# UMR: PPSTA BENEFIT TRUST: 76-413273 001

**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 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?** | **$183** person / **$366** person + one / **$549** family In-network<br>**$1,000** person / **$3,000** family Out-of-network | 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?** | **$2,250** person / **$3,500** family In-network<br>**$2,500** person / **$5,000** family Out-of-network | 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, deductibles, 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 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 |
|---|---|---|---|---|
| | | In-network (You will pay the least) | Out-of-network (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 | $25 Copay per visit | 30% Coinsurance | None |
| | Specialist visit | $25 Copay per visit | 30% Coinsurance | None |
| | Preventive care/screening/ immunization | No charge; Deductible Waived | 30% Coinsurance | 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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge; Deductible Waived labs; $25 Copay per visit x-rays for charges up to $2,500; $100 Copay per visit x-rays for charges over $2,500 | 30% Coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | $25 Copay per visit for charges up to $2,500; $100 Copay per visit for charges over $2,500 | 30% Coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% up to a $250 Maximum of the total cost of the service. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network (You will pay the least) | Out-of-network (You will pay the most) | |
| **If you need drugs to treat your illness or condition.**<br><br>More information about prescription drug coverage is available at www.umr.com. | Generic drugs (Tier 1) | $10 Copay per prescription (retail); $20 Copay per prescription (mail order) | If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount. | **$1,820** person / **$3,640** family annual Maximum out-of-pocket per calendar year<br><br>Covers up to a 31-day supply (retail); 32-90 day supply (mail order); Covers up to a 30-day supply (specialty)<br><br>You must pay the difference in cost between Generic drug and Brand-name drug when a medical professional has not specified a Brand-name drug or has not indicated that the Brand-name drug is necessary, until the Out-of-pocket is met |
| | Preferred brand drugs (Tier 2) | $35 Copay per prescription (retail); $70 Copay per prescription (mail order) | | |
| | Non-preferred brand drugs (Tier 3) | $70 Copay per prescription (retail); $140 Copay per prescription (mail order) | | |
| | Specialty drugs (Tier 4) | $50 Copay per prescription | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge; Deductible Waived | 30% Coinsurance | None |
| | Physician/surgeon fees | No charge; Deductible Waived | 30% Coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $100 Copay per visit; Deductible Waived True ER; $200 Copay per visit; Deductible Waived Non-true ER | $100 Copay per visit; Deductible Waived True ER; $200 Copay per visit; Deductible Waived Non-true ER | Copay may be waived if admitted directly from ER |
| | Emergency medical transportation | No charge; Deductible Waived Ambulance ground; $500 Copay per occurrence Ambulance air True ER; 50% Coinsurance Non-true ER | No charge; Deductible Waived Ambulance ground; $500 Copay per occurrence Ambulance air True ER; 50% Coinsurance Non-true ER | None |
| | Urgent care | $25 Copay per visit | 30% Coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network (You will pay the least) | Out-of-network (You will pay the most) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $500 Copay per admission; Deductible Waived | $500 Copay per admission; 30% Coinsurance; Deductible Waived | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% up to a $250 Maximum of the total cost of the service. |
| | Physician/surgeon fee | $25 Copay per visit | 30% Coinsurance | None |
| **If you have mental health, behavioral health, or substance abuse needs** | Outpatient services | $25 Copay per office visit; No charge other outpatient services | 30% Coinsurance | None |
| | Inpatient services | $500 Copay per admission; Deductible Waived | $500 Copay per admission; 30% Coinsurance; Deductible Waived | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% up to a $250 Maximum of the total cost of the service. |
| **If you are pregnant** | Office visits | No charge; Deductible Waived | 30% Coinsurance | 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 | $25 Copay per visit | 30% Coinsurance | |
| | Childbirth/delivery facility services | $500 Copay per admission; Deductible Waived | $500 Copay per admission; 30% Coinsurance; Deductible Waived | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-network (You will pay the least) | Out-of-network (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | $25 Copay per visit | 30% Coinsurance | 200 Maximum visits per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% up to a $250 Maximum of the total cost of the service. |
| | Rehabilitation services | $25 Copay per visit | 30% Coinsurance | 30 Maximum visits per calendar year |
| | Habilitation services | Not covered | Not covered | None |
| | Skilled nursing care | $500 Copay per admission; Deductible Waived | $500 Copay per admission; 30% Coinsurance; Deductible Waived | 100 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% up to a $250 Maximum of the total cost of the service. |
| | Durable medical equipment | No charge; Deductible Waived | 30% Coinsurance; Deductible Waived | Preauthorization is required for DME in excess of $500 for rentals or purchases. If you don't get preauthorization, benefits could be reduced by 50% up to a $250 Maximum per occurrence. |
| | Hospice service | No charge | 30% Coinsurance | 210 Maximum days per lifetime; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% up to a $250 Maximum of the total cost of the service. |
| **If your child needs dental or eye care** | Children's eye exam | $25 Copay per visit; Deductible Waived | 30% Coinsurance | 1 Maximum exam per calendar year |
| | 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.) | | |
|---|---|---|
| • Cosmetic surgery | • Long-term care | • Weight loss programs |
| • Dental care (Adult) | • Routine foot care | |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture | • Hearing aids | • Private-duty nursing (Outpatient care) |
| • Bariatric surgery | • Infertility treatment | • Routine eye care (Adult) |
| • Chiropractic care | • Non-emergency care when traveling outside the U.S. | |

**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 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. 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** | **$183** |
| ▪ **Specialist copayment** | **$25** |
| ▪ **Hospital (facility) copayment** | **$500** |
| ▪ **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 | $183 |
| Copayments | $600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |

| | |
|---|---|
| **The total Peg would pay is** | **$783** |

(a year of routine in-network care of a well-controlled condition)

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

| | |
|---|---|
| ▪ **The plan's overall deductible** | **$183** |
| ▪ **Specialist copayment** | **$25** |
| ▪ **Hospital (facility) copayment** | **$500** |
| ▪ **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* | $183 |
| Copayments | $1,700 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |

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

| The total Joe would pay is | $1,903 |
|---|---|

- **The plan's overall deductible** **$183**
- **Specialist copayment** **$25**
- **Hospital (facility) copayment** **$500**
- **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 |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $80 |
| Copayments | $200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$280** |

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.