St. Luke's Hospital

Basic Plan
2021 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 – Basic Plan	**ST. LUKE'S NETWORK** Tier 1	**UNITED HEALTHCARE NETWORK** Tier 2	**OUT OF NETWORK** Tier 3
Calendar Year Deductible			
• Individual	$150	$1080	$2,620
• Family	$450	$3,240	$5,120
Calendar Year Out-of-Pocket Maximum (Includes deductible amount listed above) • Individual	$1,650	$5,780	$9,190
• Family	$3,450	$13,520	$18,800
Pharmacy Calendar Year Out-of-Pocket Maximum			
• Individual	$750	$1,000	$2,500
• Family	$1,050	$1,500	$5,000
Pre-Certification Requirements* • Inpatient ◦ 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 ◦ 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 ◦ Clinical Trials ◦ Spinal/Back Surgery for Tier 2 and Tier 3 ◦ Pain Management including injections for Tier 2 and Tier 3 ***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.**			
Hospital / Facility Services • Inpatient	85% After deductible	65% After deductible	50% After deductible
• Outpatient – including, but not limited to X-Ray, Lab and other Diagnostic Services	85% After deductible	65% After deductible	50% After deductible
• Outpatient – CT Scan, MRI and PET Scan	85% After deductible	65% After deductible	50% 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

DESCRIPTION OF MEDICAL BENEFITS – Basic Plan	ST. LUKE'S NETWORK Tier 1	UNITED HEALTHCARE NETWORK Tier 2	OUT OF NETWORK Tier 3
Urgent Care Facility	$35 copay then 100% No deductible	$50 copay then 100% No deductible	50% After deductible
Pre-Admission Testing	85% After deductible	65% After deductible	50% After deductible
Outpatient Surgery At Hospital or Ambulatory Surgical Center			
• Facility	85% After deductible	65% After deductible	50% After deductible
• Surgeon and Anesthesiologist • Pathologist and Radiologist	85% After Tier 1 deductible		50% After deductible
Voluntary Second Surgical Opinion • Primary Care Physician	$15 copay 100% No deductible	$30 copay 100% No deductible	50% After deductible
• Specialist	$20 copay 100% No deductible	$40 copay 100% No deductible	50% After deductible
Physician Office Services – All services performed in the Physician's office including: • 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	$15 copay 100% No deductible	$30 copay 100% No deductible	50% After deductible
- Specialist	$20 copay-100% No deductible	$40 copay-100% No deductible	50% After deductible
Physician Services Other – Inpatient or Outpatient • 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.	85% After Tier 1 deductible		50% After deductible
Labs Performed Outside Physician Office – Diagnostic	85% After deductible	65% After deductible	50% After deductible
Wellness Care • 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	100% No deductible	50% After deductible
- Physician	100% No deductible		100% After deductible

DESCRIPTION OF MEDICAL BENEFITS – Basic Plan	ST. LUKE'S NETWORK Tier 1	UNITED HEALTHCARE NETWORK Tier 2	OUT OF NETWORK Tier 3
• 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) - Facility	100% No deductible	100 % No deductible	50% After deductible
- Physician	100% No deductible		100% No deductible
• Mammograms - Facility	100% No deductible		50% After deductible
- Physician	100% No deductible		100% No deductible
• Colonoscopy Limited to 1 routine test every 10 years starting at age 50. Includes anesthesia. - Facility	100% No deductible		50% After deductible
- Physician	100% No deductible		100% No deductible
• Well man PSA, including routine lab, limited to **1 per calendar year.** - Facility	100% No deductible		50% After deductible
- Physician	100% No deductible		100% No deductible

DESCRIPTION OF MEDICAL BENEFITS – Basic Plan	ST. LUKE'S NETWORK Tier 1	UNITED HEALTHCARE NETWORK Tier 2	OUT OF NETWORK Tier 3
• 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.) - Facility	100% No deductible		50% No deductible
- Primary Care Physician	100% No deductible		100% No deductible
• Other preventative/routine care as required under the Women's Preventative Services	100% No deductible		50% No deductible
Mental/Nervous Disorders • Inpatient Treatment - Partial/Day program - Residential Treatment Facility	85% After Tier 1 deductible		50% After deductible
• Outpatient Treatment - Primary Care Physician	$30 copay 100% No deductible		50% After deductible
- Specialist	$40 copay 100% No deductible		50% After deductible
Alcoholism and Drug Abuse • Inpatient Treatment - Partial/Day program - Residential Treatment Facility	85% After Tier 1 deductible		50% After deductible
• Outpatient Treatment - Primary Care Physician	$30 copay 100% No deductible		50% After deductible
- Specialist	$40 copay 100% No deductible		50% After deductible
Skilled Nursing Facility All stays are pre-certified for medical necessity.	85% After deductible	65% After deductible	50% After deductible
Clinical Trials • 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*	65% After deductible*	50% 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).	85% After deductible	65% After deductible	50% After deductible
Hospice Care Services • Inpatient (See pre-certification requirements)	85% After deductible	65% After deductible	50% After deductible
• Outpatient	85% After deductible	65% After deductible	50% After deductible

	ST. LUKE'S	UNITED HEALTHCARE	OUT OF

DESCRIPTION OF MEDICAL BENEFITS – Basic Plan	NETWORK Tier 1	NETWORK Tier 2	NETWORK Tier 3
Private Duty Nursing $5,000 maximum per Calendar Year for all Inpatient and Outpatient private duty nursing combined (excludes custodial care). • Inpatient	50% After Tier 2 deductible		50% After deductible
• Outpatient	85% After Tier 2 deductible		50% After deductible
Maternity Female Employees and Dependents	Same as any other Illness		
Newborn Well newborn covered first 5 days only by mother's coverage for nursery. Physician and circumcision (excludes grandchildren).	Same as any other Illness		
Ambulance Services	85% After Tier 1 deductible		
Physical Therapy Maximum of 60 visits in combination with occupational therapy and speech therapy. • Facility	85% After deductible	65% After deductible	50% After deductible
• Physician - Primary care Physician	$15 copay-100% No deductible	$30 copay-100% No deductible	50% After deductible
- Specialist	$20 copay-100% No deductible	$40 copay-100% No deductible	50% After deductible
Occupational Therapy Maximum of 60 visits in combination with physical therapy and speech therapy. • Facility	85% After deductible	65% After deductible	50% After deductible
• Physician - Primary care Physician	$15 copay-100% No deductible	$30 copay-100% No deductible	50% After deductible
- Specialist	$20 copay-100% No deductible	$40 copay-100% No deductible	50% After deductible
Speech Therapy Maximum of 60 visits in combination with physical therapy and occupational therapy. • Facility	85% After deductible	65% After deductible	50% After deductible
• Physician - Primary Care Physician	$15 copay-100% No deductible	$30 copay-100% No deductible	50% After deductible
- Specialist	$20 copay-100% No deductible	$40 copay-100% No deductible	50% After deductible
Habilitation Services	85% After deductible	65% After deductible	50% After deductible
Inhalation Therapy and Radiation Therapy • Facility	85% After deductible	65% After deductible	50% After deductible
• Physician - Primary Care Physician	$15 copay-100% No deductible	$30 copay-100% No deductible	50% After deductible
- Specialist	$20 copay-100% No deductible	$40 copay-100% No deductible	50% After deductible

DESCRIPTION OF MEDICAL BENEFITS – Basic Plan	ST. LUKE'S NETWORK	UNITED HEALTHCARE NETWORK	OUT OF NETWORK

	Tier 1	Tier 2	Tier 3
Transplant Services: - Physician - Facility – Designated Transplant Centers of Excellence	90% After Tier 2 deductible		Not Covered
Transplant Services: - Travel and housing Maximum Benefit per transplant	$10,000		Not Covered
Durable Medical Equipment – Charges over $500 must be pre-certified.	75% After Tier 2 deductible		50% After deductible
Artificial Limbs/Prosthesis	80% After Tier 2 deductible		50% After deductible
Chiropractic Care	Not Covered		
All Other Covered Facility Charges	85% After deductible	65% After deductible	50% After deductible
All Other Covered Physician Charges	85% After Tier 1 deductible		50% After deductible
Services for Inpatient Neonatal Intensive Care Unit, Inpatient Pediatric Intensive Care Unit, Inpatient Burns and Inpatient Eating Disorders	85% After Tier 1 deductible		50% After deductible
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. (*Refer to Appendix Section D for additional information)* • Retail – (Prescriptions refilled at Tier 1 network will be discounted).	**<u>Tier 1 & Tier 2-3 First Fills (Copay)</u>** Generic - $12.00 Preferred - $25.00 Non–Preferred - $50.00		**<u>Tier 2 & 3 Refills (Copay)</u>** Generic - $18.00 Preferred - $30.00 Non-Preferred - $55.00
• Specialty Rx/30-day All specialty prescriptions must be filled through MedImpact or at St. Luke's Hospital pharmacy	**<u>Copay $150.00</u>**		
• Mail Order / 90-day Generic Preferred Brand Non-Preferred Brand	 $24.00 copay $50.00 copay $100.00 copay		 $36.00 copay $67.50 copay $130.00 copay

Note:

1. 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.
2. Covered Person traveling outside the service area with a Medical Emergency will have hospital charge paid at the Tier 1 level.
3. For questions about services not provided at St. Luke's please contact the Benefits Office.

UMR: ST. LUKE'S HOSPITAL: 7670-00-410532 001 Basic 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 $1080 person / $3,240 family Tier 2 $2,620 person / $5,120 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?	$1,650 person / $3,450 family Tier 1 $5,780 person / $13,520 family Tier 2 $9,190 person / $18,800 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	$15 Copay per visit	$30 Copay per visit	50% Coinsurance	Deductible Waived Tiers 1 & 2
	Specialist visit	$20 Copay per visit	$40 Copay per visit	50% Coinsurance	Deductible Waived Tiers 1 & 2
	Preventive care/screening/ immunization	Physician – No charge Facility – No charge	Physician – No charge Facility – No charge	Physician - 100% Facility – 50%	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 – No charge Outpatient Setting - 15% Coinsurance	Office Setting – No charge Outpatient Setting - 35% Coinsurance	50% Coinsurance	Deductible Waived Tiers 1 & 2 office 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 – No charge Outpatient Setting - 15% Coinsurance	Office Setting – No charge Outpatient Setting -35% Coinsurance	50% Coinsurance	Deductible Waived Tiers 1 & 2 office setting
If you need drugs to treat your illness or condition.	Generic drugs	$12 Copay (retail); $24 Copay (mail order)	Retail Copays - First Fills $12 Refills $18 Mail Order Copays - First Fills $24 Refills $36	Retail Copays - First Fills $12 Refills $18 Mail order Copays - First Fills $24 Refills $36	Covers up to a 30 day supply (retail); 31-90 day supply (mail order More information about prescription drug coverage is available at; www.Medimpact.com or 888-495-3168
	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	$150 Copay	$150 Copay	$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)	15% Coinsurance	35% Coinsurance	50% Coinsurance	None
	Physician/surgeon fees	15% Coinsurance	15% Coinsurance	50% 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	15% Coinsurance	15% Coinsurance	15% Coinsurance	Tier 1 deductible applies to Tier 1 2 & 3 benefits.
	Urgent care	$35 Copay per visit	$50 Copay per visit	50% Coinsurance	Deductible waived Tier 1 & 2
If you have a hospital stay	Facility fee (e.g., hospital room)	15% Coinsurance	35% Coinsurance	50% Coinsurance	Prior authorization is required, or benefits could be reduced by $500 per admission
	Physician/surgeon fee	15% Coinsurance	15% Coinsurance	50% 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	$15 Copay per visit PCP $20 Copay per visit Specialist	$30 Copay per visit PCP $40 Copay per visit Specialist	50% Coinsurance	Deductible Waived Tiers 1 & 2
	Inpatient services	15% Coinsurance	15% Coinsurance	50% Coinsurance	Tier 1 deductible applies to Tier 2 benefits; Prior authorization is required or benefit is reduced by $500 per admission
If you are pregnant	Office visits	$15 Copay per visit PCP $20 Copay per visit Specialist	$30 Copay per visit PCP $40 Copay per visit Specialist	50% Coinsurance	Deductible Waived Tiers 1 & 2 for prenatal care. Tier 1 deductible applies to Tier 2 benefits for physician.
	Childbirth/delivery professional services	15% Coinsurance	15% Coinsurance physician	50% Coinsurance	
	Childbirth/delivery facility services	15% Coinsurance	35% Coinsurance facility;	50% 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	15% Coinsurance	35% Coinsurance	50% Coinsurance	90 Maximum visits per calendar year combined with Hospice Outpatient; Prior authorization is required
	Rehabilitation services	$15 Copay per visit PCP $20 Copay per visit Specialist office therapy 15% Coinsurance hospital therapy	$30 Copay per visit PCP $40 Copay per visit Specialist office therapy 35% Coinsurance hospital therapy	50% Coinsurance	60 Maximum visits per calendar year
	Habilitation services	15% Coinsurance	35% Coinsurance	50% Coinsurance	None
	Skilled nursing care	15% Coinsurance	35% Coinsurance	50% Coinsurance	Prior authorization required.
	Durable medical equipment	25% Coinsurance	25% Coinsurance	50% Coinsurance	Tier 2 deductible applies to Tier 1 benefits; Prior authorization is required for DME in excess of $500 for rentals or $1,500 for purchases
	Hospice service	15% Coinsurance	35% Coinsurance	50% 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	$15 Copay per visit PCP $20 Copay per visit Specialist	$30 Copay per visit PCP $40 Copay per visit Specialist	50% Coinsurance	Deductible Waived Tiers 1 & 2 1 Maximum exam per calendar year

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 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
- 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	$20
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$20
Coinsurance	$1,920
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$2,090

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	$20
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$80
Coinsurance	$1,110
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,340

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

The plan's overall deductible	$150
Specialist copayment	$20
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$20
Coinsurance	$285
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$455

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.