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, www.healthplanoperations@umchealthsystem.com or by calling 806-775-8793. 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.UMCHealthsystem.com or call 806-775-8793 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$750	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes.	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?	Individual $9,100 Family $18,200	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, coinsurance for gastric bypass surgery and pain management, 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.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

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
		Network Provider (You will pay the least)	Out-of-Network Provider (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	$30	100%	See plan document
	Specialist visit	$60	100%	See plan document
	Preventive care/screening/ immunization	No Charge	100%	See plan document
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	100%	See plan document
	Imaging (CT/PET scans, MRIs)	$200	100%	See plan document
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at [www.umchealthplanoperations.com]	Generic drugs	$35 Copay per prescription	100%	See plan document
	Brand name formulary drugs	The greater of 20% or $55 Copay per prescription	100%	See plan document
	Brand name non-formulary drugs	The greater of 20% or $75 Copay per prescription	100%	See plan document
	Formulary excluded drugs	Not covered	Not covered	See plan document
	Specialty drugs	See above	100%	See plan document
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$400/per admission	100% non emergent	For a list of required pre-authorizations see plan document.
	Physician/surgeon fees	No Charge	100% non-emergent	See plan document
If you need immediate medical attention	Emergency room care	$500 visit	$500 visit, emergent only	Emergency room copay is waived if admitted to Hospital.
	Emergency medical transportation	$200 trip	100% non emergent	Ambulance services subject to Plan review for medical necessity.
	Urgent care	$30 visit	100%	See plan document
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 per day, $2500 max	100% non emergent	Pre-authorization is required.
	Physician/surgeon fees	No Charge	100% non emergent	See plan document

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental/Behavioral $30 visit PCP/$60 visit specialist Substance $60 visit	100%	Mental/Behavioral -Limited to 20 outpatient visits per plan year, Serious mental illness 60 outpatient visits per plan year. Substance - Limited to 60 outpatient visits per plan year and 3 series of treatments per lifetime
	Inpatient services	Mental/Behavioral $500/per day, $2500 max Substance 20% co-insurance	100% non emergent	Mental/Behavioral - 15 days per contract year, Serious mental illness 45 days. Substance - Limited to 30 days per treatment, 3 treatments per lifetime.
If you are pregnant	Office visits	$30	100%	One time only.
	Childbirth/delivery professional services	No Charge	100%	See plan document
	Childbirth/delivery facility services	$500/per day, $2500 max	100% non emergent	See plan document
If you need help recovering or have other special health needs	Home health care	20% co-insurance per day	100%	See plan document
	Rehabilitation services	$15/visit	100%	See plan document
	Habilitation services	$15/visit	100%	See plan document
	Skilled nursing care	$500/per day, $2500 max	100%	Waived if transferred from inpatient
	Durable medical equipment	25% co-insurance	100%	Co-insurance applies per piece or equipment or supply
	Hospice services	No Copay	100%	See plan document
If your child needs dental or eye care	Children's eye exam	No charge	100%	Routine service
	Children's glasses	Not covered	Not covered	Coverage is through Superior Vision not health plan.
	Children's dental check-up	$0-$150-0%, $150-$500-20%, $500-$1500-50%	$0-$150-0%, $150-$500-20%, $500-$1500-50%	See plan document for dental limitations.

[* For more information about limitations and exceptions, see the plan or policy document at [www.umchealthsystem.com\foremployees\healthplan].]

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
- Chiropractic care
- Cosmetic surgery
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss program

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

- Bariatric surgery
- Dental care
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine foot care (diabetic)

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? [Yes/No]
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 Standards? [Yes/No]
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 [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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

[* For more information about limitations and exceptions, see the plan or policy document at [www.umchealthsystem.com\foremployees\healthplan].]

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	$750
Specialist *copay*	$60
Hospital (facility) *copay*	$500
Other *[cost sharing]*	%

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	$12,731

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$1060
Coinsurance	$
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1870

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

The plan's overall deductible	$750
Specialist *[cost sharing]*	$60
Hospital (facility) *[cost sharing]*	$500
Other *[cost sharing]*	%

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	$7,389

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$2250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$3060

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

The plan's overall deductible	$750
Specialist *[cost sharing]*	$60
Hospital (facility) *[cost sharing]*	$500
Other *[cost sharing]*	%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,925

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$865
Coinsurance	$49
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	$1664

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