UMR: SCHOOL DISTRICT OF BONDUEL: 76-440185 001

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**?	$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 medial 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 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 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	$25 Copay per visit	Not covered	None
	Specialist visit	$25 Copay per visit	Not covered	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	Not covered Preventive care & screening; No charge; Deductible Waived Immunizations	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	Not covered	None
	Imaging (CT/PET scans, MRIs)	$100 Copay per day	Not covered	None

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 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; $20 for a 31-90 day supply, retail; $20 for up to a 90 day supply, mail order	$10 for a 30-day supply retail; $20 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. There is no copay for diabetic test strips, lancets or syringes. Separate prescription drug out-of-pocket maximum: $2,000 person / $4,000 family. *This is in addition to the maximum out of pocket shown on page 1.* *Specialty prescriptions can only be obtained through a retail CVS Pharmacy or by CVS Caremark mail order to a maximum of a 30-day supply.
	Preferred brand drugs (Tier 2)	$30 for a 30-day supply, retail; $60 for a 31-90 day supply, retail; $60 for up to a 90 day supply, mail order	$30 for a 30-day supply, retail; $60 for a 31-90 day supply, retail; $60 for up to a 90 day supply, mail order	
	Non-preferred brand drugs (Tier 3)	$60 for a 30-day supply, retail; $120 for a 31-90 day supply, retail; $120 for up to a 90 day supply, mail order	$60 for a 30-day supply, retail; $120 for a 31-90 day supply, retail; $120 for up to a 90 day supply, mail order	
	Specialty drugs (Tier 4)	$100 for up to a 30-day supply*	$100 for up to a 30-day supply*	
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	$200 Copay per visit	$200 Copay per visit	Copay may be waived if admitted
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$25 Copay per visit	Not covered	None

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 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 substance abuse needs	Outpatient services	$25 Copay per office visit; No charge other outpatient services	$25 Copay per office visit; No charge other outpatient services	None
	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	

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 need help recovering or have other special health needs	Home health care	No charge	Not covered	None
	Rehabilitation services	$25 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