St. Luke's Hospital

High Deductible Health 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 and the legal documents, the legal documents will be followed.)

DESCRIPTION OF MEDICAL BENEFITS - HDHP	**ST. LUKE'S NETWORK** Tier 1	**UNITED HEALTHCARE NETWORK** Tier 2	**OUT OF NETWORK** Tier 3
Calendar Year Deductible			
• Individual	$1,400	$3,500	$4,200
• Family	$2,800	$6,000	$7,400
Health Savings Account /St. Luke's Contribution			
• **Individual**	$500		
• **Family**	$1000		
Calendar Year Out-of-Pocket Maximum (Includes deductible amounts listed above)			
• Individual	$1,900	$5,500	$6,700
• Family- Members of an enrolled family must pay deductible expense in a year equal to the Family Deductible before medical benefits are paid.	$3,800	$10,000	$12,400
Pharmacy Calendar Year Out-of-Pocket Maximum.			
• Individual	$750	$1,000	$2,500
• Family	$1,050	$1,500	$5,000

Pre-Certification Requirements*
• Inpatient
  o 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.
  o 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
  o 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
  o Clinical Trials
  o Spinal / Back Surgery for Tier 2 and Tier 3
  o Pain Management including injectables 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	90%	80%	70%
• Inpatient	after deductible	After deductible	After deductible
• Outpatient – including, but not limited to X-Ray, Lab and other Diagnostic Services	90% After deductible	80% After deductible	70% After deductible
• Outpatient – CT Scan, MRI and PET Scan	90% After deductible	80% After deductible	70% After deductible

DESCRIPTION OF MEDICAL BENEFITS – HDHP	ST. LUKE'S NETWORK Tier 1	UNITED HEALTHCARE NETWORK Tier 2	OUT OF NETWORK Tier 3
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	90% After Tier 1 deductible	90% After Tier 1 deductible	90% After Tier 1 deductible
Urgent Care Facility	90% After deductible	80% After deductible	70% After deductible
Pre-Admission Testing	90% After deductible	80% After deductible	70% After deductible
Outpatient Surgery At Hospital or Ambulatory Surgical Center • Facility	90% After deductible	80% After deductible	70% After deductible
• Surgeon and Anesthesiologist • Pathologist and Radiologist	90% After Tier 1 deductible		70% After deductible
Voluntary Second Surgical Opinion • Primary Care Physician	90% After Tier 1 deductible		70% After deductible
• Specialist	90% After Tier 1 deductible		70% 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	90% After Tier 1 deductible		70% After deductible
- Specialist	90% After Tier 1 deductible		70% 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.	90% After Tier 1 deductible		70% After deductible
Labs Performed Outside Physician Office – Diagnostic	90% After deductible	80% After deductible	70% After deductible

DESCRIPTION OF MEDICAL BENEFITS – HDHP	ST. LUKE'S NETWORK Tier 1	UNITED HEALTHCARE NETWORK Tier 2	OUT OF NETWORK Tier 3
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		70% After deductible
- Physician	100% No deductible		100% After deductible
• 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		70% After deductible
- Physician	100% No deductible		100% No deductible
• Mammograms - Facility	100% No deductible		70% 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		70% 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		70% After deductible
- Physician	100% No deductible		100% No deductible

DESCRIPTION OF MEDICAL BENEFITS – HDHP	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		70% 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		70% After deductible
Mental/Nervous Disorders • Inpatient Treatment - Partial/Day program - Residential Treatment Facility	90% After Tier 1 deductible		70% After deductible
• Outpatient Treatment - Primary Care Physician	90% After Tier 1 deductible		70% After deductible
- Specialist	90% After Tier 1 deductible		70% After deductible
Alcoholism and Drug Abuse • Inpatient Treatment - Partial/Day program - Residential Treatment Facility	90% After Tier 1 deductible		70% After deductible
• Outpatient Treatment - Primary Care Physician	90% After Tier 1 deductible		70% After deductible
- Specialist	90% After Tier 1 deductible		70% After deductible
Skilled Nursing Facility All stays are pre-certified for medical necessity.	90% After deductible	80% After deductible	70% 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.	90% After deductible*	80% After deductible*	70% 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).	90% After deductible	80% After deductible	70% After deductible
Hospice Care Services • Inpatient (See pre-certification requirements)	90% After deductible	80% After deductible	70% After deductible
• Outpatient	90% After deductible	80% After deductible	70% After deductible
Private Duty Nursing $5,000 maximum per Calendar Year for all Inpatient and Outpatient private duty nursing combined (excludes custodial care). • Inpatient	50% After deductible	50% After deductible	50% After deductible

DESCRIPTION OF MEDICAL BENEFITS – HDHP	ST. LUKE'S NETWORK Tier 1	UNITED HEALTHCARE NETWORK Tier 2	OUT OF NETWORK Tier 3
Private Duty Nursing (Continued) • Outpatient	90% After deductible	90% After 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	90% After Tier 1 deductible		
Physical Therapy Maximum of 60 visits in combination with occupational therapy and speech therapy. • Facility	90% After deductible	80% After deductible	70% After deductible
• Physician - Primary Care Physician	90% After Tier 1 deductible		70% After deductible
- Specialist	90% After Tier 1 deductible		70% After deductible
Occupational Therapy Maximum of 60 visits in combination with physical therapy and speech therapy. • Facility	90% After deductible	80% After deductible	70% After deductible
• Physician - Primary Care Physician	90% After Tier 1 deductible		70% After deductible
- Specialist	90% After Tier 1 deductible		70% After deductible
Speech Therapy Maximum of 60 visits in combination with physical therapy and occupational therapy. • Facility	90% After deductible	80% After deductible	70% After deductible
• Physician - Primary Care Physician	90% After Tier 1 deductible		70% After deductible
- Specialist	90% After Tier 1 deductible		70% After deductible
Habilitation Services	90% After deductible	80% After deductible	70% After deductible

DESCRIPTION OF MEDICAL BENEFITS – HDHP	ST. LUKE'S NETWORK Tier 1	HEALTHCARE NETWORK Tier 2	OUT OF NETWORK Tier 3
Inhalation Therapy and Radiation Therapy • Facility	90% After deductible	80% After deductible	70% After deductible
• Physician - Primary Care Physician	90% After Tier 1 deductible		70% After deductible
- Specialist	90% After Tier 1 deductible		70% After deductible
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.	80% After Tier 2 deductible		70% After deductible
Artificial Limbs/Prosthesis	80% After Tier 2 deductible		70% After deductible
Chiropractic Care	Not Covered		
All Other Covered Facility Charges	90% After deductible	80% After deductible	70% After deductible
All Other Covered Physician Charges	90% After Tier 1 deductible		70% After deductible
Services for Inpatient Neonatal Intensive Care Unit, Inpatient Pediatric Intensive Care Unit, Inpatient Burns and Inpatient Eating Disorders	90% After Tier 1 deductible		70% 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 – 30 Day** Generic Preferred Brand Non-Preferred Brand	Pharmacy Out of Pocket Maximum	Pharmacy Out of Pocket Maximum	Pharmacy Out of Pocket Maximum
• **Specialty Tier** – 30 Day All specialty prescriptions must be filled through MedImpact or at St. Luke's Hospital pharmacy	Pharmacy Out of Pocket Maximum	Pharmacy Out of Pocket Maximum	Pharmacy Out of Pocket Maximum
• **Mail Order – 90 Day** Generic Preferred Brand Non-Preferred Brand	Pharmacy Out of Pocket Maximum	Pharmacy Out of Pocket Maximum	Pharmacy Out of Pocket Maximum

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.
4. You are eligible to participate in a Health Savings Account (HSA) if you enroll in the HDHP. Revised 9/20

UMR: ST. LUKE'S HOSPITAL: 7670-00-410532 003, 004 High Deductible Plan

Coverage for: Individual + Family | Plan Type: HDHP

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?	$1,400 person / $2,800 family Tier 1 $3,500 person / $6,000 family Tier 2 $4,200 person / $7,400 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?	$1,900 person / $3,800 family Tier 1 $5,500 person / $10,000 family Tier 2 $6,700 person / $12,400 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	10% Coinsurance	10% Coinsurance	30% Coinsurance	none
	Specialist visit	10% Coinsurance	10% Coinsurance	30% Coinsurance	none
	Preventive care/screening/ immunization	P Physician – No charge Facility – No charge	Physician – No charge Facility – No charge	Physician - 100% Facility – 30%	none
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance	20% Coinsurance	30% Coinsurance	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)	
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	20% Coinsurance	30% Coinsurance	none
If you need drugs to treat your illness or condition.	Generic drugs	Pharmacy Out of Pocket Maximum	Pharmacy Out of Pocket Maximum	Pharmacy Out of Pocket Maximum	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	Pharmacy Out of Pocket Maximum	Pharmacy Out of Pocket Maximum	Pharmacy Out of Pocket Maximum	
	Non-preferred brand drugs	Pharmacy Out of Pocket Maximum	Pharmacy Out of Pocket Maximum	Pharmacy Out of Pocket Maximum	
	Specialty drugs	Pharmacy Out of Pocket Maximum	Pharmacy Out of Pocket Maximum	Pharmacy Out of Pocket Maximum	

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)	10% Coinsurance	20% Coinsurance	30% Coinsurance	————none————
	Physician/surgeon fees	10% Coinsurance	10% Coinsurance	30% Coinsurance	Tier 1 deductible applies to Tier 2 benefits.
If you need immediate medical attention	Emergency room care	10% Coinsurance	10% Coinsurance	10% Coinsurance	Tier 1 deductible applies to Tier 2 & 3 benefits.
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	10% Coinsurance	Tier 1 deductible applies to Tier 2 & 3 benefits.
	Urgent care	10% Coinsurance	20% Coinsurance	30% Coinsurance	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	20% Coinsurance	30% Coinsurance	Prior authorization is required or benefits could be reduced by $500 per admission
	Physician/surgeon fee	10% Coinsurance	10% Coinsurance	30% 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	10% Coinsurance	10% Coinsurance	30% Coinsurance	Tier 1 deductible applies to Tier 2
	Inpatient services	10% Coinsurance	10% Coinsurance	30% 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	10% Coinsurance postnatal	10% Coinsurance postnatal	30% Coinsurance	Deductible Waived Tiers 1 & 2 for prenatal care. Tier 1 deductible applies to Tier 2 benefits for physician.
	Childbirth/delivery professional services	10% Coinsurance	20% Coinsurance facility 10% Coinsurance physician	30% Coinsurance	
	Childbirth/delivery facility services	10% Coinsurance	20% Coinsurance facility 10% Coinsurance physician	30% 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	10% Coinsurance	20% Coinsurance	30% Coinsurance	90 Maximum visits per calendar year combined with Hospice Outpatient; Prior authorization is required
	Rehabilitation services	10% Coinsurance	20% Coinsurance	30% Coinsurance	Tier 1 deductible applies to Tier 2 benefits physician; 60 Maximum visits per calendar year combined for
	Habilitation services	10% Coinsurance	20% Coinsurance	30% Coinsurance	——————none——————
	Skilled nursing care	10% Coinsurance	20% Coinsurance	30% Coinsurance	Prior authorization required.
	Durable medical equipment	20% Coinsurance	20% Coinsurance	30% 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	10% Coinsurance	20% Coinsurance	30% 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	10% Coinsurance	10% Coinsurance	30% Coinsurance	Tier 1 deductible applies to Tier 2 benefits; 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	$1400
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$1,400
Copayments	$0
Coinsurance	$1,280
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$2,680

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

The plan's overall deductible	$1400
Specialist coinsurance	10%
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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,400
Copayments	$0
Coinsurance	$740
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,140

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

The plan's overall deductible	$1400
Specialist coinsurance	10%
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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,400
Copayments	$0
Coinsurance	$190
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,590

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.