UMR:ARCHDIOCESE OF DUBUQUE: 7670-00-411618 004

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?	**$2,500** person / **$5,000** family In-network **$2,750** person / **$5,500** family Out-of-network Copayments do not apply to the **deductible**.	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?	**$5,000** person / **$10,000** family In-network **$5,500** person / **$11,000** family Out-of-network Rx Out-of-Pocket Maximums: **$3,200** person/ **$6,400** family	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.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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	20% Coinsurance $10 copay for Teladoc	30% Coinsurance	Deductible Waived In-network To schedule a Teladoc visit you must set up your account at www.Teladoc.com or by calling 1-800-Teladoc.
	Specialist visit	20% Coinsurance; Chiropractic care; Not covered Acupuncture	30% Coinsurance	Deductible Waived In-network Chiropractic care
	Preventive care/screening/ immunization	No charge	No charge	Deductible Waived
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	30% Coinsurance	Deductible Waived In-network
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	30% Coinsurance	Deductible Waived In-network

[* For more information about limitations and exceptions, see the plan document.]

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. More information about prescription drug coverage is available at: www.medone-rx.com	Generic drugs	20% Coinsurance with $20 maximum per fill	Not Covered	Rx Out-of-Pocket Maximums **$3,200** Rx for Individuals **$6,400** for Rx for Families Retail Pharmacy 90-day supply: Generic: 20% up to $60 maximum per fill Non-specialty brands: 20% up to $180 maximum per fill Mail-order Pharmacy 90-day supply: Generic: 20% up to $40 maximum per fill Non-specialty brands: 20% up to $120 maximum per fill Accucheck and TrueTest diabetic testing strips are a generic copay. Note: Walgreens and Walmart/Sam's Club are excluded from the network.
	Brand drugs	20% Coinsurance with $60 maximum per fill	Not Covered	
	Specialty drugs	20% Coinsurance with $400 maximum per fill	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	30% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	30% Coinsurance	None
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	In-network Deductible applies to Out-of-network benefits
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	In-network Deductible applies to Out-of-network benefits
	Urgent care	20% Coinsurance	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)	20% Coinsurance	30% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefit reduces by 50% up to a $500 Maximum per claim
	Physician/surgeon fee	20% Coinsurance	30% Coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	20% Coinsurance	30% Coinsurance	Deductible Waived In-network office visit.
	Inpatient services	20% Coinsurance	30% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefit reduces by 50% up to a $500 Maximum per claim
If you are pregnant	Office visits	No charge Prenatal; 20% Coinsurance Postnatal	30% Coinsurance	Deductible Waived Prenatal
	Childbirth/delivery professional services	20% Coinsurance	30% Coinsurance	None
	Childbirth/delivery facility services	20% Coinsurance	30% Coinsurance	None

[* For more information about limitations and exceptions, see the plan document.]

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	20% Coinsurance	30% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefit reduces by 50% up to a $500 Maximum per claim
	Rehabilitation services	20% Coinsurance	30% Coinsurance	Deductible Waived In-network office therapy
	Habilitation services	20% Coinsurance	30% Coinsurance	None
	Skilled nursing care	20% Coinsurance	30% Coinsurance	90 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefit reduces by 50% up to a $500 Maximum per claim
	Durable medical equipment	20% Coinsurance	30% Coinsurance	Preauthorization is required for DME in excess of $500 for rentals or $1,500 for purchases or benefit reduces by 50% up to a $500 Maximum per claim.
	Hospice service	20% Coinsurance	30% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Deductible Waived; 1 Maximum exam per calendar year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

[* For more information about limitations and exceptions, see the plan document.]

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Outpatient only – covered for Home Health Care only)
- 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.HealthCare.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 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.HealthCare.gov.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-826-9781.

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

[* For more information about limitations and exceptions, see the plan document.]

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	$2,500
Specialist copayment	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$2,500
Copayments	$0
Coinsurance	$1,866
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,366**

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

The plan's overall deductible	$2,500
Specialist copayment	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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*	$2,500
Copayments	$0
Coinsurance	$960
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,460**

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

The plan's overall deductible	$2,500
Specialist copayment	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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*	$1,200
Copayments	$0
Coinsurance	$140
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,340**

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.