781.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-826-9781.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 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** **$200**
- **Specialist copayment** **$15**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$200
Copayments	$60
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$1,330**

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

- **The plan's overall deductible** **$200**
- **Specialist copayment** **$15**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,570**

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

- **The plan's overall deductible** **$200**
- **Specialist copayment** **$15**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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*	$200
Copayments	$200
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,410**

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.