UMR: SCHOOL DISTRICT OF LOMIRA: 76-440234 001, PLAN 1

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

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 18008269781. 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?	**$3,000** person / **$6,000** family	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?	**$3,000** person / **$6,000** family annual deductible & coinsurance out-of-pocket maximum **$1,000** person / **$2,000** family annual copay out-of-pocket maximum	The out-of-pocket limit is the most you could pay in a year for covered services. 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 18008269781 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 costs shown in this chart are applied before the deductible; coinsurance costs are applied after your deductible has been met, as applicable.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		EPO (You will pay the least)	Non-EPO (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 Copay per visit	Not covered	None
	Specialist visit	$25 Copay per visit	Not covered	None
			Not covered Preventive care	You may have to pay for services

	Preventive care/screening/ immunization	No charge; Deductible Waived	& screening; No charge; Deductible Waived Immunizations	that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.caremark.com.	Generic drugs (Tier 1)	$10 for a 30 day supply, retail; $30 for a 31-90 day supply, retail; $20 for up to a 90 day supply, mail order	$10 for a 30 day supply, retail; $30 for a 31-90 day supply, retail; $20 for up to a 90 day supply, mail order	Deductible waived. Covered prescriptions on the Value Priced Drug List have no copay. Separate prescription drug maximum out of pocket limit: $2000/person $4000/family. *This is in addition to the maximum out of pocket limits shown on page 1.* *Specialty prescriptions can only be obtained through a CVS Pharmacy or by CVS Caremark mail order to a maximum 30 day supply.
	Preferred brand drugs (Tier 2)	$25 for a 30 day supply, retail; $75 for a 31-90 day supply, retail; $50 for up to a 90 day supply, mail order	$25 for a 30 day supply, retail; $75 for a 31-90 day supply, retail; $50 for up to a 90 day supply, mail order	
	Non-preferred brand drugs (Tier 3)	$50 for a 30 day supply, retail; $150 for a 31-90 day supply, retail; $100 for up to a 90 day supply, mail order	$50 for a 30 day supply, retail; $150 for a 31-90 day supply, retail; $100 for up to a 90 day supply, mail order	
	Specialty drugs (Tier 4)	Applicable copay tier applies*	Applicable copay tier applies*	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$250 Copay per visit	$250 Copay per visit	Copay may be waived if admitted
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$100 Copay per visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization is required.
	Physician/surgeon fee	No charge	Not covered	None
If you have mental health, behavioral health, or	Outpatient services	$10 Copay per office visit; No charge other outpatient services	$10 Copay per office visit; No charge other outpatient services	None

substance abuse needs				
	Inpatient services	No charge	Not covered	Preauthorization is required.
If you are pregnant	Office visits	No charge; Deductible Waived	Not covered	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	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	None
	Rehabilitation services	$10 Copay per visit	Not covered	None
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	No charge	Not covered	60 Maximum days per confinement; Preauthorization is required.
	Durable medical equipment	No charge	Not covered	Preauthorization is required for DME in excess of $1,000 for rentals or for purchases.
	Hospice service	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge; Deductible Waived	No charge; Deductible Waived	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	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)
- Infertility treatment
- Long-term care
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (EPO only)
- Hearing aids (to age 18) (EPO only)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Outpatient care) (EPO only)
- Routine eye care (adult)
- Weight loss programs (EPO only)

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 18003182596.

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
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.

This is only a summary. It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

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

About these Coverage Examples:

- **The plan's overall deductible $3,000**
- **Specialist copayment $25**
- **Hospital (facility) coinsurance 0%**
- **Other coinsurance 0%**

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	$3,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$3,100**

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
(normal pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$3,000**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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*	$1,100
Copayments	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,210**

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

- **The plan's overall deductible** **$3,000**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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

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

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,600
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.